VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 45

(Pages 715-1434)

This volume is a compilation of Orders of the Oregon Workers' Compensation Board and decisions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

Owing to space considerations, this volume omits Orders issued by the Workers' Compensation Board that are judged to be of no precedental value.

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CITE AS

45 Van Natta ___ (1993)

In the Matter of the Compensation of
CHARLES L. BENNETT, Claimant
WCB Case No. 91-18185
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Garaventa's order which upheld the self-insured employer's denial of his occupational disease claim for a bilateral foot condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

We modify the Referee's first complete paragraph on page 2 of her order as follows. Dr. Clawson diagnosed metatarsalgia. In addition, he found objective evidence of the following: forefoot valgus, hammertoes, plantarly prominent metatarsals, and diffuse hyperkeratosis about the heels and the balls of his feet. (Ex. 1).

In lieu of the last sentence of the fourth complete paragraph on page 2 of the Referee's order, we make the following findings. Dr. Young recommended treatment of additional padding in either the work area or claimant's shoes, or preferably, redesign of the safety switch. He felt that claimant's feet were physiologically normal.

Of the Referee's findings of ultimate fact, we adopt only the first sentence.

CONCLUSIONS OF LAW AND OPINION

In order to establish compensability of his occupational disease claim, claimant must show that work activities or conditions were the major contributing cause of his diagnosed foot condition or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2). An "occupational disease" includes any series of traumatic events or occurrences which requires medical services or results in disability. ORS 656.802(1)(c).

The threshold question is to identify the "occupational disease" from which claimant suffers. Claimant asserts that his occupational disease claim is for metatarsalgia and plantar fascitis. Dr. Clawson, a podiatrist who initially treated claimant, diagnosed metatarsalgia. (Exs. 1, 2A). Dr. Fields, a podiatrist who subsequently treated claimant, diagnosed plantar fascitis and metatarsalgia, or simply "painful feet." (Exs. 4A, 7-2). Dr. Young, an orthopedist who evaluated claimant on referral from Dr. Fields, diagnosed postural foot ache in otherwise "basically excellent feet." (Ex. 6-2.).

The employer denied the following conditions: forefoot valgus, hammertoes, plantarly prominent metatarsals and diffuse hyperkeratosis. (Ex. 4-1). These conditions were identified by Dr. Clawson as part of his objective findings in his examination of claimant. (Ex. 1). There is no evidence, however, that these conditions in themselves were a disease or infection. Indeed, Dr. Young found claimant's feet to be physiologically normal. (Ex. 6-2). Moreover, claimant testified that he had never previously had this type of problem with his feet, even though he has worked for the employer for 35 years. (Tr. 12, 19). Accordingly, we conclude that claimant's occupational disease is plantar fascitis and metatarsalgia, or painful feet, not the congenital or compensatory foot conditions identified by Dr. Clawson. See Tucker v. Liberty Mutual Ins. Co., 87 Or App 607 (1987).

We find that claimant has met his burden of proving that work conditions were the major contributing cause of his occupational disease. Both Dr. Fields and Dr. Young identify claimant's work conditions, specifically his prolonged, inactive stance and trauma to the plantar area of his feet, as the cause of his painful feet. Dr. Clawson does not contradict this opinion. (See Ex. 3). Indeed, Dr. Clawson wrote to the employer requesting either a job change for claimant, or a change in the saw switch. (Ex. 5).

Dr. Fields found upon palpation a very tender and painful area around the metatarsal heads and along the plantar arch and plantar fascial area. (Exs. 4A, 7-1). These are objective findings. See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). All three medical providers recommended treatment in the form of orthotics or modification of the work site or claimant's work activities. Accordingly, we conclude that claimant's occupational disease claim for plantar fascitis and metatarsalgia, or "painful feet," 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 $3,250, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 4, 1992 is reversed. The self-insured employer's denial is set aside, and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,250, payable by the self-insured employer.

In the Matter of the Compensation of
ALEDA BROOKS, Claimant
WCB Case No. 92-03118
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Davis, et al., Defense Attorneys

Reviewed by Board Members Hooton and Lipton.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of her claim for a right toe injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant stubbed her right toe at work on January 15, 1992, but concluded there is insufficient evidence to prove that claimant's subsequent need for treatment resulted from that incident. We disagree.

To establish a compensable injury claimant has the burden of proving by a preponderance of the evidence that a work-related injury was a material contributing cause of disability or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

It is undisputed that: (1) claimant stubbed her toe at work on January 15, 1992; (2) a fractured toe was subsequently diagnosed; and (3) claimant was disabled from work and required treatment due to the fracture. The central issue in this case is whether or not the stubbing incident was a material contributing cause of the fracture.

There is ample evidence in the record that claimant experienced severe pain as a result of the stubbing incident. Claimant testified that she felt "extreme" pain following the incident. (Tr. 5). Her testimony is corroborated by her supervisor, Arnesen, who testified to hearing claimant say "Ow" and then explain that she had just stubbed her toe and it "hurts like heck." (Tr. 29). Arnesen also testified that she observed claimant favoring her right foot about an hour or two later. (Tr. 29-30. Claimant's co-worker, Asch, testified that claimant told her about the stubbing incident later that same day and mentioned that her toe "really hurts." (Tr. 39).

Notwithstanding the aforementioned evidence, the Referee was not persuaded that the stubbing incident resulted in the fracture because: (1) there is evidence that claimant had a painful right toe prior to the stubbing incident; and (2) claimant did not report any history of trauma to the emergency room doctor the day after the incident.

We agree that claimant had toe pain prior to the stubbing incident. Asch testified that, prior to the stubbing incident, claimant complained to her of toe pain and mentioned that it might be a blister due to rubbing against the shoe. (Tr. 38). Asch saw the toe and noted that it appeared to be inflamed. (Id.) Additionally, when claimant went to the emergency room the day after the incident, she reported increasing toe pain and swelling during the previous two days. (Exs. 1A, 2). Later, during an interview with the insurer's claims adjuster, claimant reported that her toe started to bother her before the stubbing incident. (Ex. 9-1).

We are persuaded that the pain became more severe following the stubbing incident. Claimant described the pain as "extreme." Her supervisor, Arnesen, verified that claimant complained that her toe "hurts like heck." Further, Arnesen testified that, whereas claimant did not appear to favor her right foot before the stubbing incident, she did favor it after the incident. (Tr. 30-31).

We agree with the Referee that claimant did not report any history of trauma or injury to the emergency room doctor the day after the incident. In fact, there is no history of trauma or injury reported by a doctor until Dr. Hoyal's February 3, 1992 chart note. Nevertheless, we are persuaded that claimant first reported the stubbing incident to Dr. Hoyal during her initial visit to him on January 20, 1992. In his February 3, 1992 chart note, Dr. Hoyal stated:

> [Claimant] reminded me this visit that this [injury] did occur at work. I misunderstood and failed to put it in my note of 01/20/92 and the fact that she was working on a display and stepped off of a ladder and she jammed her toe into a stack of rods and she's had the pain ever since then. That occurred on 01/15/92. (Ex. 4-1).

The most reasonable interpretation of this chart note is that claimant reported the incident during the January 20 visit, but the doctor failed to report it at that time. This interpretation is supported by claimant's testimony. (See Tr. 15).

Claimant's failure to report the stubbing incident immediately can be attributed to her perception that the stubbing incident was not a significant injurious event. Claimant indicated that she did not hit her toe very hard and was surprised when the severe pain developed. (Ex. 9-1). Further, the fracture was not diagnosed until late January or early February 1992. Until that diagnosis was made, it was suspected that claimant had an infection or inflammatory process in the toe joint. (See Ex. 4-1). Under those circumstances, claimant had no reason to suspect the stubbing incident had anything to do with her toe pain.

Finally, we reject the insurer's contention that the causation issue in this case is medically complex and, therefore, must be decided on the basis of expert medical evidence. In this regard, we note that claimant's symptoms were precipitated by a specific injurious incident at work and there is no evidence of any other injury to the toe. For these reasons, we conclude that claimant has sustained her burden of proving by a preponderance of the evidence that the toe stubbing incident at work was a material contributing cause of her subsequent disability and need for 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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 7, 1992 is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
FIDEL D. CHAVEZ, Claimant
WCB Case No. 92-04476
ORDER ON REVIEW (REMANDING)
Hollis Ransom, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Lipton.

Claimant requests review of Referee Podnar's order that dismissed his request for hearing from an Order on Reconsideration. On review, the issue is the propriety of the dismissal order. We remand.

FINDINGS OF FACT

Claimant compensably injured his back on May 16, 1989. The claim was closed by Determination Order dated December 10, 1990 that awarded temporary disability benefits, but did not award any permanent disability.

Claimant requested reconsideration of the Determination Order on May 10, 1991, 151 days after issuance of the Determination Order. An Order on Reconsideration issued September 4, 1991, which affirmed the Determination Order in all respects. Claimant requested a hearing on the Order on Reconsideration on March 17, 1992, more than 180 days after the December 10, 1990 Determination Order.

Prior to hearing, the employer moved for dismissal, contending that claimant's hearing request was untimely. Thereafter, the Referee dismissed claimant's hearing request, noting that more than ten days had passed since the employer's motion and claimant had not responded to the motion to dismiss. Claimant requested reconsideration of the Referee's Order of Dismissal on July 30, 1992. The Referee denied the request on August 3, 1992.

CONCLUSIONS OF LAW AND OPINION

On review, claimant objects to the Referee's dismissal order based on timeliness grounds. Specifically, he contends that the reconsideration order is invalid since no medical arbiter was appointed. In other words, claimant contends that the time in which to request a hearing has not yet run since the dispute currently remains with the Director. See Olga I Soto, 44 Van Natta 697 recon denied 44 Van Natta 1609 (1992). Consequently, claimant requests that we modify the Referee's order to provide that his hearing request is dismissed on the basis that jurisdiction over this matter remains with the Department.

Claimant's argument may be a valid one. We have held that, where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is a disagreement with the medical findings for impairment, then the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, supra. 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). That is, the party that requested reconsideration of a Determination Order and objected to the impairment findings may, at hearing, withdraw any objection to the impairment findings and thereby waive the right to examination by a medical arbiter. Id. In such cases, the Order on Reconsideration is not declared invalid. See Randy M. Mitchell, 44 Van Natta 2304 (1992).

In reaching our decision, we note that ORS 656.283(1) entitles claimant to request a hearing on any question concerning a claim. As a consequence, the Referee was authorized to resolve the present dispute by evaluating the validity of the reconsideration order and determining whether claimant's hearing request was timely.

Here, no evidence was taken concerning claimant's request for reconsideration of the Determination Order and the reconsideration order. No hearing was held and no exhibits were admitted. In the absence of any evidence concerning the validity of the Order on Reconsideration, we are unable to address claimant's contention. Peter L. Galiano, 44 Van Natta 1197 (1992).

We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under the circumstances, we find that the record is incompletely developed. We therefore find it appropriate to remand this matter to the Referee for further proceedings.

This matter is remanded to Referee Podnar to reopen the record for additional evidence concerning the issues raised by claimant's hearing request and the employer's motion to dismiss. This evidence should include, but is not limited to, a copy of claimant's request for reconsideration of the Determination Order. The proceedings to submit this additional evidence may be conducted in any manner that achieves substantial justice. The Referee shall then issue a final, appealable order addressing the issues raised by the parties.

ORDER

The Referee's order dated July 23, 1992 is vacated. The matter is remanded to Referee Podnar for further proceedings consistent with this order.

In the Matter of the Compensation of
LAVERA E. FOREMAN, Claimant
WCB Case Nos. 92-00931, 91-15237 & 91-18152
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Al Ludwick (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Myers' order which: (1) upheld the SAIF Corporation's December 12, 1991 denial of claimant's claim for right neck, shoulder, arm and knee injuries; (2) affirmed an Order on Reconsideration that did not award claimant unscheduled permanent disability for her low back injuries; (3) directed the SAIF Corporation to "reclassify" and process her second low back injury as a separate injury claim; and (4) declined to award claimant an assessed attorney fee for her counsel's efforts in obtaining the "reclassification." On review, the issues are compensability, extent of unscheduled permanent disability, 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 correction. In the first paragraph on page 2 of the Referee's order, the date of injury should be April 5, 1991, not May 4, 1991.

CONCLUSIONS OF LAW AND OPINION

Denial of December 12, 1991

SAIF denied claimant's claim for injury to her right shoulder, neck, arm and knee, which allegedly occurred on or about July 4, 1991. (Exs. 2, 8). Dr. Pribnow, who examined claimant on August 5, 1991, made objective findings of tenderness in the shoulder, arm and knee. (Ex. 2-1). However, he was unable to state with reasonable medical probability that claimant's work activities were a material contributing cause of her injuries. See ORS 656.005(7)(a). Dr. Pribnow could state only that "her symptoms are possibly related to work activity." (Ex. 2-2) (emphasis added). That is insufficient to carry claimant's burden of proof. Accordingly, we affirm that portion of the Referee's order which upheld SAIF's December 12, 1991 denial. [The cited exhibits are in the packet identified by WCB Case No. 91-18152, hereinafter known as "Set 1."]

Extent of Unscheduled Permanent Disability

Claimant contends that she is entitled to 5 percent impairment based on the thoracolumbar range of motion measurements made by the medical arbiter, Dr. Gritzka. (See Ex. 18-2). However, there is no evidence that the reduced ranges of motion were caused by the accepted low back injury, inasmuch as Dr. Gritzka opined that claimant "has no ratable impairment as a result of the fall on her buttocks." (Ex. 18-3); see OAR 436-35-007(1). Accordingly, we affirm that portion of the Referee's order which affirmed the Order on Reconsideration that did not award claimant any unscheduled permanent disability. [The cited exhibits are in the packet identified by WCB Case No. 92-00931, hereinafter known as "Set 2."]

Attorney Fees

Claimant requests an assessed attorney fee pursuant to ORS 656.386(1) for his services at hearing in setting aside the "de facto" denial of claimant's second low back injury claim. We agree that claimant's counsel is entitled to an assessed attorney fee.

Claimant filed a claim for compensation on May 30, 1991 for slipping and falling on a wet floor. (Set 2: Ex. 7). She sought medical treatment the following day, and Dr. Neuberg diagnosed coccygeal contusion reinjury. She noted that claimant was having a recurrence of the symptoms she had had following her April 1991 low back injury, prescribed medication and ice, and released claimant to modified work. (Set 2: Ex. 8). Claimant was released to full duty on June 18, 1991. (Set 2: Ex. 14). Although claimant testified that she was first released to full duty on June 18, 1991, the record indicates that she was released to full duty following her first low back injury on April 26, 1991. (Tr. 18; Set 1: Ex. 1D). Claimant testified that the symptoms after her first injury cleared up quickly. (Tr. 10).

SAIF never accepted or denied the second injury claim, but apparently processed it as part of the initial low back injury claim. After the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6), the claim became denied "de facto." See Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Subsequently, on October 22, 1991, claimant's counsel filed a request for hearing on the "de facto" denial. Following a hearing, the Referee effectively set aside the "de facto" denial by directing SAIF to process the second injury as a separate claim. Therefore, we find that claimant prevailed after hearing from a decision denying her claim for compensation, and her counsel is entitled to a reasonable assessed attorney fee pursuant to ORS 656.386(1). Accordingly, we reverse that portion of the Referee's order which declined to award claimant 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 in setting aside the "de facto" denial is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the record) and the value of the interest involved. In this case, we find that the value of the interest is minimal, considering that although claimant received compensation in the form of medical treatment following the second injury, both claims were closed and evaluated at the same time, and neither resulted in any permanent impairment. In addition, we note that claimant's counsel is not entitled to attorney fees on Board review for his services regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986); Amador Mendez, 44 Van Natta 736 (1992); Juan A. Garcia, 43 Van Natta 2813 (1991).

ORDER

The Referee's order dated May 12, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which declined to award claimant an assessed attorney fee is reversed. Claimant's counsel is awarded an assessed fee of $500, payable by the SAIF Corporation, for his services at hearing in setting aside the "de facto" denial of claimant's May 30, 1991 claim for compensation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DAVID L. GARDENHIRE, Claimant
WCB Case No. 91-12588
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant requests review of Referee Howell's order that dismissed claimant's hearing request regarding a November 19, 1990 Notice of Closure. On review, the issue is dismissal.

We affirm and adopt the Referee's order with one correction. All feminine pronouns used to describe claimant are replaced with masculine forms. Otherwise, we agree with the Referee's order in its entirety. Olga I. Soto, 44 Van Natta 697, on recon 44 Van Natta 1609 (1992); Mickey L. Platz, 44 Van Natta 1056 (1992).

ORDER

The Referee's order dated December 18, 1991 is affirmed.

Board Member Hooton dissenting.

The majority relies upon Olga I. Soto, 44 Van Natta 697, on recon 44 Van Natta 1609 (1992), and Mickey L. Platz, 44 Van Natta 1056 (1992), to support the December 18, 1991 order of Referee Howell finding that the Board and the Hearings Division lack jurisdiction to resolve the issues on this claim. I am unable to agree in that result, and therefore, respectfully dissent.

On August 9, 1990, claimant injured his right ankle in the course of his employment with Lile North American Moving Company. That injury, diagnosed as a right ankle sprain, was declared medically stationary by claimant's treating physician on October 24, 1990. The claim was closed by Notice of Closure on November 19, 1990, finding claimant entitled only to temporary disability compensation. (Ex. 10.)

On November 13, 1990, claimant's treating physician, Willis E. Peacock, M.D., opined that he had released claimant to return to work on October 22, 1990 without restrictions stating that "in my opinion he was well." However, later in that same report, he expresses the opinion that "he will go to work and get well as soon as he finds a job." (Ex. 7, emphasis added.)

On November 15, 1990, claimant was examined, at the request of Dr. Peacock, by Grant D. Lawton, M.D., an orthopedic surgeon, who stated: "I advised the patient that he did sustain a significant sprain and the reinjury. At the same time this appears to be a stable injury and one that will likely continue to heal and resolve completely." Later in that same report Dr. Lawton stated that "the fact remains that major ankle sprains may take many months and even a year or more for full recovery." (Ex. 9-2, emphasis added.)

On November 19, 1990, simultaneous with the issuance of the Notice of Closure, Liberty Northwest Insurance Corporation, on behalf of the employer, denied responsibility for claimant's ongoing ankle condition by alleging that the condition after October 30, 1990 was due to a noncompensable injury and not the injury for which the employer and insurer were responsible. (Ex. 10A.) That denial was subsequently upheld at hearing on June 12, 1991, (Ex. 13B), and, at the time of hearing in the present claim, continued on Board review.

By Order on Reconsideration dated April 22, 1991, the Department found that claimant's claim had been prematurely closed. The Order on Reconsideration found claimant to have been medically stationary without permanent impairment on October 24, 1990, but then indicated that claimant aggravated that injury on October 30, 1990 such that claimant was not medically stationary from that aggravation at the time that the Notice of Closure issued. (Ex. 11.) The Order on Reconsideration did not account for the denial of claimant's then-current condition which had issued on November 19, 1990.

On April 26, 1991, the Department acknowledged the denial dated November 19, 1990 and abated its April 22, 1991 Order on Reconsideration "for the purpose of continuing the Reconsideration proceeding." (Ex. 13.) Because claimant had raised the issue of the correctness of the impairment findings of the treating physician, the claim was referred to a panel of medical arbiters. (Ex. 13A.)

Claimant was examined on August 15, 1991, by panel examination including Clifton Baker, M.D., Thad C. Stanford, M.D., and Berl Barth, M.D. The report was dictated on August 15, 1991 by Dr. Baker. The panel examination found that claimant continued to experience right ankle pain in the lateral ankle one year after his sprain injury. They provide a diagnosis of right ankle pain of undetermined etiology, but provide two possible diagnoses. The panel notes that it is possible that claimant's pain derives from a fracture of the dome of the talus, and recommend that claimant be studied with tomograms to rule out a fracture of the dome. The other possibility noted is that claimant may experience right sinus tarsi syndrome, and that if that is the correct diagnosis, "symptoms should clear eventually with the passage of time." In its final conclusions, the panel found that if the diagnosis is sinus tarsi syndrome of the right foot, then his case is stationary and medical treatment is not indicated. I note that the panel's use of the term stationary appears to conflict with its prior finding that "symptoms should clear eventually with the passage of time." On the other hand, the panel notes that if the appropriate diagnosis is fracture of the dome of the talus, as demonstrated by tomogram, then claimant's case is not stationary and should not be closed until further medical treatment is offered. (Ex. 14.)

On August 30, 1991, the Department issued its second Order on Reconsideration, pursuant to Benziger et al v. Department of Insurance and Finance, Multnomah County Circuit Court No. A9102-01201. That case has subsequently been upheld on appeal. Benziger v. Or Dept. of Ins. & Finance, 107 Or App 499 (1991).

On November 27, 1991, Thad C. Stanford, M.D., of the medical panel that examined claimant, provided an explanatory letter to Liberty Northwest explaining that claimant's range of motion in the right ankle should be considered as normal. (Ex. 16.)

The claim was submitted to the Referee on the medical record on December 4, 1991.

Claimant raises issues of premature claim closure and, if it is found that the claim was not prematurely closed, extent of scheduled permanent partial disability. The majority concludes that the Hearings Division lacked jurisdiction to decide the issues because the August 30, 1991 Order on Reconsideration provides no indication that the Department actually considered the August 15, 1991 findings of the panel of medical arbiters.

In Olga I. Soto, supra, we determined that where claimant challenged the impairment findings of the treating phsycian at the time of claim closure in his request for reconsideration, an order of the Department on reconsideration which failed to refer the claim for examination by a medical arbiter, or where the claim had been referred but the Order on Reconsideration issued pursuant to Benziger prior to the completion of the medical arbiter's examination, the Order on Reconsideration was invalid. Further, in Mickey L. Platz, supra, we determined that the Board and the Hearings Division lacked authority to remand an extent of disability claim to the Director to complete the reconsideration proceeding. However, in Brenton R. Kusch, 44 Van Natta 2222 (1992), we decided that, though an Order on Reconsideration of the Department may be invalid for any of the above stated reasons, it is not a void order, but a voidable one. As a consequence, to obtain the invalidation of the Order, the party whose interests were to be protected by the procedure which had not been completed must specifically seek the invalidation of the Order.

In the present claim, claimant, at hearing, did seek the invalidation of the Order on Reconsideration, and a remand to the Department for a completion of the reconsideration proceeding. The claimant alleged at that time that the Department had failed to consider the report of the panel of medical arbiters in the issuance of its Order on Reconsideration. The Referee did declare that the Order on Reconsideration was invalid, but declined to remand to the Department, a decision which we have subsequently determined to be appropriate. See Mickey L. Platz, supra.

However, I am unable to find any basis on which the Order on Reconsideration is subject to invalidation. ORS 656.268(7) outlines the procedure for obtaining the examination of a panel of medical arbiters. That statute provides in pertinent part as follows:

> "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. At the request of either of the parties, a panel of three medical arbiters shall be appointed. * * * The findings of the medical arbiter, or panel of medical arbiters, shall be submitted to the department for reconsideration of the Determination Order or Notice of Closure, and no subsequent medical evidence of the worker's impairment is admissable before the department, the board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis added.)

Pursuant to ORS 656.268(7), an Order on Reconsideration is valid where one or more of the parties has challenged the impairment findings used in closing the claim, if the claim is referred to a medical arbiter and the findings of the medical arbiter, or panel of medical arbiters, are submitted to the Department prior to the reconsideration proceeding. Nowhere in the statute is there an express requirement that the Director consider the evidence submitted by the arbiter or any other physician. While common sense dictates that the Director should consider each and every piece of information submitted to him for examination in the reconsideration proceeding, the statute does not require a reasoned order, a record, findings of fact, or any explanation from the Director of the specific evidence on which he relied in making his findings.

ORS 656.283(7) provides that the Referee, at hearing, subsequent to the issuance of an Order on Reconsideration, must determine whether "the standards adopted pursuant to ORS 656.726 for evaluation of the worker's disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268." (Emphasis added.) Consequently, the Director is not required to issue a technically perfect order before the Hearings Division has jurisdiction to resolve any further dispute regarding claimant's extent of disability. Indeed, ORS 656.283(7) specifically envisions that the Referee shall correct errors in the Order where those errors are apparent.

This is not the case anticipated or contemplated by Olga I. Soto, supra, or Mickey L. Platz, supra, in which the findings of the medical arbiter were not available at the time of issuance of the Order on Reconsideration. Rather, in this case, the panel examination was completed fifteen days prior to the Order on Reconsideration. The evidence establishes that the Director had the evaluation of the medical arbiters available to him at the time of issuance of his order. Consequently, the order is not invalid and the Referee is free to correct errors in the Order on Reconsideration which issued on August 30, 1991.

Claimant contends that the claim was prematurely closed. Claimant further contends, however, that, if we find that the claim was not prematurely closed, that claimant experiences a scheduled permanent partial disability in the right ankle equal to 5 percent for chronic conditions limiting repetitive use, or, at a minimum, 2 percent for loss of range of motion.

In order to establish that the claim was prematurely closed, claimant must establish that the condition which remains unresolved is related to the compensable injury. The Opinion and Order of the Referee upholding the aggravation denial of November 19, 1990 was affirmed and adopted by the Board on March 17, 1992. It is the law of the case in the present claim that claimant's condition after October 30, 1990 was not compensably related to the injury of August 1990, or at the very least, that a noncompensable cause contributed to the condition.

In such circumstances, claimant must establish the relationship between his current condition and the compensable injury in order to receive additional benefits. Here, claimant has failed to establish a reasonable relationship between the compensable injury and the conditions that currently cause claimant's symptoms and which are anticipated to improve with the passage of time. In addition, there is no medical report in the record which establishes a causal link between claimant's disability and the compensable injury, as distinct from the contributions of the noncompensable event. Consequently, claimant has failed to establish either that his compensable claim was prematurely closed, or that he experienced any disability as a result of the compensable injury.

In the Matter of the Compensation of
BETTY L. HARPER, Claimant
WCB Case No. 92-04025
ORDER ON REVIEW (REMANDING)
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant, pro se, requests review of Referee Crumme's order that dismissed her request for hearing because the hearing request had been withdrawn. On review, the issue is the propriety of the Referee's dismissal. We remand.

FINDINGS OF FACT

Claimant, through her attorney, requested a hearing on March 16, 1992 from SAIF's March 12, 1992 denial. A hearing was set for June 18, 1992.

By letter dated June 16, 1992, claimant's counsel withdrew the request for hearing. No hearing took place. The Referee entered a dismissal order on June 29, 1992, on the grounds that the hearing request had been withdrawn.

On July 20, 1992, the Board received claimant's July 10, 1992 response to the Referee's order. Claimant's letter, addressed to Referee Crumme', began by stating, "I still wish to reopen my claim even tho [sic] claimant's former attorney will not be representing me." In a subsequent letter to the Board, claimant wrote that she wished to appeal her case because all the facts previously had not been addressed.

CONCLUSIONS OF LAW AND OPINION

A Referee shall dismiss a request for hearing if the claimant and his or her attorney fail to attend a scheduled hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-072(2). A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. We have previously held that a referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we treated a post-hearing request to reschedule a hearing as a motion for postponement.

Here, in response to the Referee's June 29, 1992 dismissal order, claimant submitted a July 10, 1992 letter indicating that she was no longer represented by her former attorney, and that despite the Referee's dismissal order, she still wished to pursue reopening her claim. Claimant also objected to the Referee's order because she felt that the facts of her case had not been addressed. Because there is no record for our review, we cannot determine whether claimant in fact authorized her attorney to withdraw the request for hearing, or whether there are any extraordinary circumstances that justify claimant's failure to appear at hearing.

Considering these circumstances, we interpret claimant's letter as a motion for postponement of the scheduled hearing. Inasmuch as the Referee did not have an opportunity to rule on the motion, this matter must be remanded to the Referee for consideration of the motion. See Ray Eaglin, 43 Van Natta 1175 (1991).

In reaching this conclusion, we note that our decision should not be interpreted as a finding on whether postponement is warranted. Rather, we find that the Referee is the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Eaglin, supra.

Accordingly, the Referee's order dated June 29, 1992 is vacated. This matter is remanded to Referee Crumme to determine whether postponement of claimant's hearing request is justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will

achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the Referee. If the Referee finds that a postponement is not justified, the Referee shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH E. MURPHY, Claimant
WCB Case No. 92-01051
ORDER ON REVIEW
Steven E. Pickens, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Daughtry's order which upheld the insurer's "back-up" denial of claimant's back injury claim. On review, the issues are propriety of the insurer's "back-up" denial and, if the "back-up" denial was proper, whether claimant was an Oregon worker at the time of his injury. We reverse.

FINDINGS OF FACT

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

On February 12, 1991, the insurer accepted claimant's November 20, 1990 back injury as a lumbar strain. (Exs. 3, 4). On December 18, 1991, it issued a "back-up" denial of the claim on the ground that claimant was not a subject worker under Oregon Workers' Compensation Law. In its denial letter, the insurer alleged: "It has now come to our attention that your injury occurred while working in the state of Washington and the work site was over 3 days old." On the basis of this "new information," the insurer concluded that claimant was not a subject worker under Oregon Workers' Compensation Law, and that his claim was not compensable in Oregon. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

Before we address the merits of whether claimant was a subject worker under the Workers' Compensation Law at the time of his injury, we must determine whether the insurer was entitled to issue its "back-up" denial. The Referee held that under ORS 656.262(6), the insurer was entitled to issue a "back-up" denial. We disagree.

ORS 656.262(6) provides, in relevant part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant * * * within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable 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." (emphasis added).

We have previously recognized that the statute expresses a clear legislative intent to allow "back-up" denials, subject only to four limitations: (1) the insurer accepts the claim in "good faith"; (2) the insurer subsequently obtains evidence that the claim is not compensable; (3) a "back-up" denial issued within two years from the acceptance; and (4) if the denial is contested at hearing, the insurer proves by clear and convincing evidence that the claim is not compensable. See Susie A. Fimbres, 44 Van Natta 1730, 1732 (1992) (on reconsideration).

We address the first three conditions, which define the circumstances under which it is proper to issue a "back-up" denial. Here, the first and third conditions have been met, since the insurer issued its "back-up" denial ten months after accepting the claim. The question is whether the second condition has been met; that is, whether the insurer's "back-up" denial was based on evidence obtained after its acceptance.

The insurer stated that its "back-up" denial was based on the "new information" that claimant was injured while working in Washington at a work site that was over 30 days old. (Ex. 5). We examine the record to determine whether the insurer obtained this information subsequent to its acceptance in February 1991. See Wayne Wood, 44 Van Natta 1277 (1992) (on reconsideration). We conclude it did not.

Claimant, who worked as a millwright and working foreman for the employer, testified that in July 1990 he began working on the employer's job in Beaver, Washington installing a new sawmill; the job was completed in April 1991. (Tr. 9-10, 16). Claimant was injured on November 20, 1990 while working on the Beaver, Washington job, and he filed a claim with the employer. (Tr. 11). There is no evidence or any allegation that claimant misrepresented to the employer any information pertaining to his injury or claim.

The employer indicated on the 801 form that it first had knowledge of the injury on November 20, 1990. (Ex. 3). The employer apparently incorrectly indicated on the 801 form that the injury occurred at its headquarters in Jackson County, Oregon. (See Ex. 3). However, an employer is presumed to exercise direction and control over its employees, absent evidence that a claimant is an independent contractor. See ORS 656.701.025(1); Gregory L. Potts, 43 Van Natta 1347 (1991). Here, there is no evidence that claimant was other than an employee, under the employer's direction and control with respect to where and when he performs his work.

Thus, we find that the employer directed claimant to work at the Beaver, Washington job site from July 1990 until April 1991. We further find that the employer knew on November 20, 1990 that claimant was injured at the job site. Accordingly, we conclude that the employer knew at the time of claimant's injury and at the time it completed the employer portion of the 801 form, that claimant was injured in Washington state while working at a job site that was more than 30 days old.

The employer's knowledge is attributable to its insurer. SAIF v. Abbott, supra, 103 Or App 49, 53 (1990), citing Colvin v. Industrial Indemnity, 301 Or 743, 725 P2d 356 (1986) and Nix v. SAIF, 80 Or App 656, 660, 723 P2d 366, rev den 302 Or 158 (1986). The employer's failure to provide correct information to the insurer does not negate that principle. See SAIF v. Abbott, supra, 103 Or App at 53. Thus, we conclude that at the time of its acceptance in February 1991, the insurer knew, either directly or through its insured, that claimant was injured in Washington state at a work site that was more than 30 days old. Therefore, we find that the insurer's "back-up" denial was based on information it was deemed to have at the time of its acceptance, not on any evidence it obtained after its acceptance. Accordingly, we conclude that because the insurer's "back-up" denial was not based on evidence obtained after its acceptance, the insurer was not entitled to issue the "back-up" denial.

Since we have held that the the insurer already knew the factual information underlying its "back-up" denial at the time of acceptance, it remains for us to consider whether the insurer's post-acceptance analysis of that information constitutes "later-obtained evidence" within the meaning of ORS 656.262(6).

To determine legislative intent, we first examine the language of the statute. Whipple v. Howser, 291 Or 475, 479 (1981), citing Greyhound Corp. v. Mt. Hood Stages, Inc., 437 US 322, 330 (1978). Here, ORS 656.262(6) plainly states that "if the insurer . . . accepts a claim in good faith but later obtains evidence that the claim is not compensable," it may issue a "back-up" denial. (Emphasis added). We find the statutory language plainly states that the evidence in support of a "back-up" denial must be obtained by the insurer subsequent to its acceptance of the claim. See Wayne Wood, on recon, supra.

However, the question remains whether "evidence" may include a new analysis or legal conclusion based on the same factual information the insurer had at the time of acceptance. We now turn to the legislative history of the 1990 amendment to ORS 656.262(6).

Senator Brenneman of the Joint Interim Special Committee on Workers' Compensation addressed the changes proposed in subsection 6 of Section 15 of SB 1197, which amended ORS 656.262(6):

> "Under the old law, once an insurer accepted a claim, the 60 days elapsed, the decision was final no matter whether or not evidence of fraud or mistake was later discovered. Now the insurer has two years to discover such evidence and issue a retroactive denial." Special Session, Senate Floor Debate, May 7, 1990, Tape 4, Side A.

Representative Mannix also addressed this provision of SB 1197:

> "Beyond that [accepting a claim within 90 days] if you have accepted the claim as you should have in good faith but you come up with evidence that the claim was improperly accepted you can turn around and deny later on, but only if you bear the burden as employer or insurer by clear and convincing evidence of establishing that there was some additional information that was material to the claim that causes the claim to be noncompensable." Special Session, House Floor Debate, May 7, 1990, Tape 2.

We find that the legislative history clearly supports the plain statutory language that evidence in support of the "back-up" denial must be obtained or discovered after acceptance of the claim. The legislators' commentary further suggests that the "evidence" contemplated is new factual information, as distinguished from a new analysis of or legal conclusion based on the same information the insurer knew, or should have known, at the time of acceptance.

Therefore, we distinguish between the evidence which may support a "back-up" denial, and the insurer's legal analysis of that evidence. The evidence on which the insurer based its "back-up" denial is the factual information -- that claimant was injured in Washington and that the job site was over 30 days old -- from which the insurer drew the legal conclusion that claimant was not a subject worker under Oregon Workers' Compensation Law. We have found that the employer knew this factual information at the time the insurer issued its acceptance. A later analysis of the same information, or a later legal conclusion based on the same facts does not constitute "later-obtained evidence." Here, the "back-up" denial was based on the same information the insurer was deemed to have at the time of its acceptance; only the legal conclusion was new. Therefore, because the insurer's "back-up" denial was not based on evidence obtained after the acceptance, we hold that the insurer was not entitled to issue its "back-up" denial.

Accordingly, we set aside the insurer's "back-up" denial and remand the claim to the insurer for processing according to law. Since we find that the insurer was not entitled to issue a "back-up" denial, we do not reach the merits of the denial and do not decide whether claimant was an Oregon worker at the time of his injury.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of the propriety of the insurer's "back-up" 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 "back-up" denial issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 20, 1992 is reversed. The insurer's "back-up" denial dated December 18, 1991 is set aside, and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $2,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
PHILIP A. PARKER, Claimant
WCB Case No. 91-16522
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Thye's order that: (1) upheld the insurer's denial of his occupational disease claim for a cervical and lumbar spine condition; and (2) declined to assess a penalty and related attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's claim is not compensable, finding that he had not sustained his burden of proving a sufficient work connection. We disagree.

Given the repetitive nature of claimant's work activities as a restaurant waiter, 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 his cervical and lumbar spine 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. ORS 656.802(2).

The only medical opinion concerning causation is submitted by Dr. Mantell, claimant's treating chiropractor. Mantell diagnosed cervicobrachial syndrome with segmental joint dysfunction of the cervical vertebrae, cervical sprain syndrome, and lumbar strain. (Ex. 6). He reported claimant's history of pain in the shoulders, back and neck, with headaches and numbness, which developed while repetitively lifting and carrying heavy trays as a waiter. (Id.) Noting that his diagnosis is consistent with claimant's history, Mantell opined that the work activities caused the condition to develop. (Id.)

The Referee was not persuaded by Mantell's uncontroverted opinion, reasoning that it was unclear whether or not Mantell considered the relative contribution of any off-work activities in forming his opinion. However, there is no evidence of any off-work contribution to claimant's condition. Claimant testified that he occasionally skied on water and snow, but that he never injured his back during those activities. (Tr. 11-12).

The Referee also found that Mantell did not provide objective findings to support his diagnosis. We disagree. In order to establish a condition "by medical evidence supported by objective findings," claimant must show that a physician has objectively evaluated his complaints and determined that he suffers from a physical condition resulting in disability or requiring medical services. See Georgia-Pacific v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Mantell objectively evaluated claimant's complaints and, based on that evaluation, determined that claimant suffered from a spine condition requiring periodic adjustments. (See Exs. 1, 1A, 2). That is sufficient to establish objective findings.

The Referee stated that the decrease in claimant's range of motion between July 31 and August 21, 1991, as reflected in Mantell's chart notes, supported a finding that Mantell did not base his diagnosis on objective findings. However, we find that the decreased range of motion merely reflects the fluctuating nature of claimant's condition prior to becoming medically stationary on August 28, 1991.

Finally, the Referee stated that Mantell did not address the relative contribution of claimant's preexisting back problems to his current condition and did not discuss how work activities were the major contributing cause of a pathological worsening of the preexisting condition. There is no evidence, however, that claimant's preexisting back problems contributed in any degree to his current condition. Indeed, there is evidence that claimant's prior back problems were primarily limited to the middle back, (see Ex. 5; Tr. 15), whereas his current complaints are primarily limited to the neck and low back, (see Exs. 2, 6). Inasmuch as the current complaints involve new body parts, claimant need not prove a pathological worsening of a preexisting condition.

Mantell's opinion indicates that he believed claimant's condition to be work related. Inasmuch as Mantell 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. Accordingly, based on this record, we conclude that claimant has sustained his burden of proving that work activities were the major contributing cause of his condition and the resulting need for treatment. Therefore, his occupational disease claim is compensable.

Penalty and Attorney Fee

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

At the time the denial was issued on October 30, 1991, the insurer was in receipt of claimant's 801 and 827 forms. Claimant wrote on the 801 form that he suffered an "aggravation of back condition due to lifting and carrying heavy objects." (Ex. 3). Dr. Mantell wrote on the 827 form under the heading "NATURE AND LOCATION OF INJURY OR EXPOSURE": "Shoulder, neck and back muscles from carrying and lifting trays." (Ex. 2). Both forms indicated that claimant worked as a restaurant waiter. The insurer also was in receipt of Mantell's chart notes, which included a report of claimant's decreased ranges of motion. (Ex. 1).

The insurer's claims examiner testified that she issued the denial based on the lack of objective medical evidence and claimant's inconsistent statements regarding whether or not he had a preexisting back condition requiring treatment. (Tr. 43-45). However, we are persuaded that the evidence available to the insurer should have prompted the insurer to investigate the claim further, by seeking either an independent medical examination or a clarifying report by Dr. Mantell. Instead, the insurer issued the denial without requesting any medical reports. Under these circumstances, we find that the insurer had no legitimate doubt of its liability for the claim. Accordingly, we assess a penalty based on all amounts due at the time of the hearing, to be paid in equal shares to claimant and his attorney.

Inasmuch as claimant is seeking a penalty-related attorney fee on the same factual basis which supports the penalty, we are not authorized to assess a separate attorney fee on that basis. See ORS 656.262(10)(a); Martinez v. Dallas Home Nursing, 114 Or App 453 (1992).

Assessed Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,250, 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 28, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. The insurer is assessed a penalty based on all amounts of compensation due at the time of hearing, to be paid in equal shares to claimant and his attorney. Claimant's attorney is awarded $3,250 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
FRANK D. SMITH, JR., Claimant
WCB Case No. 92-06220
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of that portion of Referee Lipton's order that upheld the self-insured employer's denial of his occupational disease claim for his right arm condition. On review, the issue is compensability.

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

FINDINGS OF FACT

In lieu of the Referee's finding that claimant went to Willamette Falls Hospital on February 29, 1992, with complaints of numbness, tingling and pain down his right arm, we find that claimant went to the hospital with complaints of weakness, numbness and tingling in the right hand. (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

To establish an occupational disease claimant must prove by a preponderance of the evidence that employment conditions were the major contributing cause of his condition. See ORS 656.802(2). "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); John W. Walters, 45 Van Natta 55 (1993). Because the causation issue presents a complex medical question, its resolution turns largely on 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 Referee concluded that claimant did not sustain his burden of proof. We agree.

The claimed condition, diagnosed as ulnar compression at the brachial plexis and elbow, resulted in the need for surgery on April 13, 1992. (Ex. 14-4). The central issue is whether that condition is due to claimant's work activities of grading lumber and operating the hula saw, or due to a noncompensable nonunion of the clavicle resulting from an old fracture sustained in an off-work motorcycle accident in 1984.

Dr. McWeeney, attending orthopedic surgeon, provided the only medical opinion supporting the compensability of the condition. He opined that claimant's employment was the major contributing cause of the condition requiring surgery, "based on a temporal relationship." (Ex. 15). He reasoned that, if the nine-year-old nonunion of the clavicle had been the precipitating cause by itself, the condition would have arisen sooner.

We ordinarily defer to the attending physician's opinion, unless there are persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We do so because attending physicians generally have had a much better opportunity to evaluate workers' conditions than consulting physicians or independent examiners. See id.

In this case, however, Dr. McWeeney assumed claimant's care in April 1992 when the previous attending physician, Dr. Hazel, became ill. Dr. McWeeney had been claimant's attending physician for less than one month before issuing his opinion regarding causation. Given his limited opportunity to evaluate claimant's condition, we decline to give his opinion the greater weight ordinarily given to attending physicians' opinions.

We also decline to defer to Dr. McWeeney's opinion, because the resolution of the causation issue here requires expert analysis, rather than expert external observation. See Hammons v. Perini Corp., 43 Or App 299 (1979).

Finally, we are not persuaded that Dr. McWeeney's opinion establishes compensability with reasonable certainty. See Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981). In the same medical report where he opined that claimant's employment was the major contributing cause of the condition, Dr. McWeeney also stated:

> "Essentially, [claimant] had a lesion of the ulnar nerve with significant intrinsic muscle atrophy where he had compression of the ulnar nerve both at the elbow and also at the brachial plexis underneath an old nonunion of the clavicle. As to which is the major contributing cause of his condition resulting in surgery, is uncertain. The EMG nerve conduction velocity studies show compression at both sites. Possibly without compression at one of the two sites, there may not be significant compression on the other side. This is noted as double crush syndrome." (Id.) (Emphases added.)

Thus, Dr. McWeeney concedes that he is uncertain as to whether the nerve compression at the elbow, or the nerve compression at the site of the old fracture, was the major contributing cause of claimant's condition requiring surgery.

Dr. Watson, a neurological consultant who reviewed claimant's medical records, noted Dr. McWeeney's uncertainty and suggested the following explanation for claimant's condition:

> "It is conceivable that the only reason that the right sided symptoms and findings developed was because there was a compressive lesion in the shoulder, unsuspected, which helped generate the presence of peripheral symptoms in the hand. That is the double crush phenomena. Surely therefore, it does not necessarily follow that the major contributing cause for [claimant's] need for corrective surgery at the elbow is in fact his employment. It could just as easily be the result of an underlying and so far undetected neuropathic condition such as I outlined above [e.g., diabetes, anemia, nutritional deficiencies or hypothyroidism], and made symptomatic only because of the shoulder phenomena, long standing, and not per primum related to work." (Ex. 17-5).

Dr. Watson suggests that claimant's condition could have resulted from the lesion at the site of the old fracture and any one of several neuropathic conditions unrelated to work. Although Dr. Watson concedes that this explanation is speculative, he notes that a thorough medical evaluation could resolve this uncertainty. The evaluation never took place, and there is no evidence that the neuropathic conditions identified by Dr. Watson were ruled out.

As the Referee noted, there is no adequate explanation in the record regarding the relationship of the lesion at the shoulder to the lesion at the elbow and the relationship of either to claimant's work activities. It is apparent from the record, however, that the shoulder lesion bears some relationship to the noncompensable fracture, and it could have generated claimant's condition.

Yet, based on the facts that claimant's condition arose during his employment and his fracture occurred approximately nine years earlier, Dr. McWeeney found a major causal connection between the employment and the condition. That explanation alone is not persuasive. Given the concerns raised by Dr. Watson, and the lack of any response from Dr. McWeeney, we are not persuaded that it is more probable than not that claimant's condition was caused, in major part, by his work activities. Accordingly, we conclude his claim is not compensable.

ORDER

The Referee's order dated July 31, 1992 is affirmed.

In the Matter of the Compensation of
ERMAL L. TRUMP, Claimant
WCB Case No. 91-15625
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of Referee Thye's order which upheld the SAIF Corporation's denial of the condition causing claimant's current right neck and right arm symptoms. In addition, claimant moves to remand this case to the Referee for the receipt of further evidence, based on new evidence obtained after surgery. On review, the issues are remand and compensability. We deny the motion and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

Claimant moves to remand this case to the Referee for the taking of additional evidence, based on his treating doctor's operative and post-operative reports. Claimant contends that the reports support his position that there is a distinction between a disc protrusion caused by an accepted work injury and a worsening of a preexisting osteophyte, and that the new evidence reveals that a disc protrusion, not an osteophyte, was causing pressure on claimant's C7 nerve root. SAIF opposes the motion and contends that the proffered evidence is merely cumulative of the treating doctor's pre-surgery report. We agree with SAIF.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 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 evidence could not have been obtained by the time of the hearing, since the surgery took place on April 15, 1992, and the Opinion and Order issued on April 9, 1992 following a hearing on February 4, 1992. However, we do not consider the record to be incompletely developed without the additional evidence.

On April 15, 1992, Dr. Brett, neurosurgeon, performed an anterior cervical discectomy and fusion at C6-7 and made the following operative findings: "There was some spondylotic disease at C6-7 but with superimposed soft disk protrusion on the right with very edematous and erythematous right C7 root." He also noted that prior to surgery, magnetic imaging continued to show "foraminal narrowing at C6-7 anteriorly from a combination of spondylotic and soft disk disease." In his post-operative report, Dr. Brett stated, "We did find soft disc protrusion on the right at C6-7, clearly a result of his work activities of 8-23-89 with quite an edematous and erythematous right C7 root. This was superimposed on some spondylotic change which was previously asymptomatic." (Emphasis in original).

Previously, Dr. Brett had opined that although claimant had preexisting spondylotic disease at C6-7 with foraminal narrowing on the right, "it was his work activities of 8-23-89 which precipitated his pathologic worsening with right C7 root inflammation and swelling and foraminal entrapment." (Ex. 28-1) (emphasis in original). He added, "I do feel that the major contributing factor resulting in his nerve entrapment and need for treatment at this time, as well as his present symptoms, is his work activity of 8-23-89." Id. Thus, we find that the post-operative evidence merely confirms Dr. Brett's earlier opinion, which was already in the record and considered by the Referee. Moreover, even if the evidence

establishes that claimant's right neck and right arms symptoms were caused in major part by a protruding disc, the question remains whether the major contributing cause of the disc protrusion was the compensable August 1989 injury or claimant's preexisting degenerative disc disease. The proferred evidence does not aid in resolving that question.

Under these circumstances, we do not find that the record was "improperly, incompletely or otherwise insufficiently developed." For these reasons, claimant's motion to remand is denied.

Compensability

We affirm and adopt the Referee's conclusions and reasoning with regard to this issue, but add the following comment with regard to whether the present claim was precluded.

The Referee held that claimant's present claim was precluded because compensability of claimant's degenerative disc disease was litigated and found not compensable in a prior proceeding. Claimant contends that he is entitled to bring the present claim on the theory that his current condition is caused not by a worsening of his degenerative disc disease, but by a prior compensable injury. Moreover, the parties stipulated in the prior proceeding that the present claim was not ripe to be litigated. (Ex. 29-2 at n1).

We agree with claimant that his current claim is not precluded by the prior litigation. The current claim was not litigated nor, as the parties agreed, was it ripe to be litigated at the prior proceeding. Accordingly, we conclude that the current claim is not precluded. See Drews v. EBI Companies, 310 Or 134, 139-40 (1990).

However, although we agree with claimant that he was entitled to go forward with his current claim, we agree with the Referee that he failed to carry his burden of proving compensability of his current right neck and right arm conditions. Accordingly, we affirm the Referee's order regarding compensability.

ORDER

The Referee's order dated April 9, 1992 is affirmed.

April 6, 1993 Cite as 45 Van Natta 733 (1993)

In the Matter of the Compensation of
CINDY L. CHANCE, Claimant
WCB Case Nos. 92-03229 & 92-05197
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Howell's order that: (1) found that claimant's left wrist condition claim was not prematurely closed; (2) declined to award claimant temporary disability benefits beyond that granted by the Notice of Closure; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are claim processing, premature closure, penalties and attorney fees.

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

On February 6, 1991, the insurer closed claimant's accepted left wrist condition claim as a nondisabling injury claim and awarded no compensation. That closure was upheld by a Determination Order dated August 15, 1991. On February 14, 1992, Referee Johnson set aside the August 15, 1991 Determination Order, ordered the insurer to accept the claim as disabling and pay time loss benefits beginning December 27, 1990 until closure under the workers' compensation laws. That order became final when neither party appealed it within 30 days of its issuance.

On March 3, 1992, the insurer again issued a Notice of Closure. That notice classified claimant's claim as disabling and awarded temporary disability compensation from December 27, 1990, to January 18, 1991. An Order on Reconsideration dated March 27, 1992, rescinded the insurer's Notice of Closure. The insurer requested a hearing concerning the reconsideration order. Claimant cross-requested a hearing, seeking payment of temporary disability compensation from December 27, 1990, to the date of the hearing.

The Referee concluded that claimant became medically stationary on January 18, 1991, and remained medically stationary on March 3, 1992. Consequently, the Referee reinstated the insurer's March 3, 1992, Notice of Closure, and declined to award claimant temporary disability benefits beyond January 18, 1991.

Claimant does not dispute the accuracy of the Referee's conclusions. Instead, she contends that the insurer was precluded from litigating the issues of proper closure and extent of temporary disability by Referee Johnson's February 14, 1992, order. In short, she contends that those issues are res judicata. We disagree.

Preclusion by former adjudication, which is generally referred to as res judicata, consists of two doctrines, issue and claim preclusion. Issue preclusion bars litigation of an issue only if that issue was actually litigated and determined in a prior action where that issue was essential to the judgment. North Clackamas School Dist. v. White, 305 Or 48, 53 (1988). Claimant does not contend that issue preclusion bars the insurer from litigating the issues of proper closure for her disabling injury claim and extent of temporary disability, nor could she. Neither of those issues was litigated or determined by the February 14, 1992 order. See Hanes v. Washington County Community Action, 107 Or App 304, 308 (1991). Instead, claimant contends that claim preclusion bars the insurer from litigating those issues.

Under the doctrine of claim preclusion, if an action is litigated to final judgment, that judgment precludes a subsequent action between the same parties on the same claim(s), or any part thereof, if the later claim could have been litigated as part of the earlier action. Drews v. EBI Companies, 310 Or 134, 140 (1990). Generally, a "claim," for claim preclusion purposes, includes "all rights or remedies between the parties with respect to all or any part of a transaction, or series of connected transactions, out of which the action arose." Drews v. EBI Companies, supra, 310 Or at 146. Specifically, under the workers' compensation laws, a "claim," for claim preclusion purposes, consists of a transaction, or series of connected transactions, resulting in a condition, and concerns all of the worker's rights or remedies for that condition under the workers' compensation laws. See e.g., Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 564 (1989), rev den 309 Or 645 (1990); Ronald L. Ziemer, 44 Van Natta 1769 (1992); Deborah K. Brickley, 44 Van Natta 669, 670 (1992); Chella M. Morton, 43 Van Natta 321, 322 (1991). Finality results when the issues concerning a worker's rights and remedies for a condition, or a change in a condition, are conclusively resolved. See e.g., Drews v. EBI Companies, supra, 310 Or at 150; Christopher H. Peppler, 44 Van Natta 856, 857 (1992). Until that finality obtains, the issues that could have been, but were not, litigated in a prior proceeding concerning that condition are not precluded.

Claimant contends that the issues of proper closure and extent of temporary disability could have been litigated at the hearing that yielded the February 14, 1992, order, because all of the facts that were necessary to decide those issues could have been established at that time. Initially, we disagree with claimant's premise that all of the facts necessary to decide the disputed issues could have been established at the prior hearing. The critical evidence concerning the propriety of the current claim closure consists of medical reports generated after a May 5, 1992, exploratory surgery on claimant's left forearm. That evidence was not available at the time of the prior hearing.

Moreover, we note that even if the relevant facts concerning claim closure could have been established at the time of the prior hearing, the referee at that hearing had no authority to close the disabling injury claim that he had just ordered opened. See Wilbur E. Gunderson, 42 Van Natta 263 (1990). Consequently, the insurer could not have litigated that issue at the prior hearing, as is required to support claim preclusion.

ORDER

The Referee's order dated July 13, 1992, is affirmed.

In the Matter of the Compensation of
JULIO G. MEJIA, Claimant
WCB Case No. TP-92-010
ORDER ON REMAND
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 24, 1993 order, we have been directed to consider the parties' proposed claim disposition agreement (CDA). On March 30, 1993, we approved a CDA, in which claimant released his rights to workers' compensation benefits, except medical services, for his compensable injury. WCB Case No. C3-00488. Pursuant to that CDA, the insurer further agreed to waive its lien to claimant's third party judgment.

Inasmuch as the issue in this case concerns the insurer's entitlement to a share of the proceeds from claimant's third party judgment and since the insurer has waived its rights to such proceeds in the approved CDA, we conclude that this matter has been resolved, in lieu of our prior orders. See Julio Mejia, 44 Van Natta 2140, on recon 44 Van Natta 2288 (1992). Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
TALALOTU E. SAMUELU, Claimant
WCB Case No. 91-13215
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Hazelett's order which dismissed claimant's hearing request, finding that the Hearings Division lacked jurisdiction to consider an invalid Order on Reconsideration. In its brief, the insurer contends that claimant's appeal is frivolous and requests sanctions. On review, the issues are jurisdiction and penalties.

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

The insurer contends that claimant's request for review constitutes "a frivolous appeal." The insurer, therefore, requests "sanctions be imposed on claimant's counsel."

We are without authority to grant the insurer's request. See e.g. Verl E. Smith, 43 Van Natta 1107 (1991). We, therefore, deny it.

ORDER

The Referee's order dated June 22, 1992 is affirmed.

In the Matter of the Compensation of
JACOB E. BALLWEBER, JR., Claimant
WCB Case No. 91-08518
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of that portion of Referee Hoguet's order that upheld the SAIF Corporation's partial denial of his psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed claimant's claim under both ORS 656.005(7)(a)(A) and ORS 656.005(7)(a)(B). We agree with his conclusion that claimant's claim would not be compensable under either statute.

At the outset, we reject SAIF's contention on review that this case should be analyzed as an occupational disease claim under ORS 656.802. In Boeing Co. v. Viltrakis, 112 Or App 396 (1992), the court held that ORS 656.802 is not applicable when a claimant seeks benefits for a mental disorder that is a consequence of a compensable injury, but does not seek to establish the independent compensability of the disorder. Also see Diana L. Bert, 44 Van Natta 1827 (1992). Here, claimant is not seeking to establish the independent compensability of his mental disorder. Accordingly, ORS 656.802 does not apply.

In this case, claimant alleges that his psychological condition is compensable as either a consequence of the hand injuries he sustained in the August 1989 industrial accident or as a resultant disability (a combination of the injury with his preexisting psychological condition). Consequently, under either theory, claimant is required to prove that his injury was the major contributing cause of his mental condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

On review, claimant argues that the Referee should have relied on the opinions of Drs. Smith, Dondershine and Boehnlein, rather than on the opinions of the independent medical examiners, Drs. Swarner and Glass. Claimant contends that neither of the IME's had an accurate history.

Claimant argues that Dr. Swarner's opinion should be discounted because he did not discuss stressors associated with claimant's return to work. Claimant also contends that Dr. Swarner's opinion is inconsistent as he stated that any stressful incidents "might have precipitated this present state of affairs...," yet Swarner could find no direct cause between the psychological condition and the hand injury.

After reviewing Dr. Swarner's reports, we agree with the Referee that his opinion is thorough and well-reasoned. Dr. Swarner reviewed claimant's medical and vocational reports and discussed numerous problems that claimant had in returning to work. Accordingly, we do not find that Dr. Swarner's emphasis on other stressors is equivalent to an inaccurate or incomplete history. Moreover, Swarner did agree that the hand injury was seriously stressful to claimant, however, he also found that claimant's hand injury was "stable" at the time he was fired from work. Swarner acknowledged that claimant's case was complex, but he was ultimately unable to come to a firm conclusion linking claimant's hand injury to his current depression and post traumatic stress disorder.

Claimant also contends that Dr. Glass's report was inaccurate because Glass concluded that claimant was doing well at the sales job. Claimant argues that Dr. Glass did not discuss any of claimant's stressors associated with his hand injury, surgeries and problems that occurred when he returned to work.

We do not find Dr. Glass's report to be inaccurate or inconsistent. The Referee found, and we agree, that claimant did not experience injury related problems when he returned to work in sales. Rather, the record establishes that claimant had personality problems with other employees when he returned to work. Moreover, Dr. Glass's report does discuss claimant's problems with other employees and his frustration with the work of others. Under the circumstances, we conclude that Dr. Glass had an accurate and complete history and we agree with the Referee's conclusion that his opinion is persuasive.

Finally, the Referee provided extensive reasoning with regard to why the opinions of the remaining doctors, Drs. Smith, Boehnlein and Dondershine do not support claimant's claim. After reviewing the record, we agree with the Referee and we adopt his reasoning on that issue.

Accordingly, we conclude that claimant has failed to establish that his hand injury is the major contributing cause of his current psychological condition. We, therefore, affirm.

ORDER

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

In the Matter of the Compensation of
DORIS E. BURNETT-STANBERY, Claimant
WCB Case No. 92-03985
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of Referee Myers' order which affirmed an Order on Reconsideration awarding no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Dr. Abeliuk, neurologist, was claimant's treating physician until he discharged her from his care on March 5, 1991. At that time, he noted that the relationship between claimant's current symptoms and her industrial injury was unclear to him. (Ex. 18).

Dr. Scherman, neurologist, performed an independent medical examination on April 15, 1991. He found claimant to be medically stationary, not disabled and able to return to her regular work without restrictions. (Ex. 19). Dr. Abeliuk concurred in this report. (Ex. 20).

Upon request for reconsideration, a panel of medical arbiters examined claimant on February 11, 1992. They found limitations in cervical and lumbar ranges of motion. (Ex. 27-3, 27-7). However, in an addendum to the panel's report issued prior to the Order on Reconsideration, one of the panel members commented that claimant "may have been guarding her movements during the physical exam," due to over-focusing on her pain. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

In rating the extent of claimant's permanent disability, we apply the disability standards in effect on June 21, 1991, the date of the Determination Order. See WCD Admin. Order 2-1991. Under OAR 436-35-007(9), when a medical arbiter is used on reconsideration, impairment is determined by the medical arbiter, except when a preponderance of medical opinion establishes a different level of impairment. It is claimant's burden to prove by a preponderance of the evidence the nature and extent of any permanent disability due to her compensable injury. ORS 656.266.

Here, although the panel of medical arbiters measured limitations in cervical and lumbar ranges of motion, they subsequently amended their report, questioning the validity of those measurements. The only other closing examination, which was concurred in by claimant's treating physician, found no permanent disability. Accordingly, we conclude that there are no valid findings of impairment. Since there is no measurable impairment under the standards, there can be no award of unscheduled permanent disability. OAR 436-35-270(2). The Order on Reconsideration is affirmed.

ORDER

The Referee's order dated June 23, 1992 is affirmed.

In the Matter of the Compensation of
JANET S. DOUGHERTY, Claimant
WCB Case Nos. 91-16664, 91-10467 & 91-12511
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defemse Attorneys
Dennis Ulsted (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

EBI/Security Insurance of Hartford requests review of that portion of Referee Baker's order that: (1) set aside its denial of claimant's occupational disease claim for her bilateral thumb condition; (2) upheld the SAIF Corporation's denial (on behalf of the noncomplying employer) of claimant's claim for the same condition; and (3) upheld Kemper Insurance Company's denial of claimant's claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

Claimant worked as a cook for the noncomplying employer until March 5, 1988. During her employment with the noncomplying employer, claimant had an accepted bilateral carpal tunnel condition for which she was awarded 5 percent permanent disability for each wrist.

Claimant began working as a cook for Kemper's insured in August of 1989. EBI came on the risk for the employer on May 1, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant first became disabled while EBI was on the risk, EBI was responsible for her bilateral thumb condition. We agree that EBI is responsible, and we add the following supplementation.

We conclude that ORS 656.308 does not apply in this responsibility case as claimant does not have an accepted thumb condition. See Fred A. Nutter, 44 Van Natta 854 (1992) (application of ORS 656.308 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 an occupational disease case, 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); 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).

On review, EBI contends that claimant's first date of disability was actually in February 1988, while she was employed by the noncomplying employer. EBI argues that claimant received treatment for a thumb condition at that time and she eventually quit work due to her hand condition. EBI, therefore, contends that responsibility should initially be fixed with SAIF and the noncomplying employer. We disagree.

Dr. Robertson, claimant's treating orthopedist, testified that her thumb problems in 1988 were not specifically related to her thumb dislocation condition in 1991. Dr. Robertson stated that claimant's 1988 x-ray of her thumb was normal, but in 1991, claimant's thumb x-rays showed subluxation. He further stated that carpal tunnel could have caused pain in that area of the thumb. Under the circumstances, we conclude that the Referee correctly found that claimant was first disabled due to her bilateral thumb condition at a time when EBI was on the risk.

Finally, we conclude that EBI is responsible even if claimant was first disabled during her employment with the noncomplying employer. Dr. Robertson testified that claimant's work as a cook, wherever she had performed such work, was the cause of her problem and a major contributing cause of the deterioration that occurred. Accordingly, because claimant worked as a cook for EBI's insured and her work there contributed to a worsening of her underlying condition, we conclude that even if SAIF were initially responsible, responsibility would shift to EBI.

Although compensability was not raised as an issue on review, it was an issue at hearing. Accordingly, claimant is entitled to an attorney fee for participating at Board level. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992); ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review is $1,000, to be paid by EBI, the insurer responsible for claimant's condition. 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 concerned.

ORDER

The Referee's order dated June 19, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by EBI/Security Insurance of Hartford.

April 7, 1993 Cite as 45 Van Natta 739 (1993)

In the Matter of the Compensation of
JOHN C. FORSE, Claimant
WCB Case No. 91-11621
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Lipton.

Claimant requests review of Referee Baker's order that upheld the insurer's denial of his claim for a low back injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to prove that his lumbar disc herniation at L3-4 was work-related. We agree.

On the date of his injury, claimant was operating a forklift on an unpaved area when he sneezed and felt a popping sensation in his back followed by severe pain in the low back and right leg. A disc herniation was subsequently discovered at L3-4. Claimant attributes his disc herniation to operating the forklift over rough terrain at work.

An injury is distinguished from an occupational disease both by the fact that the former is said to be unexpected, and the fact that where an occupational disease is gradual in onset, an injury is "sudden in onset." James v. SAIF, 290 Or 242, 248 (1981); Clark v. Erdman Meat Packing, 88 Or App 1; (1987); Jimmie D. Wray, 44 Van Natta 1882 (1992). Here, claimant's disc herniation was both sudden in onset and unexpected. Consequently, we analyze claimant's condition as an injury.

To establish compensability of his low back condition as an injury, claimant must establish that operation of his forklift on the date of injury was a material contributing cause of his disability and need for medical treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Although claimant has a preexisting degenerative disc disease in his lumbar spine, there is no evidence that the preexisting condition combined with a compensable injury to cause or prolong disability or a need for treatment. Therefore, we do not analyze this claim under ORS 656.005(7)(a)(B).

There are two medical opinions which address causation of the disc herniation. Dr. Sirounian, an osteopath, is claimant's treating physician and surgeon. Dr. Sirounian opined that the herniated disc was due to driving the forklift on rough terrain. Dr. Sirounian explained that his findings at surgery suggested a sudden "blow out" of the disc with migration of the disc fragments away from the disc space. These findings in turn indicated that the herniation was sudden in onset, rather than gradual as would occur with a chronic degenerative process.

Dr. Baker, orthopedic surgeon, saw claimant in an independent medical examination. He opined that claimant's sneeze was the culminating event which finally caused the disc protrusion. However, he felt that the majority of the cause of the disc protrusion was preexisting degenerative disc disease. Dr. Baker noted that claimant had had a previous, similar episode of pain down the right side of his posterior thigh and calf associated with a 1983 prior injury. Dr. Baker felt that this was an indication that claimant had a previous right lumbar disc problem similar to the present condition. In addition, Dr. Baker was aware of claimant's off-work surfing activities.

We give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to rely on Dr. Sirounian's opinion. Sirounian fails to explain the relationship, if any, between claimant's preexisting lumbar degenerative disease and the L3-4 disc. In addition, Dr. Sirounian fails to explain whether there is a relationship between claimant's herniation and the sneezing episode, which was followed immediately by the popping sensation and severe pain. Nor does Dr. Sirounian explain how driving a forklift over rough terrain is consistent with his opinion of a sudden "blow out." Finally, we note that Dr. Sirounian was apparently unaware of claimant's strenuous off work activities which included frequent surfing. For these reasons, we find Dr. Sirounian's opinion lacking in explanation and analysis. Consequently, we find it unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

On the other hand, we find Dr. Baker's opinion to be well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we accept his opinion that claimant's disc herniation is most likely related to his degenerative disease and to the sneezing incident as opposed to operating the forklift at work. In addition, we agree with and adopt the Referee's reasoning that driving the forklift was not a material contributing cause of the disc condition.

Finally, we note that Dr. Sirounian's opinion of a sudden "blow out" of the disc is consistent with claimant's sneezing as a cause of that event. However, claimant does not contend that the sneeze was related to work and we find no evidence in the record that establishes a link between the sneeze and a risk of employment. Accordingly, claimant has not established compensability on this basis. See Ruben G. Rothe, 45 Van Natta 369 (1993); Jimmy D. Ellis, 42 Van Natta 590 (1990).

ORDER

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

In the Matter of the Compensation of
KENNETH F. HENGEL, Claimant
WCB Case No. 91-17899
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Holtan's order that upheld the insurer's denial of his occupational disease claim for right plantar fasciitis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings with the exception of his finding that plantar fasciitis was a preexisting, congenital abnormality.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's right plantar fasciitis condition was preexisting and that his work activities did not cause or worsen that condition.

On review, claimant contends that the Referee erred in concluding that his plantar fasciitis condition was a congenital abnormality which preexisted his employment. Claimant further contends that Dr. Schachner's opinion supports a conclusion that his employment conditions, which involved standing and walking on concrete, were the major contributing cause of the plantar fasciitis condition. After our review of the record, we agree with both of claimant's contentions.

To establish a compensable occupational disease, claimant must prove, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his right plantar fasciitis. 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). However, for the purpose of determining whether a worker has met the major contributing cause standard, we do not consider his susceptibility or predisposition to the disease. Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991); Rodney T. Buckallew, 44 Van Natta 358 (1992).

Dr. Schachner identified claimant's congenital foot deformities as splay foot, a flattened arch on weight bearing, hammer toes and halux valgus. He did not identify plantar fasciitis as a congenital deformity. Rather, Dr. Schachner explained that plantar fasciitis was an inflammation of the bands that are on the sole portion of the foot. According to Dr. Schachner, claimant's bilateral foot deformities, excessive weight, and continuous weight bearing all contributed to the development of his plantar fasciitis. In his report, Dr. Schachner stated:

> The pre-disposing factors are the foot deformities where he has a multitude of developmental abnormalities and to some degree exacerbation is being made by his excessive weight, but an equal factor is noted in his history where standing on concrete results in exacerbation whereas when standing on padding he is relatively asymptomatic.

Based on Dr. Schachner's opinion, we conclude that the plantar fasciitis was not one of claimant's congenital, preexisting deformities. Instead, we conclude that claimant's foot deformities and weight were factors which predisposed him to develop the plantar fasciitis. Of the three factors identified as contributing to the plantar fasciitis, Dr. Schachner opined that continuous weight bearing was the major contributing cause of the plantar fasciitis. Although, he acknowledged that weight bearing both on and off the job contributed to claimant's condition, Dr. Schachner stated that it was medically probable that the major cause of the plantar fasciitis was walking and standing on the concrete floor at work.

Based on this evidence, we conclude that claimant has established that his work activities were the major contributing cause of the development of his right plantar fasciitis condition. Accordingly, claimant has established compensability of his right plantar fasciitis condition as an 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 $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 hearings record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 9, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $2,500 payable by the insurer.

In the Matter of the Compensation of
JACQUELINE R. INGRAM, Claimant
Own Motion No. 93-0101M
OWN MOTION ORDER
Francesconi & Busch, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable cervical, thoracic, lumbar and left shoulder injury. SAIF contends claimant's aggravation rights expired on April 18, 1988. However, we find that claimant's aggravation rights expired on February 15, 1989. SAIF recommends that the Board reopen claimant's claim for temporary total disability compensation for a proposed surgery. We disagree.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

In October of 1990, Dr. Berkeley, claimant's treating physician, requested authorization for surgery which was denied by SAIF. Claimant requested a hearing, WCB Case No. 91-00265. On May 12, 1992, the Referee issued an Opinion and Order that found claimant's current low back condition compensable and set aside the December 3, 1990 denial. SAIF requested Board Review. On January 29, 1993, the Board affirmed the Referee's Opinion and Order.

On March 8, 1993, we requested evidence that claimant's treating physician currently seeks authorization for surgery now or in the near future. In response to claimant's attorney's request for information regarding the likelihood that claimant will need back surgery in the future, Dr. Berkeley: (1) sent a copy of a December 23, 1991 letter wherein he again recommended surgery; (2) stated that claimant had not been seen since July 19, 1991; and (3) requested that his office be contacted if claimant's attorney wanted claimant to be re-evaluated.

On this record, claimant fails to demonstrate that her treating physician is currently seeking authorization for surgery now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim at this time. Accordingly, we deny the request for own motion relief. Id. If claimant is requesting authorization for a currently proposed surgery, she may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN P. LAMBERT, Claimant
WCB Case Nos. 90-21305 & 90-21162
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Claimant requests reconsideration of that portion of our March 12, 1993 Order on Review which declined to award claimant a reasonable assessed fee under ORS 656.382(2) for legal representation on Board review, on the basis that claimant's attorney did not file a respondent's brief.

We erred. Although claimant withdrew his cross-appeal on the issue of temporary total or partial disability, he filed a respondent's brief addressing the remaining issues. Accordingly, because claimant's compensation remained at risk, claimant is entitled to an assessed attorney fee for legal representation 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 attorney's services on review concerning the compensability issue is $1,000, to be paid by Liberty Northwest Insurance Corporation, on behalf of West Coast Steel Fabricators. 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.

Accordingly, our March 12, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 12, 1993 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
MICHAEL THORNTON, Claimant
WCB Case No. 91-15175
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig, Brazeau and Hooton.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of his left thumb injury. On review, the issue is compensability.

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

The test for determining whether an employee's misconduct involves activities that are outside the course and scope of employment is stated by Professor Larson:

> "When misconduct involves a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to the method of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, Workmen's Compensation Law 6-10, § 31.00 (1990). (Emphasis in original.)

Here, we find that claimant's misconduct was more than a violation of a regulation or prohibition relating to the method of accomplishing his work. He was specifically directed not to work on the day of the injury. Mr. Kashuba, the owner of the business, directed claimant to take a few days

off because there would be no one to supervise claimant's work on the equipment, including the saw at which claimant was ultimately injured. Nonetheless, claimant ignored the direction and proceeded to work at the saw the next day. By doing so, claimant overstepped the boundaries of the work that he was to do for the employer. See, e.g., Davis v. R & R Truck Brokers, 112 Or App 485, 491 (1992).

ORDER

The Referee's order dated January 24, 1992 is affirmed.

Board Member Hooton dissenting:

This is a case which is resolved completely by a finding that claimant is not a credible witness. I agree that the record places the testimony of the employer and the testimony of the claimant in direct conflict. I also agree that either claimant is not credible, or the employer, and most of the employer's supporting witnesses, are not credible. Unfortunately, though balancing the claimant's testimony with the testimony of employer and employer's three supporting witnesses might appear easy, I am unable to agree that the claimant is not a credible witness. A careful analysis of the record reveals only one possible resolution of this claim that reasonably comports with all the evidence presented. It is the employer, and employer's supporting witnesses, and not claimant, whose testimonies are not credible.

Claimant's story has the virtue of simplicity. He acknowledges that the employer and the employer's supervisor were both absent from the place of employment on the date of the injury. He states, however, that he came to work as scheduled, found a note detailing the jobs he was to perform, and began to work at completing the tasks on the list of jobs provided. During the course of completing cutting tasks involving the use of a table saw, claimant sustained severe lacerations to his left thumb. (Tr. 8-10.)

Because claimant's testimony is simple and direct, it also appears credible. There are no internal contradictions which cast doubt on reliability. This means that the claimant's testimony can only be found not credible based on demeanor, or based on contradiction by other credible testimony. It is the latter which the Referee and the majority rely upon to resolve this claim. The contention is that claimant's testimony is contradicted by the employer, and therefore, claimant is not credible. That analysis, however, depends completely on the credibility of the employer's testimony. I conclude that it has none. If the employer's testimony is not credible, it cannot impeach or contradict the claimant's testimony.

My problem with the employer's testimony begins at the very beginning. He argues that he only hired claimant because Ms. Gibson, a long trusted employee, lost her license as the result of a DUII, and claimant was in a position to give her a ride to work. (Tr. 130.) The evidence, however, demonstrates that the claimant was hired to cut frames for a large wholesale order for a company in Seattle, which employer could not efficiently complete with his regular, limited workforce. (Tr. 129.) Ms. Gibson also testified that claimant never drove her to work, (Tr. 104), a fact disputed by claimant, but demonstrative of the contradictions between the testimony of employer and the testimony of his supporting witnesses.

The employer testified that claimant had been told not to report to work on the date of injury. He testified that claimant could not safely use the tools he had been hired to use and required constant supervision. Claimant was supposedly provided with direct supervision throughout the day either by employer or by Mr. Moore, employer's supervisor. On the date of injury, Mr. Moore was on vacation and employer was delivering a load of futons to his retail outlet in Eugene. Because there was no one to supervise claimant's activity, employer testified that he told claimant not to report for work on the date of injury. (Tr. 41.)

The employer testified that his conversation with claimant occurred after work hours and that no one else was present. (Tr. 136.) However, Ms. Ransom testified that she overheard the entire conversation from a distance of six feet. (Tr. 121.) It seems incomprehensible that Ms. Ransom could have been six feet away and remained completely unnoticed. And again, the testimonies of the employer and the employer's supporting witnesses are inconsistent.

It is also unclear whether claimant was actually ever advised that he was only to work when supervised. Mr. Moore, claimant's supervisor in employer's absence, testified that employer had told him not to permit claimant to work unless supervised. But Mr. Moore also testified that he never told claimant of the requirement. Ms. Gibson, the only other employee of the firm, knew nothing of the requirement and did not find it surprising that claimant appeared for work on the date of injury, even though employer was not in the city, and Mr. Moore was on vacation. Given the employer's delaying tactics in actually terminating the claimant, it is likely that he relied upon Mr. Moore to tell the claimant he was not to work unsupervised. Unfortunately, Mr. Moore never conveyed that concern.

Employer also characterizes claimant as a shirker, one who seeks to avoid work whenever possible. Employer testified that claimant came to work late and left early, and would occasionally "hide out" during the course of the day to avoid his work duties. Yet, the employer asks the Board to believe that this same shirker voluntarily appeared for work on July 11, 1991, after being told not to. If, in fact, claimant had been told not to come to work on July 11, 1991, then he could have had no reasonable expectation of being paid for his services on that day. Claimant acknowledges that his work history is not good, and that he has a past history of illicit drug use. This is not the kind of person who is likely to appear for work knowing that he will not receive any pay for his efforts on that day. Even the average wage earner does not volunteer his services without pay. Claimant's employment motivations appear, by his work history, to be substantially below average.

I agree with the majority that the only question of significance in this case is whether the employer prohibited claimant from appearing for work on the date of injury. If claimant was prohibited from appearing, his appearance was an overstepping of the boundaries of the employment relationship, and his claim is not compensable. Davis v. R & R Truck Brokers, 112 Or App 485, 491 (1992).

However, the testimony of the employer is so full of inconsistency, and is contradicted on every major point by the supporting witnesses the employer brought to the hearing. Therefore, I am unable to conclude that claimant is not credible when testifying that the employer did not tell him that he required supervision and did not advise him to remain away from work on the date of injury. I am persuaded that employer actually did leave a note listing for claimant the jobs he was to do that day.

The only possible explanation for the result reached by the majority is an underlying belief that claimants are less honest than employers, or that by virtue of the application for benefits, the claimant is more likely to exaggerate or dissemble than is employer. Such a belief, if it exists, has no place in a workers' compensation proceeding. It eliminates the ability of the fact finder to be impartial in all respects. However, even if the party with the most to gain or lose is more likely to exaggerate or dissemble, the evidence in this case still points to the employer.

This employer acknowledged that he operated a business on a shoe string budget. He failed to withhold or pay state and federal income taxes, social security, workers' compensation and unemployment taxes. The testimony of Andrea Ransom confirms that the employer considered the probable cost to his business in dollars and cents as well as maintaining a competitive price for his product in deciding not to provide workers' compensation insurance coverage for his employees. There is also some evidence that employer feared losing his business entirely if the claim was found compensable.

Employer had already demonstrated a willingness to ignore the requirements of the law when the continued profitability of his business was at stake. The risk of losing that business entirely ultimately resulted in the perjured testimony of employer and at least two other witnesses, whose livelihood depended on the continued viability of the business.

The only witness that I can find believable in this record is the claimant. Therefore, I must wholeheartedly dissent.

In the Matter of the Compensation of
DANNY R. WOOSLEY, Claimant
WCB Case No. 92-03807
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of that portion of Referee Myzak's order that found that the insurer correctly calculated the rate of claimant's temporary total disability (TTD) benefits. On review, the issue is rate of temporary total disability.

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

The Referee found that, at the time of his injury, claimant worked varying hours and was paid varying wages for hours actually worked. Therefore, the Referee based claimant's TTD rate on a weekly wage calculated pursuant to OAR 436-60-025(5)(a), which provides for averaging weekly wages earned during the 26 weeks preceding the injury.

On review, claimant does not dispute either the finding that he worked varying hours at varying wages prior to the injury or the accuracy of the Referee's calculation of his weekly wage under OAR 436-60-025(5)(a). Rather, he contends that the Director's rule itself exceeds the authority allowed the Director by ORS 656.210. Relying on ORS 656.210(2)(b)(A), he argues that his weekly wage must be calculated on the basis of the hourly wage he was earning on the date of injury. We disagree.

Claimant correctly cites ORS 656.210(2)(b)(A) for the general rule that "[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury." However, that subsection must be read in conjunction with ORS 656.210(2)(c), which provides, in relevant part: "[F]or workers * * * whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage."

Here, because claimant was paid on an hourly basis for varying hours prior to the injury, his remuneration was "not based solely upon daily or weekly wages." See Gerald A. Couzens, 43 Van Natta 1321 (1991). Therefore, his weekly wage was correctly calculated according to the method prescribed by the Director. The method of averaging weekly wages earned during the 26 weeks preceding the injury has been approved by the court as an appropriate exercise of the Director's authority under ORS 656.210. See Lowry v. Du Log, Inc., 99 Or App 459, 462 (1989), rev den 310 Or 70 (1990). Accordingly, we conclude that claimant's TTD rate was correctly based on weekly wage calculated pursuant to OAR 436-60-025(5)(a).

ORDER

The Referee's order dated July 16, 1992 is affirmed.

In the Matter of the Compensation of
KATHY M. ARCHER, Claimant
WCB Case No. 91-04167
ORDER OF ABATEMENT
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our March 12, 1993 Order on Review that: (1) reversed a Referee's order that found that res judicata barred litigation of the issues of reclassification and aggravation; (2) found that medical reports received by the SAIF Corporation within one year from the date of claimant's injury constituted a claim for reclassification; (3) remanded the matter to SAIF to be reported to the Director for purposes of classification; and (4) awarded claimant an out-of-compensation attorney fee.

Specifically, claimant contends on reconsideration that SAIF's failure to process the claim was an unreasonable resistance to the payment of compensation, which entitles her to an attorney fee pursuant to ORS 656.382(1). Furthermore, claimant's accompanying "Petition for Attorney Fees" asserts an entitlement to an assessed attorney fee pursuant to ORS 656.386(1).

In order to further consider claimant's motion, we withdraw our March 12, 1993 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TODD M. BRODIGAN, Claimant
WCB Case No. 91-12483
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our March 11, 1993 order which: (1) reduced claimant's unscheduled permanent disability award for an integumentary condition from 50 percent to 41 percent; (2) reduced claimant's scheduled permanent disability for loss of use or function of his right leg from 66 percent to 5 percent; (3) declined claimant's request to set aside the Director's temporary standards as invalid; and (4) directed the self-insured employer to pay claimant's scheduled permanent disability at a rate of $145 per degree. Specifically, claimant contests his unscheduled and scheduled permanent disability awards, as well as our conclusions regarding the validity of the Director's temporary standards and the rate of claimant's scheduled permanent disability award.

In order to further consider claimant's motion, we withdraw our March 11, 1993 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY J. JOHNS, SR., Claimant
WCB Case No. 91-14220
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Garaventa's order that set aside its denial of claimant's occupational disease claim for left trigger fingers. On review, the issue is compensability.

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

We are not persuaded by Dr. Button's opinion for the reasons given by the Referee. In addition, Dr. Button incorrectly assumed that claimant's work activity did not require strenuous, repetitive gripping with the left fingers.

We also agree with the Referee's conclusion that claimant filed a timely occupational disease claim. Several years before claimant filed his claim, he was informed by Dr. McCullough that his condition was the result of strenuous activity with his hands and could be work related. (Ex. 1; Tr. 17-18, 21-22, 24-26, 28-29). A doctor's opinion that work may have caused an occupational disease is not sufficient to trigger the duty to file a claim. Ralph T. Masuzumi, 45 Van Natta 361 (1993). More importantly, claimant's condition first became disabling in February 1991 at the earliest, when he sought treatment from Dr. Singer. Claimant filed his claim within one year of the onset of disability. Accordingly, the claim was timely filed under ORS 656.807(1). Bohemia, Inc. v. McKillop, 112 Or App 261 (1992).

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 $750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 15, 1992 is affirmed. Claimant's attorney is awarded a $750 assessed attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
NANCY J. JONES, Claimant
WCB Case No. 92-07462
ORDER ON REVIEW
Michael B. Dye, P.C., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Hoguet's order that set aside its denial of claimant's occupational disease claim for skin lesions. 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 employment conditions were the major contributing cause of her skin condition. See ORS 656.802. The insurer contends that it is not responsible. Because the insurer did not give notice that it intended to disclaim responsibility for claimant's condition on the basis of exposure with other employers, it is precluded from defending this

claim on the basis of claimant's prior employment exposures. ORS 656.308(2); Richard F. Howarth, 44 Van Natta 1531, 1532, on recon 44 Van Natta 1673 (1992). Consequently, the insurer is responsible for claimant's compensable condition.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 9, 1992 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the insurer.

April 8, 1993 Cite as 45 Van Natta 749 (1993)

In the Matter of the Compensation of
DONALD E. LOWRY, Claimant
WCB Case No. 92-06158
CORRECTED ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

It has come to our attention that our prior Order on Review, which was dated April 7, 1993, was not signed by two Board Members. In order to correct this oversight, we withdraw our prior order and issue the following corrected order. THe parties' rights of appeal shall begin to run from the date of this order.

The SAIF Corporation requests review of Referee Livesley's order that affirmed an Order on Reconsideration that increased claimant's scheduled permanent disability for loss of use or function of the leg (knee) from 6 percent (9 degrees), as awarded by a Notice of Closure, to 13 percent (19.5 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 supplementation.

The claim was closed by a December 2, 1991 Notice of Closure, corrected on December 18, 1991, awarding claimant 6 percent (9 degrees) for the right knee and temporary total disability from May 9, 1991 through July 19, 1991 and temporary partial disability from July 20, 1991 through October 8, 1991.

Claimant requested reconsideration on February 20, 1992.

Dr. Baker, orthopedist, performed a medical arbiter examination on March 23, 1992.

A May 4, 1992 Order on Reconsideration increased claimant's scheduled permanent disability award to 13 percent (19.5 degrees) for the right leg (knee). The additional amount was based on an increased award for loss of range of motion and a 5 percent chronic condition.

Claimant filed a request for hearing on May 5, 1992, raising the issues of extent, premature closure, and temporary total disability. SAIF filed a response on June 12, 1992, asserting that the Order on Reconsideration and the awards of temporary disability should be affirmed and raising the issue of an offset in the amount of $198.48. On July 2, 1992, SAIF filed a cross-request for hearing, raising the issue of extent and requesting reduction of scheduled permanent disability.

Prior to hearing, claimant withdrew his request for hearing.

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is whether claimant has a chronic right knee condition, and, if so, whether the award for the chronic condition should be reduced. We affirm the Referee with the following supplementation.

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. OAR 436-35-010(6).

Where a worker has an asymptomatic and nondisabling preexisting condition or other physical defect, and the preponderance of medical opinion establishes that the injury caused the preexisting condition or defect to become symptomatic and disabling, the percentage of disability attributable to the increased symptoms from the preexisting condition or defect is not deleted from the worker's award. OAR 436-35-007(2).

Claimant experienced a 1973 right knee injury that resulted in a tear of the right medial collateral ligament (avulsion fracture of the anterior tibial spine) and excision of the medial meniscus. Claimant twisted his right knee in November 1979. However, Dr. Donahoo, orthopedist, reported that his right knee had been asymptomatic until the May 8, 1991 injury. (Ex. 7).

On October 8, 1991, Dr. Donahoo, who performed an independent medical examination, reported that claimant had "grinding" in the patellar area and discomfort after walking four blocks. Although he noted that claimant remained symptomatic, he predicted that the contusion and ligament strain would resolve in about three months with no anticipated residuals and proceeded to declare claimant medically stationary.

On March 23, 1992, Dr. Baker, orthopedist, performed a medical arbiter examination. He reported that claimant continued to have symptoms. He also stated:

> [Claimant] does have a permanent and chronic condition limiting repetitive use of his right knee due to traumatic arthritis which is related more than 50 percent to his preexisting right knee injury that occurred in 1973 and less than 50 percent to a contusion and strain of his right knee as a result of the work injury of May 8, 1991. (Ex. 17-4).

Based on this record, we are convinced that claimant is unable to repetitively use his right knee due to a chronic and permanent medical condition that has become symptomatic and disabling as a result of the compensable injury. Accordingly, the percentage of disability Dr. Baker attributes to the increased symptoms from the preexisting condition is not deleted from claimant's award.

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 extent issue is $1,175, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 31, 1992 is affirmed. Claimant's attorney is awarded $1,175 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ROBERT C. PLEW, Claimant
WCB Case Nos. 92-05246 & 92-02886
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Travelers Insurance Company (Travelers) requests review of Referee Bethlahmy's order that: (1) set aside its denial of claimant's claim for a low back condition; and (2) upheld the self-insured employer's denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. We replace the last sentence of the seventh paragraph with the following.

Claimant returned to his physician and was given anti-inflammatories and was put on light duty work for two weeks. (Ex. 15, Tr. 12).

CONCLUSIONS OF LAW AND OPINION

Although Travelers requested review of the Referee's order, none of the parties submitted briefs in this case. At hearing, Travelers continued to deny both compensability and responsibility. (Ex. 19, Tr. 4). After de novo review, we adopt the Referee's reasoning and conclusions regarding the responsibility issue with the exception of her discussion of objective findings. Thus, like the Referee, we conclude that Travelers did not establish that claimant sustained a new injury while working for the employer in its self-insured capacity. However, the Referee did not explicitly address compensability of the aggravation claim against Travelers.

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. A worsened condition is established with evidence of increased symptoms or a worsened underlying condition resulting in diminished earning capacity. If the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity must exceed that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991). In addition, the worsening must be established with medical evidence supported by objective findings. ORS 656.273(3).

Claimant sustained a symptomatic worsening as a result of the original injury. Dr. Rosenbaum noted that when he evaluated claimant "there were no objective findings but his symptoms were consistent with a lumbosacral strain." Thus, Dr. Rosenbaum diagnosed a worsening of the compensable condition based on expert analysis of his examination findings and claimant's reported symptoms. We have held that such evidence meets the definition of "objective findings." See Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991). Such findings may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471, 474 (1992).

At the time claimant's claim was closed on January 11, 1988, claimant was released to his "usual occupation with slight limitations at work to avoid heavy lifting and repetitive bending." (Exs. 14-1, 17). Following his symptomatic worsening, claimant was put on light duty for two weeks. (Ex. 15, Tr. 12). Thus, claimant sustained a diminished earning capacity as a result of the worsening.

Claimant also has the burden to prove that he has sustained a worsening of his compensable condition that is more than a waxing and waning of symptoms as contemplated by the last award or arrangement of compensation. ORS 656.273(8).

The record contains no medical evidence prior to the last arrangement of compensation regarding the possibility of future flare-ups. Thus, we conclude that no waxing and waning of symptoms was contemplated by the last award.

After our review of the record, we conclude that claimant has established a compensable worsening of his low back condition.

Travelers initiated review and claimant's compensation was not reduced or disallowed. If claimant had submitted a brief on Board review, he would have been entitled to to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290, 295-96 (1989). However, inasmuch as claimant submitted no brief, we conclude that he is not entitled to an attorney fee. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated June 19, 1992 is affirmed.

In the Matter of the Compensation of
ENRIQUETA M. RESTREPO, Claimant
WCB Case No. 92-01832
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Menashe's order which corrected a clerical error and increased claimant's scheduled permanent disability award for loss of use or function of the right forearm (wrist) from 6 percent (9 degrees), as awarded by Order on Reconsideration, to 8 percent (12 degrees), but otherwise affirmed the Order on Reconsideration. On review, the issue is extent of scheduled and unscheduled permanent disability.

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

In the second paragraph of the Referee's Opinion and Order, the date of the Determination Order should be May 21, 1991, not May 21, 1990.

Claimant contends that she is entitled to an impairment rating for loss of lumbar flexion based on the values measured by the medical arbiter. Alternatively, claimant asks that we remand for another arbiter's examination to obtain valid lumbar flexion measurements.

We have no authority to remand this matter to the Department. See Mickey L. Platz, 44 Van Natta 1056 (1992). We have, however, remanded to the Referee for receipt of a supplemental arbiter's report. In Anne W. Younger, 45 Van Natta 68, 69 (1993), the Department had determined that the medical arbiter's examination was incomplete and had instructed the arbiter to perform a supplemental examination. We reasoned that the Department is capable of correcting situations where an arbiter appointed by the Department fails to satisfactorily perform the examination.

Here, however, the Department accepted the medical arbiter's report and relied on it to determine the extent of claimant's scheduled and unscheduled permanent disability. The Department did not find the report incomplete and did not direct the arbiter to perform a supplemental examination. Instead, because the medical arbiter reported that the lumbar flexion measurements were not valid, the Department awarded no impairment for lumbar flexion. Under these circumstances, there is no basis to remand to the Referee. Anne W. Younger, supra.

Moreover, we find that the preponderance of medical evidence does not support a finding of permanent impairment due to reduced lumbar flexion, since claimant's treating doctor found no impairment and the medical arbiter's impairment measurements were invalid. (See Exs. 24, 31-3).

Accordingly, we affirm the Referee's order and decline to award claimant permanent disability based on the medical arbiter's measurements of impairment.

We further affirm the Referee's finding that claimant has no loss of strength in her right arm attributable to nerve injury, loss of muscle, or disruption of the musculotendinous unit. (Ex. 31-4). OAR 436-35-110(2)(a) (WCD Admin. Order 2-1991); Kent D. Anderson, 45 Van Natta 31 (1993). Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated May 19, 1992 is affirmed.

In the Matter of the Compensation of
ANA R. SANCHEZ, Claimant
WCB Case Nos. 92-04428 & 91-15830
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Bottini & Bottini, Defense Attorneys

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of Referee Mills' order that dismissed her request for hearing on the basis that she was a nonsubject worker. On review, the issues are dismissal and subjectivity. We reinstate claimant's request for hearing and remand.

FINDINGS OF FACT

On November 27, 1990, claimant filed a claim for a work-related injury. On April 26, 1991, the employer accepted the claim as a thoracic/lumbar strain. On June 16, 1992, the employer issued a "back-up" denial on the basis that claimant was not a subject worker at the time of her injury. Claimant requested a hearing contesting the employer's denial.

The employer moved to dismiss claimant's request for hearing contending that since claimant was not a subject worker, the Hearings Division did not have jurisdiction. On June 23, 1992, a hearing was held before the Referee. No exhibits were admitted nor was any testimony taken. On July 8, 1992, the Referee dismissed claimant's request for hearing based on his conclusion that claimant was not a subject worker.

CONCLUSIONS OF LAW AND OPINION

Relying on the court's decision in Kerns v. Guido-Lee, 107 Or App 721 (1991), the Referee dismissed claimant's request for hearing. We disagree that dismissal based on the proceedings before the Referee here was the correct remedy.

The Hearings Division has jurisdiction over any matter concerning a claim. ORS 656.283(1). Here, the employer issued a "back-up" denial of claimant's claim. Claimant requested a hearing on that denial. The employer's denial is a matter concerning a claim. Accordingly, the Referee had jurisdiction over claimant's hearing request. While the Referee could have set aside or upheld the employer's denial, it was not appropriate to reach the merits of the denial and dismiss claimant's request for hearing on a motion to dismiss for lack of jurisdiction without taking any evidence. Consequently, we reinstate claimant's request for hearing.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. See ORS 656.295(5).

The Referee dismissed claimant's request for hearing based on his conclusion that claimant was not a subject worker. As noted above, this is not grounds for dismissal but requires a decision on the merits. Because he dismissed claimant's request for hearing, the Referee did not admit any documentary evidence nor take testimony from claimant or any other witness.

Under these circumstances, we conclude that the record has been incompletely developed. Accordingly, we remand this matter to Referee Mills for further proceedings consistent with this order in any manner that will achieve substantial justice to all parties.

ORDER

The Referee's order dated July 8, 1992 is vacated. The matter is remanded to Referee Mills for further proceedings consistent with this order.

In the Matter of the Compensation of
GLORIA J. SCRIVEN, Claimant
WCB Case Nos. 91-08719 & 91-07641
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Charles Lundeen, Defense Attorney

Claimant requests reconsideration of that portion of our March 11, 1993 Order on Review that awarded an assessed attorney fee of $300 for her counsel's services on review. Considering the efforts expended by her counsel and the successful results obtained on review, claimant seeks an increased attorney fee award. The SAIF Corporation has responded, asserting that our $300 award was appropriate.

After reviewing claimant's motion and reconsidering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services on review is $500. This fee is in lieu of, not in addition to, the attorney fee granted in our prior order.

In reaching this result, we particularly note that responsibility, not compensability, was litigated on Board review. Thus, although compensability was theoretically at risk pursuant to our de novo review authority, in light of the insurer's respective responsibility arguments, that risk was minimal. Finally, claimant's attorney's efforts devoted to the penalty issue have been compensated through her counsel's 50 percent share of our penalty assessment.

Accordingly, our March 11, 1993 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our March 11, 1993 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
TERRY R. TOWNSEND, Claimant
WCB Case No. 91-05374
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Gruber's order that set aside its April 23, 1991 denial, as revised June 19, 1991, which denied claimant's medical services and aggravation claims for his current low back condition. Contending that claimant's September 1987 compensable low back injury is not the major contributing cause of his current condition, the insurer argues that its denials should be reinstated and upheld.

We have conducted our review of this case in conjunction with our review of the insurer's appeals from two other orders. WCB Case Nos. 92-06170; 92-10241.

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

The insurer has essentially two theories in defense of its denials. One, the major contributing cause of claimant's current low back condition is an off-the-job "power saw / heavy lifting" incident. See ORS 656.273(1). Secondly, claimant's compensable low back injury combined with a preexisting degenerative condition creating a resultant condition, the major contributing cause of which is no longer claimant's compensable injury. See ORS 656.005(7)(a)(B).

Concerning the first theory, claimant has the initial burden of proving that his compensable injury is a material contributing cause of his 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). Once that test is satisfied, if a carrier denies an aggravation claim on the grounds that an off-the-job injury or repetitive activity is the major contributing cause of the worsened condition, the carrier has the burden of proof of establishing such a contention. Roger D. Hart, 44 Van Natta 2189 (1992); Lucky L. Gay, 44 Van Natta 2172 (1992).

Here, Dr. Crocker, claimant's treating physician, concluded that the 1987 industrial injury caused claimant's low back degenerative condition to become symptomatic and that the injury continued to be "a major contributing cause of the need for treatment of his current disability." Such a conclusion meets claimant's initial burden of proving a material relationship between the compensable injury and his current condition. ORS 656.266; Roger D. Hart, supra. However, Dr. Crocker's opinion does not establish the insurer's burden of proving that the major contributing cause of claimant's worsened condition was an off-the-job injury or repetitive activity. Roger D. Hart, supra; Lucky L. Gay, supra. Consequently, we hold that the insurer's aggravation denial is not sustainable under ORS 656.273(1).

Turning to the insurer's "resultant condition" denial, we acknowledge that Dr. Crocker did not expressly state that claimant's compensable injury was the major contributing cause of his current condition. Specifically, after conceding that it was "conjecture" as to whether claimant's degenerative condition predated his 1987 compensable injury, Crocker stated that "it is probably more likely that the abnormalities found on the x-rays of November 1987 actually were present at the time of the injury." After making that qualification, Dr. Crocker proceeded to conclude that claimant's industrial injury caused his condition to become symptomatic and continued to be "a major contributing cause of the need for treatment of his current disability."

To be sufficient to establish the compensability of a claim, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Considering the admitted conjectural nature of Dr. Crocker's "preexisting" conclusion, we find his overall opinion sufficient to establish that claimant's 1987 compensable low back injury remains the major contributing cause of any current resultant condition. Accordingly, we agree with the Referee's ultimate conclusion that claimant's need for medical treatment and low back disability is compensable.

Finally, the insurer seeks our consideration in this case of an exhibit which was admitted in a subsequent case (WCB Case No. 92-06170). Noting that these cases have been consolidated for purposes of review, the insurer asserts that the records are likewise consolidated.

Inasmuch as our review of a Referee's order is statutorily confined to the record developed before that Referee, we are not inclined to grant the insurer's request. ORS 656.295(5). Nevertheless, we need not resolve that question because even if we could consider the exhibit (a May 1991 letter from a Department vocational consultant to claimant's attorney regarding claimant's excuses for failing to report his lack of attendance at January 1991 vocational training and claimant's discussions with his treating physician), we would continue to reach the aforementioned conclusion that claimant's claim for benefits is compensable.

Since the insurer has requested review and we have found that claimant's compensation awarded by the Referee's order has not been disallowed or reduced, claimant is entitled to an attorney fee. ORS 656.382(2). After consideration of the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services on review is $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 and counsel's combined statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 12, 1992 is affirmed. For services on Board review, claimant's attorney is awarded $500, to be paid by the insurer.

In the Matter of the Compensation of
TERRY R. TOWNSEND, Claimant
WCB Case No. 92-10241
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Myzak's order which declined to address issues involving premature closure, extent of permanent disability, offset, and vocational assistance because those issues had either been litigated or reserved pursuant to an earlier referee's order. On review, the issue is the propriety of the Referee's dismissal order.

We have conducted our review of this case in conjunction with our review of the insurer's appeals from two other orders. WCB Case Nos. 91-05374; 92-06170.

We affirm and adopt the order of the Referee.

Although the insurer has initiated Board review and we have affirmed the Referee's order, claimant is not entitled to an attorney fee for services on review because the Referee's order did not award claimant compensation. See ORS 656.382(2).

ORDER

The Referee's order dated October 13, 1992 is affirmed.

In the Matter of the Compensation of
KATHLEEN A. WILFONG, Claimant
WCB Case Nos. 92-02770 & 91-14341
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of that portion of our March 4, 1993 Order on Review that set aside its denial of claimant's aggravation claim for her neck condition. SAIF contends that our order did not address its contention that claimant's current condition is not materially related to her accepted claim.

On March 19, 1993, we withdrew our order to allow the parties an opportunity to respond. Having received the parties' responses, we proceed with our reconsideration.

We affirmed and adopted the Referee's order wherein she considered and rejected SAIF's argument that neither claimant's current condition nor her need for treatment is materially related to her accepted claim, and concluded that claimant's current condition is a continuation of the occupational disease claim previously accepted by SAIF. On reconsideration, SAIF does not contend that claimant's current condition constitutes a "consequential" or "resultant" condition. See ORS 656.0055(7)(a)(A),(B). Rather, SAIF requests that we address its argument that "the causal link between the injurious work exposure has continuously declined such that it no longer plays any causal role in claimant's current need for treatment and her current disability."

SAIF relies on the opinion of its medical reviewer, Dr. Strukel, as allegedly supported by treating physician Hoeflich. SAIF accepted claimant's claim for cervical spine "muscle fatigue." Dr. Strukel noted that claimant has preexisting abnormal neck musculature, and then theorized that because claimant's current work activities are the primary cause of her pain, with "the passage of time," the 1984 exposure has essentially been eliminated as a cause of claimant's current need for treatment. We do not find his opinion persuasive.

Dr. Hoeflich agrees that claimant's continuing work as a data entry operator is the primary cause of her ongoing pain. Nonetheless, she opines that the compensable 1984 injury "triggered" claimant's chronic neck condition, which causes the pain.

Having considered SAIF's arguments, we continue to conclude that claimant's current condition and need for treatment are materially related to her accepted claim with SAIF. Consequently, SAIF remains responsible for claimant's compensable occupational disease.

Claimant is entitled to an additional attorney fee for services on reconsideration. See ORS 656.382(2). After consideration of the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services on reconsideration is $150, to be paid by the SAIF Corporation. This fee is in addition to the attorney fee granted by our prior order. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our March 4, 1993 order. On reconsideration, as supplemented herein, we adhere to and republish our March 4, 1993 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
RICHARD R. MILLUS, Claimant
WCB Case No. C3-00554
ORDER DISAPPROVING CLAIMS DISPOSITION AGREEMENT
Davis, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

On March 3, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

When a CDA is approved under the provisions of ORS 656.236 and OAR 438-09-020, an attorney fee may be approved by the Board in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of any amount of the proceeds in excess of $12,500. See OAR 438-05-052. Under extraordinary circumstances, a fee may be approved in excess of 25 percent of the proceeds. Id; Rollie Clark, 43 Van Natta 194 (1991).

Here, the attorney fee exceeds the amount allowed pursuant to OAR 438-15-052. Specifically, the disposition provides for a total consideration of $22,500, from which $15,007.50 is to be paid to claimant and $7,492.50 is to be paid to claimant's attorney. In addition, a statement of services and statement of costs have been submitted in support of an extraordinary attorney fee.

Upon receipt of the CDA and the accompanying statements, we requested an addendum clarifiying the extraordinary attorney fee. Claimant's second addendum, dated March 25, 1993, provides that the statement of costs should be deleted. See Debbie Ziebert, 44 Van Natta 51 (1992). However, the remainder of the addendum provides that all services listed in claimant's attorney's statement of services "relate directly to obtaining the CDA and to the eventual stated cash value of the CDA."

After a review of counsel's statement of services, we do not agree that the services relate directly to obtaining the CDA. The above-referenced CDA settles claimant's accepted cervical, thoracic and lumbar strain conditions. (CDA, Pg. 2, Ln. 12). However, the CDA statement of services provides that claimant's attorney spent time preparing to go to hearing on the issues of "de facto" denials of claimant's psychological condition and rheumatoid arthritis condition.

As we have previously held, where the services provided are for different proceedings and are separate and distinct from the obtaining or formulation of a proposed CDA, such services are not directly related to the CDA and do not constitute extraordinary circumstances sufficient to justify a larger attorney fee. See David D. Buchanan, 43 Van Natta 1187 (1991). In the present case, claimant's counsel's services were not only provided for prior proceedings, they were also provided for conditions that had not been accepted and could not be disposed of via a CDA.

Furthermore, we find that counsel was previously compensated for his legal services relating to the psychological and arthritis conditions. In this regard, we note that an extraordinary attorney fee was approved by a Referee in a February 1993 Disputed Claim Settlement (DCS) which settled claimant's psychological and arthritis conditions in WCB No. 92-10124. Accordingly, because the statement of services submitted on this CDA is identical to the statement of services submitted on the DCS, we conclude that the services cited in support of an extraordinary CDA attorney fee are not for services directly related to the obtaining or formulation of the proposed CDA.

Consequently, we are not persuaded that extraordinary circumstances exist to justify a fee greater than provided under normal circumstances. Thus, the agreement is unreasonable as a matter of law, and therefore must be disapproved. See ORS 656.236(2); David D. Buchanan, supra.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD ANGELL, Claimant
Own Motion No. 92-0551M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable cervical condition. Claimant's aggravation rights expired on October 14, 1986. SAIF opposes the reopening of the claim on the ground that the requested surgery is not reasonable and necessary for the compensable injury.

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.

Neither the Hearings Division nor the Board has original jurisdiction over questions regarding the reasonableness and necessity of medical services. ORS 656.327; 656.704(3); Stanley Meyers, 43 Van Natta 2643 (1991). Here, claimant is subject to the rules of an MCO. Therefore, pursuant to OAR 436-10-046(1), a dispute regarding medical services must first be processed through the MCO's dispute resolution procedures. Dr. Grewe, claimant's treating physician, recommended an anterior discectomy and interbody fusion at C3-C4 and C4-C5, with decompression of the nerve roots. However, Caremark Comp, the MCO in this case, determined that the proposed cervical surgery was not appropriate. SAIF indicates that Dr. Grewe has appealed this determination to the next level of review within the Caremark Comp organization.

Until this dispute involving the appropriateness of the proposed surgery is resolved, we are unable to proceed regarding the own motion claim because we are unable to determine whether claimant sustained a worsening of the compensable condition that requires surgery or hospitalization. Therefore, we defer action on this request for own motion relief. We request that the parties advise the Board of their respective positions regarding own motion relief upon resolution of the dispute regarding the appropriateness of the proposed surgery.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELMER F. KNAUSS, Claimant
WCB Case No. 91-08465
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Lipton and Hooton.

The SAIF Corporation requests review of Referee Herman's order that set aside its denial of claimant's injury claim for a cardiovascular condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant was unloading and loading 16 foot, not 6 foot, "2 by 4's" immediately preceding his myocardial infarction.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's cardiovascular condition is compensable, based on the treating physician's report. SAIF argues that that conclusion is erroneous, because the report of the independent medical examiner is more persuasive. We disagree.

Claimant contends that his myocardial infarction was sudden and unexpected. Moreover, neither party contends, and nothing in the record suggests, that his claim involves a consequential condition or a worsening of a preexisting condition. Consequently, claimant need only prove that his work was a material contributing cause of his disability and need for treatment. Jon A. Rogers, 44 Van Natta 2313, 2315 (1992); Mark N. Wiedle, 43 Van Natta 855, 856 (1991). Because claimant's cardiovascular condition could have resulted from various medical causes, we conclude that the question of medical causation in this case requires expert medical evidence. Thurston v. Mitchell Bros. Contractors, 58 Or App 568, 575 (1982).

There are two medical opinions concerning the cause of claimant's myocardial infarction. Dr. Drips, an internist and claimant's treating physician, opined that claimant's work activities were the major contributing cause of claimant's disability and need for treatment. He based his conclusion on his observations of claimant and the medical records, including the electrocardiogram (EKG) readings taken soon after claimant's admission to the hospital. In his view, those readings show that "the initial episode of chest pain for which the patient was admitted to the hospital did in fact represent a partial thickness or non Q wave myocardial infarction." (Ex. 49). Because claimant is moderately obese, had been physically inactive for a protracted period of time prior to engaging in the strenuous labor, and reported working up a sweat just prior to experiencing chest pain, Dr. Drips concluded that "the physical activity that he had been involved in prior to the onset of his chest pain seemed to be of a sufficient level that could provoke symptoms of myocardial ischemia and/or infarction." (Ex. 49).

Dr. Toren, a cardiologist, conducted an independent medical examination. He reviewed claimant's complete medical file and concluded that claimant's work activities had no causative influence on his myocardial infarction, and that it is just as likely that claimant would have suffered that infarction had he stayed home. He opined that claimant suffered a non-work related, Q-wave myocardial infarction, based on the lack of fixed arteriosclerotic disease and the presence of coronary thrombosis. He stated that with non Q-wave infarctions, there are always very tight obstructions found within several coronary arteries and, in some cases, coronary thrombosis is not found. Dr. Toren noted that claimant's reaction to various treatment modalities indicates that thrombosis was present, and an angiogram revealed that claimant had moderate obstructions in his arteries due to coronary artery disease. Dr. Toren further opined that, even if claimant's myocardial infarction was non Q-wave type, his work activities just prior to the onset of his pain were not sufficient to cause the infarction. Dr. Toren said:

> When an imbalance of supply and demand caused by physical exertion leads to myocardial infarction, one expects the physical exertion to be severe, and once pain begins, one expects to see the exertion continued for at least 20 to 30 minutes in order for cell death, or myocardial infarction, to be expected as the result of an exertion-related

imbalance of supply and demand. In this case, the pain did not begin until after Mr. Knauss had ceased carrying the 2X4's, and had entered the nearby building. (Ex. 47).

In response to Dr. Toren's report, Dr. Drips opined that the coronary artery disease revealed by the angiogram "could reasonably have resulted in myocardial infarction." (Ex. 49). He also indicated that he was unaware of any data that states that a person must remain physically active following the onset of ischemic chest pain for a myocardial infarction to result. In his experience, "many such episodes occur in the absence of physical activity or, indeed, following varying interval episodes of vigorous physical activity." (Ex. 49).

The Referee found that the claim was compensable based on Dr. Drips' opinion. SAIF contends that Dr. Toren's report is more persuasive, because the medical opinions were based upon expert analysis of objective evidence, not upon observation of claimant, and Dr. Toren is a specialist.

We agree with SAIF that, when a case involves expert analysis of objective evidence, rather than external observation of the claimant, we do not give special credit to the evidence from treating physicians as opposed to other doctors. Allie v. SAIF, 79 Or App 284, 287 (1986). We also agree that this case is based upon the analysis of objective medical evidence. Nevertheless, that does not necessarily mean that Dr. Drips' opinion is not persuasive. Rather, when medical experts disagree, we give more weight to the medical opinion that is based on the most complete information and is the most well reasoned. Somers v. SAIF, 77 Or App 259, 263 (1986). In conducting that evaluation, we note that Dr. Toren's status as a specialist in cardiology, as opposed to Dr. Drips' status as an internist, is not dispositive. Thurston v. Mitchell Bros. Contractors, supra, 58 Or App at 575.

After reviewing the opinions of Dr. Drips and Dr. Toren, we find Dr. Drips' report more persuasive. Although both reports are well reasoned, Dr. Drips' report is more thorough and is based on a better understanding of claimant's physical condition and work activities just prior to the onset of his chest pain. In his report, Dr. Toren fails to explain the significance of the EKG readings that, in Dr. Drips' opinion, did not show Q-waves. Dr. Toren also described claimant's work activities as "not very heavy," although that work involved moving 16 foot long 2X4's, and claimant is moderately obese and physically deconditioned. Dr. Drips explained the significance of claimant's physical condition and work activities as they relate to myocardial infarction. He also opined that claimant's coronary artery disease was sufficient to cause a non Q-wave myocardial infarction. Although Dr. Toren stated that thrombosis is associated with Q-wave infarctions, he did not say that thrombosis could not be associated with non Q-wave infarctions.

In concluding that Dr. Drips' report is more persuasive, we recognize that his opinion asserts that claimant's work activities "seemed to be of a sufficient level" to cause claimant's myocardial infarction. That statement could be read as suggesting only a possibility of work-related causation, which is insufficient to satisfy the material contributing cause standard. Wayne B. Palmer, 44 Van Natta 951, 952 (1992). Nevertheless, when viewed in context, we read Dr. Drips' opinion as saying that, within reasonable medical certainty, claimant's work was a material contributing cause of his myocardial infarction.

Because Dr. Drips' opinion is more thorough and based on a clearer understanding of claimant's history, we find it more persuasive. Therefore, claimant proved by a preponderance of the evidence that his work activities were a material contributing cause of his myocardial infarction, and we agree with the Referee's conclusion that the claim is compensable.

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 $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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 25, 1992 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MARY J. HARP, Claimant
WCB Case No. 92-06856
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The SAIF Corporation requests review of that portion of Referee McCullough's order that assessed a penalty for its allegedly unreasonable denial of claimant's occupational disease claim. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings, except for the last sentence in the "Findings of Fact" section.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAIF's May 15, 1992 denial of claimant's bilateral forearm tendinitis claim was not unreasonable when issued. Finding, however, that Dr. Hoppert's July 23, 1992 letter "destroyed any legitimate doubt SAIF previously had about the compensability of claimant's claim," the Referee concluded that SAIF's continued denial of the claim was unreasonable. We disagree.

A penalty for unreasonable denial may be assessed against an insurer or self-insured employer for unreasonable delay or refusal to pay compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Although an insurer may reasonably deny a claim, it may later obtain information that makes continuation of the denial unreasonable. The insurer is under a continuing obligation to process the claim, and must continually reevaluate its denial and rescind a denial which is or becomes unreasonable prior to the issuance of an order setting the denial aside. Id. at 592.

Here, SAIF contends that it continued to have a legitimate doubt as to its liability for claimant's condition. Specifically, SAIF argues that Dr. Hoppert's letter was vague and conclusory and was, therefore, not sufficient to render its originally reasonable denial unreasonable, particularly in light of an independent medical examination by Dr. Button, who failed to document objective findings to support a compensable condition.

Although Dr. Hoppert's post-denial report was arguably favorable to claimant, SAIF also had Dr. Button's report strongly suggesting that claimant's claim was not compensable. The existence of this contrary report continued to provide SAIF with legitimate doubt, even after a new report came in supporting compensability.

Based upon this evidence, we conclude that SAIF continued to have a legitimate doubt concerning its liability for claimant's occupational disease claim. Accordingly, the Referee's penalty assessment is reversed.

ORDER

The Referee's order dated August 27, 1992, as reconsidered September 18, 1992, is reversed in part and affirmed in part. That portion of the Referee's order that assessed a penalty against the SAIF Corporation for allegedly unreasonable denial is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JUDY M. LUSBY, Claimant
WCB Case Nos. 92-05280 & 92-00195
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Lipton and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Sea Breeze Restaurant, requests review of those portions of Referee Peterson's order that: (1) found that claimant's aggravation rights arising from a 1986 back injury had not expired when she perfected her aggravation claim in 1991; (2) directed it to process the claim under ORS 656.273; and (3) awarded an assessed attorney. Claimant has moved for an order dismissing Liberty Northwest's request for review on the ground that the insurer's request raised only a "responsibility" issue, which Liberty Northwest and another insurer settled prior to hearing. On review, the issues are dismissal, timeliness of claimant's aggravation claim, and attorney fees. We deny the motion and affirm.

FINDINGS OF FACT

We adopt those portions of the Referee's order entitled "Issues" and "Findings of Fact." We supplement the Opinion and Order with our Finding of Ultimate Fact.

FINDING OF ULTIMATE FACT

Claimant perfected her aggravation claim by August 29, 1991, less than five years from the October 30, 1986 Determination Order which first closed her back injury claim.

CONCLUSIONS OF LAW AND OPINION

Motion to dismiss

Claimant has moved for an order dismissing Liberty Northwest's request for review on the ground that its request raised only a "responsibility" issue which was settled prior to hearing.

Liberty Northwest's request for review asserts that the Referee "made errors of fact finding and errors of law regarding responsibility." In its Appellant's Brief, Liberty Northwest responds to claimant's motion, conceding that the reference to "responsibility" in its request was "simply a mistake." We have previously held that when a request for Board review inaccurately reflects the issue for resolution, we are without authority to dismiss a timely filed request for review. James F. Herron, 44 Van Natta 2065 (1992). Consequently, we deny claimant's motion to dismiss and proceed to the issues raised on review.

Aggravation claim

We adopt the Referee's "Conclusions of Law and Opinion" and his conclusion, inter alia, that claimant perfected her aggravation claim by August 29, 1991, the date Liberty Northwest received Dr. Nash's August 22, 1991 report (see Ex. 46). See ORS 656.273(4). In our view, Nash's report was sufficient to make a prima facie case that claimant's compensable condition had worsened from a medical standpoint and that the worsening, which included new left leg symptoms, was more than a waxing and waning of symptoms contemplated by the prior permanent disability award. See Herman M. Carlson, 43 Van Natta 963 (1991), aff'd on other grounds Carlson v. Valley Mechanical, 115 Or App 371 (1992).

Attorney fees

Liberty Northwest argues that, insofar as the Referee's attorney fee award was based on claimant prevailing on the compensability of her aggravation claim, the award was improper because it never denied compensability. We disagree.

Liberty Northwest did not timely accept or deny claimant's request for claim reopening. Rather, its position was that, since claimant's request for reopening was filed after the expiration of her 5-year aggravation rights, authority to consider the matter rested with the Board under its "own motion" authority under ORS 656.278. However, as we have stated, claimant perfected her aggravation claim by August 29, 1991 prior to the expiration of her aggravation rights. There is no evidence that Liberty Northwest accepted or denied the claim within 90 days, as required by ORS 656.262(6). Thus, the claim is deemed denied "de facto," after expiration of 90 days, i.e., well before the May 28, 1992 hearing when Liberty Northwest conceded "responsibility." See Safeway Stores, Inc., v. Smith, 117 Or App 224, 227-28 (1992); Barr v. EBI Companies, 88 Or App 132 (1987). Consequently, we agree with the Referee's conclusion that claimant is entitled to an assessed attorney fee for pre-hearing services connected with prevailing on the "de facto" denied aggravation claim without a hearing. See Lisa A. Hyman, 44 Van Natta 2516 (1992).

In addition, claimant is entitled to an assessed attorney fee for prevailing over Liberty Northwest'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 $700, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 18, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $700, payable by Liberty Northwest.

In the Matter of the Compensation of
JUDITH MALEJS, Claimant
WCB Case No. 92-05456
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of that portion of Referee Black's order that upheld the SAIF Corporation's "de facto" denial of medical treatment for claimant's diabetes condition. On review, the issue is compensability.

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

Claimant contends that her February 1991 fall while performing her work activities triggered a temporary worsening of her preexisting diabetes condition. Inasmuch as claimant's compensability theory is premised on a combination of her work-related injury and her preexisting condition, she must establish that her work-related injury is the major contributing cause of her diabetes condition and resulting need for medical treatment.[1] ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). For the reasons expressed by the Referee, we conclude that claimant has not satisfied her requisite burden of proof.

ORDER

The Referee's order dated September 28, 1992 is affirmed.

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[1] Relying on Albany General Hospital v. Gasperino, 113 Or App 411 (1992), claimant asserts that, since her worsened diabetes condition was a primary consequence of her work-related fall, she need only establish that the fall was a material contributing cause of her diabetes condition. We disagree.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. Albany General Hospital v. Gasperino, supra. In Gasperino, the Board had found that claimant's work-related slip and fall directly caused her thoracic outlet syndrome. Based on such a finding, the court held that the Board had correctly analyzed the claim based on a "material contributing cause standard." Id.

The present case is distinguishable. In Gasperino, the claimant's thoracic outlet syndrome directly arose from her work-related fall. Here, in contrast, claimant's diabetes condition preexisted her work-related fall. Since the record does not establish that claimant's fall directly caused her diabetes condition, the "material contributing cause standard" of Gasperino is not applicable. Rather, because claimant is seeking compensation for a temporary worsening of her preexisting diabetes condition and the evidence establishes that her work-related injury has combined with that preexisting condition to cause claimant's current diabetes condition and need for medical treatment, claimant must prove that her work-related injury is the major contributing cause of her resultant diabetes condition and need for medical treatment for that resultant condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra.

In the Matter of the Compensation of
BEVERLY Y. MOORE, Claimant
WCB Case No. 90-21625
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of that portion of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for a right knee condition. The insurer also requests review of our March 17, 1992 order that remanded the case to the Referee for the taking of additional evidence. On review, the issues are compensability and remand. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On March 17, 1992, we remanded this case to the Referee for the submission and consideration of additional evidence. Beverly Y. Moore, 44 Van Natta 474 (1992). Contending that our conclusions in that case are erroneous, the insurer seeks withdrawal of our prior decision and affirmance of the Referee's initial order which had upheld the insurer's denial. For the reasons expressed in our prior order, we conclude that we properly remanded this case for receipt of additional evidence. Accordingly, we proceed to the merits.

Compensability

The Referee concluded that claimant's right knee condition is compensable. The insurer contends that the physicians' opinions were insufficient to satisfy claimant's burden of proof. We agree.

Claimant contends that her right knee condition came on gradually over time. We agree. Consequently, to establish compensability, claimant must prove that her employment conditions were the major contributing cause of her right knee condition or its worsening. ORS 656.802(1)(c); ORS 656.802(2). Moreover, she must establish the existence of the condition by medical evidence supported by objective findings. ORS 656.802(2).

The existence of claimant's right knee condition is not in dispute. The sole issue is whether claimant's employment conditions were the major contributing cause of that condition or its worsening. Considering claimant's preexisting right knee condition and total right knee arthroplasty, we conclude that the medical causation issue is a complex one requiring expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967).

The record contains two physicians' opinions regarding whether claimant's work activities were the major contributing cause of her knee condition. Dr. Smith, M.D., the physician who performed a July 1990 right knee surgery, opined that claimant's "work aggravated her knee, however, in all honesty, I feel that it is probably a combination of her size as well as relatively young age that will lead to further problems in the future as well." (Ex 11). Significantly, Dr. Smith made that report in response to a letter from claimant's counsel's asking him to determine whether claimant's "work activity as described was a material contributing cause to the worsening of her knee condition." (Ex 11). (Emphasis supplied).

Dr. Johnson, M.D., the physician who initially replaced claimant's knee in April 1988 and who, in December 1990, surgically corrected some minor problems resulting from claimant's July 1990 surgery, also opined that claimant's work activities had some causative relationship to her need for treatment. He said:

"Although Patella problems of this sort occurs [sic] in 30-40% of patients after total knee replacements, certain excessive activities such as repetitive stair climbing and squatting will aggravate and worsen postoperative patella fractures and subluxation, if not become the primary cause of such problems. This seems especially true in patients with persistent quadriceps weakness and those whose postoperative flexion does not develop beyond 105-110 [degrees] of motion.

"Therefore, I do feel that the work activities [claimant] was required to do prior to July 17, 1990 was a significant factor in the patella fragmentation and her need for subsequent surgeries." (Ex 12).

Neither physician's opinion expressly states that claimant's work activities prior to July 17, 1990 were the major contributing cause of her disability and need for treatment. Although magic words are not required to prove compensability, McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), we are not persuaded in this case that the physicians' opinions prove that claimant's work activities were the major cause of a worsening of her underlying knee condition.

As previously noted, Dr. Smith's opinion responded to counsel's inquiry as to whether claimant's work activities were a material contributing cause of her knee condition. That is a lesser causal standard than the major contributing cause that claimant must prove. Nevertheless, Dr. Smith could only assert that claimant's work activities aggravated her knee condition. From his statement that other factors would most likely cause future problems with claimant's knee, we conclude that he believed that those factors were at least equally causal, if not the major cause of her current knee condition. In any event, his failure to expressly state that claimant's work activities were the major contributing cause of here right knee condition suggests that he was not of that opinion.

Concerning Dr. Johnson's report, we note that he initially said that certain excessive activities, such as stair climbing, can become the primary cause of patella problems. However, when he specifically commented on the causative influence of claimant's work activities, he said that those activities were "a significant factor." Although Dr. Johnson does not define "primary cause" or "significant factor," when his report is viewed in context, we infer that he considered "primary" to be a greater contribution than "significant." Because Dr. Johnson did not explain the distinction between a primary cause and a significant factor, and eventually attributed claimant's work to the lesser "significant factor" standard, and because Dr. Johnson acknowledged that there was a 40 percent chance that claimant's current knee condition is not work related, we do not conclude that he considered claimant's work activities to be the major contributing cause of that condition. Moreover, although Dr. Johnson indicated that "excessive" activities, such as stair climbing, can be a primary cause of patella problems, he failed to specify what constitutes "excessive" activities. Consequently, we cannot conclude that claimant's activities were "excessive."

Because we find neither physician's opinion persuasive, we conclude that claimant has failed to prove the compensability of her0right knee condition. See Carolyn Ettinger-Charley, 43 Van Natta 2355, 2356 (1991). Therefore, we reinstate the insurer's denial.

ORDER

The Referee's order dated September 24, 1992 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $3,000 is also reversed.

In the Matter of the Compensation of
GERALD K. HALE, Claimant
WCB Case No. 90-07637
ORDER ON RECONSIDERATION (REMANDING)
Parks & Ratliff, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

On February 9, 1993, we withdrew our January 11, 1993 Order on Review that had set aside the SAIF Corporation's denial of claimant's left shoulder injury claim. We took this action to consider SAIF's motion for reconsideration. Among other issues, SAIF contends that: (1) we failed to address a procedural issue involving an open Arizona claim for claimant's left shoulder; and (2) we did not apply the major contributing cause standard consistent with the court's holding in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

While this matter has been under consideration, claimant has submitted materials concerning his compensable bilateral shoulder injury claim in Arizona. All those materials were generated subsequent to the date of the initial hearing in this case. (March 12, 1991). SAIF has no objection to the inclusion of the supplemental exhibits, labeled A through G, in the record. Inasmuch as we are not at liberty to consider such post-hearing evidence, we treat the submission of the proposed exhibits as a motion for remand and consider the materials solely for that purpose.

We may remand a case for further evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Although evidence in the original record refers to a prior bilateral shoulder injury and surgery in Arizona, there are no medical or lay reports from Arizona concerning the injury and claimant's bilateral rotator cuff surgery. Moreover, the dates of injury and surgery mentioned in reports that were admitted in the original record are not the same as dates in recently submitted reports of the State Workers' Compensation Insurance Fund of Arizona. (See Ex. 20-A, Supp. Ex. A-1). Finally, the newly submitted exhibits also clarify claimant's medically stationary date and the amount of permanent disability he received under his Arizona claim. (Supp. Exs. F-1, G-1).

In light of such circumstances, we consider the current record (without the "Arizona" exhibits, as well as any additional documentary or testimonial evidence concerning this compensability issue) to be incompletely and insufficiently developed. See ORS 656.295(5). Moreover, we conclude that the proferred evidence was not obtainable at the time of hearing and is reasonably likely to affect the outcome of the case. Finally, the admission of this evidence, as well as other documentary or testimonial evidence bearing on this compensability issue, will assist the Referee in considering the "open Arizona claim" and Nazari issues raised by SAIF. See Cain v. Woolley Enterprises, 301 Or 650, 654 (1986).

Accordingly, we vacate all prior orders and remand this case to Referee Baker to admit this "Arizona claim" submission, as well as any additional documentary or testimonial evidence the parties wish to offer which the Referee considers relevant to this compensability issue and the parties' arguments. The proceedings to admit this evidence shall be conducted in any manner that the Referee finds achieves substantial justice and will insure 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
ALBERT H. IVERSON, Claimant
WCB Case Nos. 91-04142, 91-02798 & 91-04141
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
David Lillig (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Barber's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (3) upheld Cigna Insurance's denial of claimant's aggravation claim for the same condition. Claimant cross-requests review contending that: (1) Oregon Workers' Compensation Law and administrative rules pertaining to unilateral termination of temporary disability benefits are unconstitutional; and (2) Liberty Northwest should be penalized for a frivolous appeal. On review, the issues are compensability, responsibility, constitutionality, and penalties.

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

In his cross-request for review, claimant contends that Oregon Workers' Compensation Law and administrative rules pertaining to termination of temporary disability benefits violate the due process clauses of the United States and Oregon Constitutions. Inasmuch as claimant has prevailed on the merits of the temporary disability issue, the issue is moot and we decline to address it.

Claimant also contends that Liberty Northwest should be penalized on the basis that its appeal is "frivolous." We disagree. We have previously held that the Board has not been granted statutory authorization to assess a penalty for a frivolous request for Board review. Verl E. Smith, 43 Van Natta 1107 (1991); Donald G. Messer, 42 Van Natta 2085 (1990). In any event, even if we possessed such authority, we would not consider Liberty's request to be frivolous.

To begin, claimant has not advanced any factual argument in support of its assertion that Liberty Northwest's appeal is frivolous. Moreover, since claimant has two previous accepted back claims and was contending that his "new injury to his back stemmed from the knee-twisting incident," we consider Liberty Northwest to have had a legitimate basis for its appeal.

Inasmuch as Liberty Northwest requested review, claimant is entitled to an attorney fee pursuant to ORS 656.382(2). However, claimant's respondent brief was rejected as untimely, and claimant's counsel did not provide any other services on review regarding the issues appealed by Liberty Northwest, therefore, no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated May 29, 1992 is affirmed.

In the Matter of the Compensation
CHRISTOS KEKRIDES, Claimant
WCB Case No. 92-04564
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Hoguet's order that affirmed a Medical Director's order under ORS 656.327(2) finding acupuncture and physical therapy treatment provided by claimant's attending physician more often than twice a month to be excessive. In his brief, claimant contends that the Director's order should be set aside because the insurer's "Notice of Intent to Request Review by the Director" was allegedly deficient. Alternatively, claimant contends that the Director's order was not supported by substantial evidence. On review, the issues are sufficiency of the insurer's notice and substantial evidence. We affirm.

CONCLUSIONS OF LAW AND OPINION

Sufficiency of Notice

Contending that the insurer's request for review did not address "any harm" which might befall him should his current treatment be reduced, claimant argues that the insurer failed to comply with the procedural requirements of former OAR 436-10-046(2)(d) (WCD Admin. Order 32-1990). Therefore, claimant argues, the Director's order must be set aside. For the following reasons, we disagree.

First, we find no authority in the statutes, rules or case law granting us the authority to provide the relief requested by claimant. Neither does claimant cite specific authority supporting his request. Second, we note that claimant failed to challenge the sufficiency of the insurer's notice before the Director. Rather, after the insurer notified him that it was seeking to limit his acupuncture treatments to twice a month, claimant provided additional evidence for inclusion in the record and participated fully in the review before the Director. Finally, we do not find that the insurer's notice was defective. The insurer based its request to reduce the frequency of claimant's acupuncture treatments on the opinion of Dr. Wilson, independent examining neurologist. Wilson reported, as have all other examining and consulting physicians, that claimant's pain is not organic. Therefore, Dr. Wilson opined, no physical treatment is reasonable or necessary. Thus, we do not find that it was unreasonable for the insurer to conclude that no harm would befall claimant if its request to limit treatment was granted.

In his March 4, 1992 order, the Director concluded that acupuncture and physical therapy treatment more than twice a month is excessive for claimant's current low back condition. ORS 656.327(2) provides, in pertinent part, that "[r]eview of the 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." Substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988); Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992); Armstrong v. Asten-Hill Co., supra at 206.

Here, the Director relied on the opinion of Dr. Wilson, as supported by the opinions of the Medical Consultants. The Director also considered the opinion of Dr. Chiasson, attending physician and treating acupuncturist, who opined that claimant requires weekly treatment. Claimant contends that the Director erred in not giving greater weight to the opinion of attending physician Chiasson. As noted above, we review a Director's order under the "substantial evidence" standard. We find that the Director's order meets this standard.

Claimant further argues that the Director misconstrued the appropriate rule concerning the requested medical services. Specifically, claimant contends that the Director should have applied former OAR 436-10-040(3) (WCD Admin. Order 32-1990). We disagree.

This medical services dispute concerns acupuncture and physical therapy treatment by claimant's attending physician, Dr. Chiasson. The rule cited by claimant concerns "physical therapy . . . or acupuncture by a medical service provider other than the attending physician." (Emphasis supplied). The Director properly considered the guidelines for treatment by an attending physician, former OAR 436-10-040(2), in reviewing this claim.

On this record, we find that the Director's findings were based on substantial evidence and support the Director's conclusion that acupuncture and physical therapy treatment more than twice a month is excessive for claimant's current low back condition. Accordingly, the Director's order is affirmed. ORS 656.327(2).

ORDER

The Referee's order dated August 3, 1992 is affirmed.

April 14, 1993 Cite as 45 Van Natta 771 (1993)

In the Matter of the Compensation of
PATRICIA J. SAMPSON, Claimant
WCB Case No. 92-02174
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Westerband and Kinsley.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the insurer's denial of claimant's aggravation claim; (2) did not award interim compensation; and (3) did not assess penalties and attorney fees for an allegedly unreasonable failure to pay interim compensation. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the fourth and fifth full paragraphs on page 3, with the following supplementation.

For purposes of evaluating claimant's aggravation claim, the last arrangement of compensation was the August 12, 1991 Determination Order.

Claimant's compensable condition did not worsen such that she suffered more than a waxing of symptoms contemplated by the August 12, 1991 Determination Order.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of scheduled body parts, claimant must show that she is more disabled, i.e., has sustained an increased loss of use or function of those body parts, 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). The worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1). In addition, claimant must prove that her worsening resulted in greater loss of use or function than that which would result from waxing and waning of symptoms contemplated in the last award of compensation. ORS 656.273(8); see Leroy Frank, 43 Van Natta 1950 (1991).

The August 21, 1991 Determination Order which closed the claim is the "last arrangement of compensation," for purposes of determining whether claimant has proved a compensable worsening under ORS 656.273. See Frank L. Stevens, 44 Van Natta 60 (1992). The Determination Order awarded

4 percent unscheduled permanent disability, based on Dr. Foggia's July 16, 1991 letter.[1] (Ex. 6). Foggia opined that claimant is "unable to return to working as a surgical nurse * * * [and] unable to participate in any hospital ward nursing type endeavors in view of the fact that she would not be able to carry out her absolute functions as a nurse on the ward relative to the many encounters they have with using gloves, et cetera. Therefore [claimant] will probably not be able to return to hospital type employment[.]" (Ex. 6-1-2). In addition, Foggia described claimant's allergic condition as chronic, stating, "I do not believe that her limitation of performance is great other than the fact that her hands are unable to come in contact with any degree of trauma, any degree of chemical irritation or probably any friction of any consequence on a daily basis." (Ex. 6-1, emphasis added).

In our view, Foggia's opinion concerning claimant's permanent disability included a prediction of future problems associated with exposure, of the type and degree that claimant experienced in September 1991 when she attempted to return to work requiring rubber gloves and frequent hand washing. (See Exs. 11-7, 12-2, 13). Under these circumstances, we are not persuaded that the claimed worsening is greater than a waxing of symptoms which was anticipated at claim closure. Thus, claimant has not proved a compensable worsening.

Interim compensation

Even though the aggravation claim is not compensable, claimant may be entitled to interim compensation beginning 14 days after the insurer's receipt of notice containing all the elements of a prima facie aggravation claim under ORS 656.273. See ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), remanded on other grounds, Stanley Smith Security v. Pace, 118 Or App 602 (1993).

Claimant argues that Dr. Foggia's November 12, 1992 letter, (Ex. 10), was notice sufficient to trigger the employer's duty to pay interim compensation under ORS 656.273(6). Even assuming that the contents of Foggia's letter satisfy the statute, we conclude that the claim for interim compensation fails, because claimant has not established when the employer received the letter.

Claimant argues that it is reasonable to assume that the employer received the letter about the same date that claimant's attorney received a copy, i.e., December 2, 1991 (see Ex. 10). In support, claimant cites ORS 40.135(1)(q) which codifies the presumption: "A letter duly directed and mailed was received in the regular course of the mail." However, in order to take advantage of the rule's presumption, claimant must come forward with evidence concerning when the letter to the employer was mailed. See Carol M. Cote-Williams, 44 Van Natta 367, 369 (1992), citing Shari Hallberg, 42 Van Natta 2750 (1990). We find no such evidence here. Because claimant has not established when the employer received notice of her aggravation claim, she has not proved that the time between the employer's notice and its denial of the claim exceeded 14 days. See ORS 656.273(6). Thus, claimant has not proved entitlement to interim compensation. Finally, because the claims are not compensable, penalties and attorney fees are not available.

ORDER

The Referee's order dated June 3, 1992 is affirmed.

[1] The Determination Order's unscheduled award was later replaced by a scheduled award of 19 percent for each forearm (wrist). (Ex. 14).

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 13, 1992 Notice of Closure which closed his claim with an award of temporary disability compensation from April 3, 1990 through September 23, 1992. SAIF declared claimant medically stationary as of September 22, 1992. Claimant contends that he is entitled to additional benefits as 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 claim closure may be considered to the extent the evidence addresses the condition at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625 (1987), rev den 303 Or 590 (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).

Claimant compensably injured his low back on September 23, 1966 and has undergone several surgical procedures regarding this injury. Subsequent to his injury, claimant relocated to Texas. His most recent surgery occurred in Texas on December 9, 1991 and included a laminectomy and implantation of a spinal cord stimulator to relieve his leg pain. Following the surgery, claimant continued to have back pain, although the spinal cord stimulator substantially relieved his leg pain. (January 12, 1993 Case Management Staffing Report (CMSR) from Dr. Rashbaum). Dr. Guyer, M.D., is claimant's attending physician regarding his low back condition. Dr. Rashbaum, M.D., and Dr. Hanks, Ph.D., followed claimant's progress regarding the spinal cord stimulator. (September 22, 1992 CMSR from Dr. Rashbaum).

On August 19, 1992, Dr. Quarum, M.D., performed a medical record review at SAIF's request. He opined that claimant appeared to be medically stationary regarding his back condition. On September 2, 1992, SAIF sent copies of Dr. Quarum's medical report to Drs. Guyer, Rashbaum, and Hanks for their review and asked whether they agreed that claimant's condition was medically stationary. SAIF noted that the "definition of medically stationary, according to ORS 656.005(17) is 'that no further improvement would reasonably be expected from medical treatment, or the passage of time.'" Drs. Guyer, Rashbaum, and Hanks all agreed that claimant was medically stationary. On October 13, 1992, SAIF closed claimant's claim and noted September 22, 1992 as the medically stationary date, based on the latest concurrence date.

Claimant contends that he was not medically stationary when his claim was closed. Claimant has the burden of proving this contention.

In a chart note dated October 19, 1992, Dr. Guyer opined that:

> "[w]hile [claimant] has reached maximum medical improvement [MMI], that does not mean that he has reached MMI and is normal. He has reached MMI but still remains significantly disabled and is unable to work."

In a report dated February 2, 1993, Dr. Guyer confirmed his October 19, 1992 opinion, stating that, although claimant had "reached maximum medical improvement," he was "not normal" in that he remained significantly disabled and unable to work. However, medically stationary status does not require that a claimant be "normal," nondisabled, or able to work. Instead, a claimant is medically stationary if no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Dr. Guyer's statements do not indicate that further material improvement in claimant's condition would reasonably be expected from medical treatment or the passage of time.

Furthermore, when presented with the definition of "medically stationary," Dr. Guyer agreed on September 16, 1992 that claimant was medically stationary. To the extent that these later medical opinions indicate that Dr. Guyer changed his opinion regarding claimant's medically stationary status, he offers no explanation for this change of opinion. We do not find Dr. Guyer's unexplained change of opinion persuasive.

In addition, on October 19, 1992, Dr. Guyer noted that, although he did not go along with a recommendation of a morphine pump for claimant's back pain, he would recommend a pain management program. However, Dr. Guyer did not indicate whether, as of the date of claim closure, a pain management program would reasonably be expected to provide further material improvement in claimant's condition. The term "medically stationary," does not mean that there is a lack of need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984); Tommy L. Brown, 42 Van Natta 558 (1990). See also Linda F. Wright, 42 Van Natta 2570 (1990) (a need for palliative treatment and diagnostic measures does not preclude a medically stationary status).

Furthermore, at the time that Dr. Quarum opined that claimant was medically stationary, he noted that claimant continued to receive medical treatment for his low back pain and approved Dr. Rashbaum's referral of claimant to Dr. Adams, M.D., who specializes in pain management. Dr. Quarum noted that Dr. Hanks had stated that claimant would become a candidate for an implantable morphine pump for his back pain. Dr. Quarum opined that a morphine pump is not reasonable treatment for claimant due to his lack of relief with the use of PCA morphine while an inpatient and his chronic pain syndrome. A copy of Dr. Quarum's report was sent to Drs. Guyer, Rashbaum, and Hanks for review. All of these doctors agreed that claimant was medically stationary.

Subsequent to claim closure, the record contains mention of proposed medical treatment in the form of a morphine pump. However, the record is absent of any evidence that, at the time of claim closure, there was a reasonable expectation that this treatment would materially improve claimant's condition. As noted above, Dr. Quarum had opined that this treatment was not reasonable for claimant. Also, on January 12, 1993, Dr. Rashbaum noted that he had "a real concern as to whether or not this man is going to be a candidate for a morphine pump."

After being presented with the definition of the term "medically stationary," Dr. Rashbaum agreed on September 22, 1992 that claimant was medically stationary. On January 12, 1993, Dr. Rashbaum stated that claimant "was given an MMI per my assumption that he was under Texas Work Comp law." Dr. Rashbaum noted that claimant needed continued treatment, was not working or released to work, had lumbar radicular syndrome, and was not "MMI." However, as noted above, the need for ongoing treatment does not preclude a medically stationary status. Furthermore, a diagnosis of lumbar radicular syndrome does not preclude a medically stationary status without some evidence that, at claim closure, further material improvement would reasonably be expected from medical treatment or the passage of time. Finally, like Dr. Guyer, Dr. Rashbaum provides no explanation for his change of opinion.

The record indicates that claimant's neurogenic bladder condition is part of his compensable injury. Therefore, if this condition was not medically stationary at claim closure, claimant's claim was prematurely closed. In a letter dated November 8, 1992, claimant stated that Dr. Mulchin recommends bladder surgery. However, there is no report from Dr. Mulchin in the record. In a November 22, 1992 chart note, Dr. Rashbaum notes the possibility of bladder surgery. In a letter dated December 9, 1992, Dr. Reyna, physiatrist, opined that claimant was not "at maximum medical improvement yet or fully stabilized, as we are now exploring" the options of a morphine pump and the possibility of bladder surgery. Dr. Reyna's opinion suggests that claimant's condition is not stable because a "possible" bladder surgery is now being considered. Neither Dr. Rashbaum nor Dr. Reyna address claimant's bladder condition at the time of claim closure.

In addition, there is no medical evidence in the record that, at the time of claim closure, bladder surgery was recommended. Even after claim closure, Drs. Rashbaum and Reyna only present bladder surgery as a possibility. See Ronald E. Smith, 44 Van Natta 2329 (1992) (claimant failed to establish he was not medically stationary where surgery was not recommended at claim closure and the possibility of surgery was not considered until after claim closure).

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 claim closure. On this basis, we affirm the Notice of Closure.

Parenthetically, it appears that several of the physicians involved in this case either misunderstood or were misinformed about claimant's entitlement to medical services after he becomes medically stationary. Claimant is entitled to lifetime medical benefits related to his compensable injury, with certain limitations on palliative care. ORS 656.245.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE E. GATCHET, Claimant
Own Motion No. 93-0099M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our March 16, 1993 Own Motion Order of Dismissal in which we found that claimant's claim was not within our own motion jurisdiction because he had made an aggravation claim before his aggravation rights had expired. Specifically, SAIF argues that our reliance on Thomas L. Runft, 43 Van Natta 69 (1991), and Robert E. Wolford, 45 Van Natta 435 (1993), was misplaced.

In order to consider SAIF's motion, we withdraw our March 16, 1993 order. Claimant is granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation
JOSEPH E. KELLY, Claimant
WCB Case Nos. 91-06705 & 91-05122
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

The SAIF Corporation, on behalf of Image Graphics and Litho, Inc., requests reconsideration of our February 24, 1993 Order on Review which held it, rather than Kemper Insurance Company (Kemper), responsible for claimant's left elbow condition and right wrist de Quervain's tenosynovitis. We previously abated our order to allow adequate time to consider the motion and to allow Kemper and claimant to respond to it. Only Kemper has timely responded. Accordingly, we now proceed with our reconsideration.

On reconsideration, SAIF argues that responsibility should be initially assigned with Kemper under the last injurious exposure rule, because claimant first sought treatment for his left elbow condition and right wrist de Quervain's tenosynovitis during his employment with Kemper's insured. SAIF further argues that responsibility remains with Kemper. In support of its argument concerning the initial assignment of responsibility, SAIF relies on medical evidence indicating that claimant probably had a left elbow condition and right wrist de Quervain's tenosynovitis long before he worked for SAIF's insured.

We agree with SAIF that the evidence suggests that claimant's left elbow and right wrist conditions preexisted his employment with SAIF's insured. However, as we stated in our Order on Review, that is not the dispositive question for assignment of responsibility under the last injurious exposure rule.[1]

Rather, the question is: When did claimant first seek treatment for his left elbow condition and right wrist de Quervain's tenosynovitis? See Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

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[1] The last injurious exposure rule regarding the initial assignment of responsibility does not depend on actual causation. See Bracke v. Baza'r, 293 Or 239, 248 (1982).

Claimant's physicians were uncertain about the cause of claimant's continuing complaints after his bilateral carpal tunnel syndrome (CTS) surgery. With the benefit of hindsight, Dr. Gill, treating physician, opined that the CTS overshadowed the left elbow problem for some time. (See Ex. 29). On this record, we believe that the CTS may have similarly masked the right wrist de Quervain's tenosynovitis condition. After reconsidering the record however, we remain persuaded that February 12, 1991 was the date claimant first actually sought treatment for his current left elbow and right wrist de Quervain's conditions. Our finding in this regard does not depend on the fact that Gill diagnosed de Quervain's tenosynovitis on that date. (Ex. 22). Instead, it is based on the fact that claimant sought treatment on February 12, 1991 and Gill, on that date, first identified claimant's post-CTS surgery right wrist and left elbow conditions as "separate" from and "unrelated" to the prior problems. (Id). Thus, on this record, we continue to conclude that claimant first sought treatment for his separable left elbow and right wrist de Quervain's conditions on February 12, 1991, when SAIF was on the risk.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 24, 1993 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 15, 1993 Cite as 45 Van Natta 776 (1993)

In the Matter of the Compensation of
RAYMOND L. MACKEY, Claimant
WCB Case No. 91-08671
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by the Board en banc. [1]

Claimant requests review of those portions of Referee McWilliams' order which: (1) found that, for purposes of rating claimant's unscheduled permanent disability, claimant was barred from challenging the adaptability factor at the hearings level; (2) affirmed an Order on Reconsideration which awarded 27 percent (86.4 degrees) unscheduled permanent disability for his low back condition; and (3) declined to assess penalty-related attorney fees for allegedly unreasonable claims processing violations. On review, the issues are extent of unscheduled permanent disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

A corrected Notice of Closure was issued on December 11, 1990. The corrected Notice awarded claimant an additional 14 percent unscheduled permanent disability for his low back condition, for a total award of 24 percent unscheduled permanent disability.

On April 8, 1991, claimant requested reconsideration of the corrected Notice of Closure. For purposes of making his request, claimant utilized a form prepared by the Department of Insurance and Finance. See former OAR 436-30-050(4) & DIF Bulletin No. 227. The Department's reconsideration request form provided that the worker must check a box for each potential issue. On the form, claimant specified that he disagreed with the insurer's rating of his unscheduled permanent disability. However, claimant checked a box on the form which indicated that he did not object to the age, education or adaptability values used in rating his unscheduled permanent disability.

A June 25, 1991 Order on Reconsideration increased claimant's impairment value to 22, which combined with the educational value of 5 for a total of 27 percent unscheduled permanent disability.

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[1] Because he was the attorney of record, Member Hooton has not participated in this review. OAR 438-11-623.

CONCLUSIONS OF LAW AND OPINION

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

The Referee concluded that because claimant failed to specifically challenge the adaptability factor at the time of reconsideration, he was precluded from doing so at the time of hearing. We agree.

On review, claimant contends that a Referee may address any factor regarding the evaluation of permanent disability, whether or not the issue was raised at the time of reconsideration. Claimant relies on ORS 656.283(7), which provides, in part, that nothing in the section shall be construed to prevent a party from establishing, at hearing, that the standards were incorrectly applied in the reconsideration order. We conclude that, although no provision in ORS 656.283(7) prevents claimant from arguing that the standards were incorrectly applied at the time of reconsideration, claimant is nonetheless precluded from raising an issue at hearing that was not specifically raised at the time of reconsideration. See also 656.295(5).

We first note that ORS 656.268(4)(e) provides that a worker who objects to a notice of closure first must request reconsideration by the Department. Similarly, ORS 656.268(5) requires that reconsideration of a determination order must be requested by a party who objects to the determination order. At the reconsideration proceeding, the parties are allowed an opportunity to correct erroneous information in the record or to submit medical evidence that should have been submitted by the attending physician at the time of claim closure. ORS 656.268(5).

The mandatory language of the statute, which requires parties to proceed through the reconsideration process and provides for the submission of additional information, evidences a legislative intent to provide an administrative remedy at the Department level for issues involving extent of disability. Moreover, the legislative history of the mandatory reconsideration process indicates that a significant goal of the mandatory process was to reduce the number of appeals to the Hearings Division as a means of reducing costs to the system. Statement of Sen. Shoemaker, May 7, 1990 Special Session, Tape 4, Side A; Statement of Rep. Shiprack, May 7, 1990 Special Session, Tape 1, Side A; Statement of Cecil Tibbetts, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side A.

The administrative rules providing for reconsideration of determination orders or notices of closure also support our conclusion that issues pertaining to reconsideration must be raised at the Department level. In this regard, former OAR 436-30-050(2) provides that, "[d]uring a reconsideration proceeding, the Determination Order or Notice of Closure will be reconsidered in its entirety. All information to correct the record and 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 and all supporting documentation must be presented during the reconsideration proceeding." WCD Admin. Order 33-1990.

Consistent with the statutory and administrative procedures for reconsideration, we have held that parties may not raise issues arising out of a determination order without first requesting administrative reconsideration. See e.g. Charlene J. Erspamer, 44 Van Natta 1214 (1992) (an issue of rate of payment of scheduled permanent impairment will not be considered at hearing or on review unless reconsideration was first requested); Chester L. Schulze, 44 Van Natta 1493 (1992) (an issue of premature closure will not be considered at hearing or on review unless reconsideration was first requested). We now hold that to allow parties at hearing to raise new issues stemming from a notice of closure or determination order which were not raised on reconsideration would similarly circumvent the administrative process created by the legislature and would run counter to the expressed legislative goal of reducing litigation.

Accordingly, we conclude that claimant was first required to raise the issue of adaptability on reconsideration. We find that such a conclusion is consistent with the language of the statute itself and with the statutory scheme defining the reconsideration process. Because claimant did not raise adaptability on reconsideration, but instead explicitly indicated that it was not at issue, claimant may not subsequently raise the issue for the first time at the hearings division or Board level. Consequently, we affirm the Referee's decision to affirm the Order on Reconsideration.

ORDER

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

Board Member Gunn dissenting.

I must respectfully dissent because I believe the majority opinion transfers too much authority to the reconsideration process, especially since the reconsideration "process" in actuality equates to checking a set of boxes. The majority's opinion purges the statutory language in ORS 656.283(7). It also puts in question whether we have eliminated claimants' hearing rights when a party has been through reconsideration.

The issue in the instant case is whether a party who has complied with the reconsideration process, can upon appeal to the Hearings Division, raise an objection to a Notice of Closure or Determination Order when the objection was not raised at the reconsideration process. In other words, here, the issue stayed the same (disagreement over the disability rating found by the Notice of Closure or Determination Order); however, the specification of the objection was refined.

The majority relies on wording in ORS 656.268(5) which allows a party to correct erroneous information at the reconsideration proceeding. But there is no proceeding. There is only a form, i.e., a set of boxes to be checked. There is no practicable method for the proper information to be submitted or for erroneous information to be corrected. There is only notice of potential dispute, after which, if a party objects to the reconsideration order, the party is allowed to request a hearing under ORS 656.283. The majority, however, usurps this next step in the reconsideration process.

The majority would have the reconsideration stage replace the hearing process, rather than let it be the procedural hoop to jump through to get to hearing (albeit one to fall victim to confusion) that it is. Therefore, contrary to the majority's conclusion that its analysis meets the legislative purpose of reducing litigation, the result instead is one in which litigation will abound. This is due to the simple fact that objecting parties will now be forced to check any and all boxes in order not to lose any and all potential (or even slightly feasible) hearing rights under ORS 656.283. This, I believe, would cause the reconsideration process to come to a screeching halt. Legal issues would unnecessarily grow to the size of boulders and then attempt to fit through the reconsideration hourglass which originally was meant to streamline the process by only accommodating those issues more in align with the size of sand.

Under the majority's reasoning, the words in ORS 656.283(7): "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insurer employer to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268," will be decimated into meaninglessness. All parties will be limited to only evidence from those issues checked on the appropriate box at reconsideration. I note that the only limitation on evidence in ORS 656.268 exists at section (7) and that is only to medical evidence.

I do believe the reconsideration process was intended to limit the medical evidence that any party could use at both reconsideration and hearing. I am not convinced the same applies to issues, let alone specification of objections, that a party is allowed to raise at hearing. To adopt the majority's conclusion would expand the medical evidence limitation, although this notion is nowhere to be found in the language of the statute.

Since objecting parties are required to go through the reconsideration process before we will even give them a hearing, this opinion would also limit the hearing to only those issues not disputed at reconsideration. In effect, we eliminate hearings except for those issues not resolved by reconsideration. I do not believe the legislative history supports such an expansion of the reconsideration process. The process was intended to be simple, uncomplicated and to be accomplished with or without lawyers. Like most new inventions it has had a stormy start, but I do not believe that the legislature intended to turn the process into a legal tidal wave of entanglement. Nor do I believe the majority's opinion adds anything but legal complications to the process and encourages all issues to be raised, if only for protection. Most poignantly, such a reading is beyond the actual words or authority of ORS 656.268 and negates the language in ORS 656.283(7).

The question of law created by the problems of legislative draftsmanship, and in turn a failure to give sufficient focus to policy choices involved, ought not be solved by construing inferences from statutory text and legislative history, regardless of whether we agree with the outcome. After all, had the legislature intended to veto ORS 656.283(7), it would have just said so.

For these reasons, I dissent.

In the Matter of the Compensation of
VERNON W. MILLER, Claimant
Own Motion No. 93-0120M
OWN MOTION ORDER
Francesconi & Busch, Claimant Attorneys

The insurer has submitted claimant's request for temporary disability compensation for his compensable right foot and arm, and left arm and eye injury. Claimant's aggravation rights expired on May 14, 1989. The insurer opposes the authorization of temporary disability compensation on the ground that claimant has withdrawn from the work force.

We are persuaded that claimant's compensable injury has worsened requiring surgery to the left wrist. Dr. Struckman, treating orthopedist, reported that claimant is a good candidate for a Darrach's resection or a resection of the radial portion of the distal ulna. Neither of these procedures would eliminate all of claimant's symptoms; however, the pain in his left arm would be reduced.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

In order to 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).

Claimant has submitted evidence that, on December 23, 1991, Dr. Struckman restricted him from standing for over an hour, no walking on an uneven surface and no climbing. In a letter dated March 17, 1993, Dr. Struckman stated these restrictions were due to a non-work related degenerative arthritis low-back condition. Because his employer could not provide work which would accomodate these limitations, claimant was terminated from his job on January 14, 1992. Claimant has been receiving unemployment compensation due to his inability to perform the duties required of his prior job and is currently seeking vocational rehabilitation services.

Inasmuch as claimant has submitted evidence that he was willing to work and seeking work, we conclude that he was making reasonable efforts to find work and, therefore, remains in the work force.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning March 25, 1993, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK A. PENDELL, Claimant
WCB Case No. 91-13051
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On March 16, 1993, we affirmed a Referee's order which held that an Order on Reconsideration, which had issued without appointment of a medical arbiter, was invalid. On our own motion, we withdraw our March 16, 1993 order for further consideration.

The parties are granted an opportunity to submit further argument regarding the issues addressed in our prior order. To be considered, those written arguments must be submitted within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRGINIA L. POPE, Claimant
WCB Case No. 91-12416
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of Referee Galton's order that upheld the insurer's denial of her claim for a neck and back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been employed as a highway flagger for a general highway contractor since 1989. She is responsible for directing traffic at road construction sites. Her work hours and location vary depending on the employer's needs. She drives her private vehicle to work.

Claimant had been flagging at a particular road construction site for more than one year. On July 28, 1991, claimant was told to report for work at 7 a.m. the next morning. On July 29, 1991, claimant left home at approximately 6:30 a.m. and drove her private vehicle to work, arriving at the job site at approximately 6:50 a.m. She arrived a little early because she did not yet know the precise location she would be flagging that day. She waited for specific instructions from her foreman.

Because her foreman was busy working with the paving crew, claimant waited in her car. After waiting five minutes, she decided to use one of the port-a-potties provided by the employer for use by employees.

There were three port-a-potties on the construction site at that time. The two closest port-a-potties were located approximately 1600 feet from where claimant was parked. (See Ex. OA; Tr. 47). Claimant drove her vehicle to one of the closest port-a-potties, passing through the job site and onto public streets. While waiting on a public street to turn into the employer-controlled area where the port-a-potty was located, claimant's car was struck by another car. Claimant sustained neck and back injuries in the collision. Claimant had not yet begun her flagging duties at the time of the accident.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant was on a personal mission at the time of the accident, the Referee concluded that claimant's injury did not arise out of and in the course of employment. On review, claimant offers several theories in support of her claim; among them, she argues that she was preparing for work and/or was engaged in a personal comfort activity at the time of her injury and that her injury is, therefore, compensable. We agree.

Our analysis begins with the work relationship of claimant's activity in awaiting prior instructions from her foreman before beginning her scheduled shift.

Claimant arrived at work 10 minutes before her 7 a.m. shift. Her foreman had told her the previous day that she would be flagging at one of three locations on the construction site, but did not specify which location. Because claimant did not know exactly where she would be flagging, she arrived early and waited on the construction site for instructions from the foreman. (Tr. 21). Claimant testified that she generally checked with the foreman every day to determine where she would be flagging. (Tr. 7). Under these circumstances, we find that claimant's early arrival for specific instructions from the foreman was in preparation for the performance of her work duties.

In Bailey v. Peter Kiewit & Sons, 51 Or App 407 (1981), the Court of Appeals held that an injury, which occurred within a reasonable time prior to the claimant's shift time while he was on the premises engaged in preparation for work, was compensable. There, the claimant cut his finger while adjusting rain gear supplied by the employer for use on the job. The court found that the adjustment of the rain gear was acquiesced in and contemplated by the employer.

The court in Bailey appeared to apply some of the factors identified in Jordan v. Western Electric, 1 Or App 441 (1970), for determining whether a particular activity is sufficiently work related. Those factors are: (1) whether the activity was for the employer's benefit; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Id. at 443-44; Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 574, rev den 300 Or 249 (1985)

Here, claimant's early arrival for instructions benefited the employer because it allowed claimant to begin her assigned duties promptly. Inasmuch as her foreman did not tell her the previous day precisely where she would be flagging, the employer must have contemplated that claimant would be seeking prior instructions before beginning her duties. Though claimant was not paid for awaiting instructions prior to her shift, the activity was incidental to her employment and occurred on the construction site. Moreover, claimant's uncontroverted testimony that she sought prior instructions from her foreman every day suggests that the employer was aware of, and acquiesced in, that activity. See Clark v. U.S. Plywood, 288 Or 255, 267 (1980). Finally, we do not find that the activity constituted a personal mission by claimant.

Based on these factors and Bailey, we find that claimant's activity of awaiting prior instructions from her foreman was sufficiently work related. See Mellis v. McEwen, Hanna, Grisvold, supra; Jordan v. Western Electric, supra. Had claimant been injured while awaiting instructions, the injury would have been compensable. See Rogers v. SAIF, 289 Or 633, 643 (1980).

However, claimant was not injured while awaiting instructions; rather, she was injured after she had decided to use the port-a-potty and while driving on a public street. Therefore, the dispositive issue is whether claimant's activity in driving to the port-a-potty was a departure from the work relationship. On this issue, we turn to the "personal comfort" doctrine.

Injuries incurred in certain "personal comfort" activities incidental to employment have been held to be compensable. E.g., Clark v. U.S. Plywood, 288 Or 255 (1980; Halfman v. SAIF, 49 Or App 23 (1980). The basis of the personal comfort doctrine is that certain activities by employees are expected and necessary and the conduct of those activities is not a departure from the employment relationship. Halfman v. SAIF, supra.

We again apply the aforementioned Jordan factors. We find that the employer was benefited by claimant using its facility on the construction site, rather than a restroom elsewhere. Presumably, the employer provided on-site facilities to minimize the length of work breaks and to maximize employee productivity. The employer also benefited from claimant driving her private vehicle to the facility, because it relieved the employer of the burden of providing either more facilities for employees or transportation to and from available facilities.

We also find that the employer contemplated that claimant would drive to the facility on public streets. The facility was located approximately 1600 feet away from where claimant would have worked. The employer must have contemplated that employees would sometimes drive, rather than walk, that substantial distance, particularly while in need of the facility. In fact, claimant testified that she sometimes drove to the facilities during work hours, without objection by any supervisor. (Tr. 20). Additionally, there were public streets between claimant and the facility, which the employer must have contemplated would be driven by employees.

Although the risks encountered by claimant, and the accident which resulted in her injury, are not the risks encountered in work breaks in other jobs, a different situation was created by the employer in this case. By not providing more accessible facilities (which do not require crossing public streets to use), the employer created a potentially hazardous situation where the risk of injury in a motor vehicle accident was an ordinary risk of, and incidental to, the employment. See Halfman v. SAIF, supra, 49 Or App at 29. See also Kiewit Pacific v. Ennis, 119 Or App 123 (1993) (held that employer's parking lot, which required the claimant to enter by stopping on and turning from busy public road, created a hazard peculiar to the employment, and thus, injury sustained in auto accident on that road is sufficiently work related).

Because it was expected that employees would drive through public streets to use the facilities, and indeed, claimant had done so on some occasions without objection by any supervisor, we find that claimant's activity was acquiesced in by the employer.

Although, in a sense, claimant was on a personal mission of her own at the time of injury, the activity of travelling to and using the port-a-potty is certainly the type of activity that is contemplated by the employer. It is an expected and necessary activity by employees. Accordingly, we do not find that claimant was engaged in the type of personal mission that would constitute a departure from the employment relationship.

Claimant was on public premises, over which the employer did not exercise any control, at the time of the injury. However, we do not find that fact to be of great significance, because the employer effectively created the situation in which an employee must travel public streets for a basic necessity that is certain to arise during the work day. See id.

Finally, the fact that the injury occurred before claimant's scheduled shift is not of great significance. Although claimant was not being paid for any time before the shift, she was preparing for work by awaiting prior instructions from her foreman. As we found above, that activity itself was sufficiently work related.

Based on these factors, we conclude that claimant's activity in crossing public streets to the employer's facility was not a departure from the employment relationship. Accordingly, claimant's injury 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 $3,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 18, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
DENA M. CALISE, Claimant
WCB Case No. 92-04726
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Lipton and Hooton.

The SAIF Corporation requests review of Referee Schultz' order that upheld its denial of claimant's right foot osteoid osteoma condition, but ordered payment of surgery and time loss benefits for claimant's compensable stress fracture. In its brief, SAIF also objects to the Referee's reopening of the record for the receipt of additional evidence. On review, the issues are evidence, compensability, and medical services. We affirm.

FINDINGS OF FACT

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

The hearing was convened and closed on June 29, 1992.

Dr. Irvine referred claimant to Dr. Bos, orthopedic oncologist, for a second opinion on the nature of claimant's condition. Dr. Bos's report was received by claimant on July 14, 1992.

On July 15, 1992, claimant filed a motion to reopen the record to receive exhibits 15 and 16, the medical report and a supporting clinic note from Dr. Bos. SAIF did not respond to the motion within ten (10) days. OAR 438-06-045.

By order dated July 27, 1992, the Referee reopened the record and received the exhibits. He allowed the parties until August 6, 1992, to present arguments pertaining to the newly received evidence. SAIF did not submit argument responsive to the additional evidence. The Referee closed the record and issued his Opinion and Order on August 6, 1992.

On August 6, 1992, the Referee received SAIF's "Motion In Response To Motion To Reopen Record And Order Reopening Record." Although the Referee found that the motion was filed untimely, he stated that he had considered the issues raised in SAIF's motion when he decided to reopen the record. The Referee treated SAIF's motion as a motion for reconsideration, which he denied on August 7, 1992.

CONCLUSIONS OF LAW AND OPINION

Evidence

SAIF contends that the Referee abused his discretion in allowing the record to be reopened to receive exhibits 15 and 16. We disagree.

A Referee has discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(1). A party seeking reopening of the record for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing. OAR 438-07-025(2); Renia Broyles, 42 Van Natta 1203 (1990). We review the Referee's ruling for abuse of discretion. Rodney D. Jacobs, 44 Van Natta 417 (1992); Renia Broyles, supra.

Following the hearing, on July 15, 1992, claimant moved to reopen the record for the admission of newly discovered material evidence, specifically a July 14, 1992, medical report and a June 22, 1992, clinic note from Dr. Bos. In his July 27, 1992 order, the Referee made findings that these exhibits had not been received by claimant's counsel until July 15, 1992, and that SAIF had not responded to claimant's motion. The Referee allowed the parties until August 6, 1992 to present arguments pertaining to the newly received evidence. SAIF again did not respond and the Referee proceeded to issue his order on August 6, 1992. We accordingly conclude that the Referee did not abuse his discretion in admitting additional material evidence in the absence of a timely objection by SAIF.

Even if SAIF had timely responded, we conclude: (1) SAIF has shown no material prejudice in the timing of the disclosure; and (2) that the Referee's decision was correct, based on the newly obtained evidence.

Compensability

We affirm and adopt the Referee's opinion with the following comment. After our review of the record, we too give more weight to the opinion of Dr. Bos, an orthopedic oncologist. An osteoid osteoma is a tumor of the bone. Given the circumstances of this claim, we give more weight to the opinion of an oncologist, whose specialty is the diagnosis of bone tumors and cancers, than to the opinion of an orthopedic surgeon.

Attorney Fee

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 $1,552.50, 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 statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 6, 1992, is affirmed. Claimant's attorney is awarded $1,552.50 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DANIEL P. KELSEY, Claimant
WCB Case No. 91-10681
And, In the Matter of the Complying Status of
DRUSHELLA-KLOHK, Noncomplying Employer
WCB Case No. 91-14721
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Karen M. Werner, Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brazeau's order that: (1) set aside the Department's Proposed and Final Order finding the employer to be noncomplying; (2) set aside the SAIF Corporation's acceptance of claimant's injury claim on behalf of the alleged noncomplying employer; and (3) upheld the employer's denial of that claim. In its brief, the employer moves to dismiss, contending that we lack jurisdiction because claimant failed to properly notify all parties concerning this appeal. On review, the issues are jurisdiction and compensability (subjectivity). We deny the motion to dismiss and affirm.

FINDINGS OF FACT

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

On March 3, 1992, the Board received claimant's request for review from the Referee's February 24, 1992 order. On April 10, 1992, the Board acknowledged its receipt of claimant's request by mail to all parties, including the employer.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The employer moves to dismiss claimant's request for review, contending that we lack jurisdiction because claimant allegedly failed to properly notify employer's counsel or the Compliance Section of the Department of Insurance and Finance regarding this appeal. See ORS 656.295(2). We deny the motion, for the following reasons.

ORS 656.295(2) requires that copies of the request for review "shall be mailed to all parties to the proceeding before the Referee." Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed, or actual notice received, within the statutory period following the Referee's order. See ORS 656.289(3); Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). "Party" means a claimant for compensation, the employer of the injured worker at the time of the injury and the insurer, if any, of such employer. ORS 656.005(19).

Under the statutory definition, neither the Compliance Section nor the employer's attorney are "parties" to this dispute, subject to the notice provisions of ORS 656.295(2). See Chester Johnson, 40 Van Natta 336 (1988). Under these circumstances, we have jurisdiction to consider claimant's request for review and the employer's motion to dismiss is denied. See Chester Johnson, supra.

Compensability/subjectivity

We adopt the Referee's "Conclusions of Law and Opinion" on this issue.

ORDER

The Referee's order dated February 24, 1992 is affirmed.

April 16, 1993 Cite as 45 Van Natta 785 (1993)

In the Matter of the Compensation of
WILLIAM J. McADAMS, Deceased, Claimant
WCB Case No. 91-02578
ORDER ON REVIEW
Darrell E. Bewley, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant's beneficiaries request review of Referee Howell's order which: (1) upheld the SAIF Corporation's denial of claimant's injury or occupational disease claim for a fatal myocardial infarction; and (2) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable claims processing. On review, the issues are compensability and penalties and attorney fees.

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

Analyzing claimant's fatal heart attack as an "injury" under ORS 656.005(7), the Referee concluded that claimant's beneficiaries did not sustain their burden of proving that claimant's work exposure was a material contributing cause of the heart attack. We agree that claimant's beneficiaries did not sustain their burden of proving a compensable injury, but we modify the Referee's analysis as follows.

Claimant had preexisting coronary heart disease which allegedly combined with work activity to produce a fatal heart attack. Therefore, in order to establish a compensable injury, claimant's beneficiaries must prove that the work activity was the major contributing cause of the fatal heart attack. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

Based on the Referee's opinion and conclusion that claimant's beneficiaries did not sustain their burden of proving compensability under the material contributing cause standard, we likewise conclude that the beneficiaries did not sustain their burden of proof under the major contributing cause standard.

ORDER

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

Board Member Hooton dissenting.

I agree with the majority that, since claimant had been previously diagnosed with, and treated for, significant coronary artery disease, claimant's beneficiaries must prove that claimant's work was the major contributing cause of his death. Had the majority discussed the evidentiary basis for concluding that work was not the major cause of claimant's death, this dissent may not have been necessary. In a patient with a history of coronary disease that has already caused one heart attack sufficiently severe to demonstrate an abnormal EKG as much as eight years later, there is evidence on both sides of the question sufficient to support a finding that the work is not the major cause of the onset of this particular myocardial infarction. Consequently, though I would personally find that the best medical evidence supports compensability, little good would be served by a dissent where the majority opinion rests on a proper and complete analysis of the record.

However, rather than provide their own analysis, the majority adopts the findings and conclusions of the Referee at hearing. Instead of deciding the case on the evidence presented, the Referee appears to supplant that evidence with his own opinion.

The EMT crew that worked with claimant on the fatal night described him as "pumped up." The first accident to which claimant responded required that he free a victim from a vehicle on which the door had jammed by forcibly opening the door. He then had to lift the victim free of the vehicle, and, without causing further injury, strap him to a back board. With the assistance of others, claimant then had to carry the victim to a waiting ambulance. The treating cardiologist, a medical professional whose experience in dealing with emergency situations is most certainly greater than the Referee's, described the physical exertions required to complete these tasks as extreme. The Referee discounts that opinion because he personally finds the level of exertion minimal. That opinion reflects only that this Referee has never been involved in the anticipation for, and the completion of, an emergency rescue. The cardiologist, more probably than not, does have that experience, even if only in a hospital setting. Certainly, the EMT crew have. The Referee, by discounting the history, demeans the demanding work done by these dedicated individuals.

Dr. DeMot, who virtually always testifies that there is no correlation between physical exertion and coronary artery disease indicated that exertion can correlate to symptoms. In this case, those symptoms included the death of the claimant. I would conclude that Dr. Trelstad's analysis is far more reasonable than that of Dr. DeMot because it integrates an understanding both of claimant's preexisting condition and the physical exertions of his employment in the cause of the myocardial infarction that led to claimant's death. That report supports compensability even under the major cause standard.

I cannot accept the Referee's opinion of the level and significance of claimant's exertion over that of an experienced cardiologist, or over the EMT crew that assisted at the accident scene. I would, therefore, conclude that claimant's employment led directly to his death on May 12, 1990. Because the majority never attempts a complete analysis, but instead, relies upon the bare opinion of the Referee, who stands very close to the line at which the analysis of the case becomes the evidence relied upon, I must dissent.

In the Matter of the Compensation of
FLOYD M. ALLEN, Claimant
WCB Case No. 92-04837
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

The insurer requests review of Referee Livesley's order which found that claimant was a subject worker and not an independent contractor. On review, the issue is whether claimant is a subject worker.

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

Applying the "nature of the work" test set forth in Castle Homes, Inc. v. Whaite, 95 Or App 269, (1989), the Referee found that claimant was a subject worker for the employer. We agree with the Referee's conclusion, but for the following reason.

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). See also OAR 436-50-030. The statute provides that, as used in provisions of certain chapters, including ORS Chapter 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).

Subsequent to the Referee's order, we have held that the "right to control" test is no longer determinative in evaluating whether a claimant was a subject worker or independent contractor. Mark Walton, 44 Van Natta 2239 (1992). Rather, 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). Therefore, we do not adopt that portion of the Referee's order which applied the "right to control" test. We turn to an application of the rationale expressed in Walton and Potts.

In Walton, supra, the claimant was hired to build storage sheds for the employer. Rather than being paid for the completion of specific portions of the storage sheds, he was paid an hourly wage. Here, also, claimant was paid at the rate of $250 for every six-hour day he completed. The pay was not dependent on productivity or other measurement. It was based only on hours worked. (Tr. 10). Claimant was paid approximately every two weeks. (Tr. 14, 15).

Accordingly, because we find that claimant was not paid upon completion of the performance of specific portions of the project, at least one of the provisions of ORS 670.600 has not been met. Thus, claimant is not an independent contractor as defined by the statute and used in ORS Chapter 656. See Gregory L. Potts, supra.

The insurer concedes that claimant does not clearly meet each of the eight subsections of ORS 670.600. It suggests that we use a balancing approach and determine by a preponderance of the evidence whether claimant is an independent contractor or subject worker. In light of our conclusions in Walton and Potts, supra, we decline to take such an approach. Consequently, we conclude that claimant is a subject worker and the employer is responsible for workers' compensation benefits.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services and respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 31, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
SUSAN K. ESCUJURI, Claimant
WCB Case No. 92-04488
ORDER ON REVIEW
Stunz, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of Referee Schultz's order that: (1) excluded Exhibit 1 from admission into evidence; and (2) awarded claimant 27 percent (86.4 degrees) unscheduled permanent disability for her headache and depressive reaction conditions, whereas a Determination Order and Order on Reconsideration awarded no unscheduled permanent disability. On review, the issues are evidence and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt the Referee's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the Referee admitted Exhibits 1 through 100, as supplemented. Claimant had no objection to the admission of the exhibits. However, in his order, the Referee concluded that Exhibit 1 should be excluded because it was not one of claimant's medical records.

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." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See e.g. Brown v. SAIF, 51 Or App 389 (1981). Evidence, however, is relevant if it has any tendency to make the existence of any fact that is of consequence to the determination more or less probable. See Brian D. Lindstrom, 45 Van Natta 543 (1993).

On review, the employer contends that the exhibit bears claimant's name and there was no objection at hearing by claimant to the admission of the report. After reviewing the report, we agree with the employer that the exhibit consists of one of claimant's medical records. Accordingly, because the issue is extent of disability and the medical record pertains to claimant's condition, and claimant did not object to the exhibit's admission at hearing we conclude that it was an abuse of discretion for the Referee to exclude the medical report. Under the circumstances, we agree that Exhibit 1 should have been admitted into the record. Because the exhibit is present in the record, we admit it into evidence and proceed with our review. Warren G. Kucera, 43 Van Natta 2782 (1991).

Extent of unscheduled permanent disability

Headache condition

The Referee concluded that, pursuant to OAR 436-35-320(5), claimant was entitled to a chronic condition award for her headache condition. We disagree.

The Referee found that claimant's credibility was damaged by the unrebutted testimony of the employer's witnesses who testified that claimant had serious migraine pre-injury headaches. We conclude that even if the medical reports in the record could be construed to support claimant's contention that she has a chronic condition limiting repetitive use, she must still establish that the condition is due to the compensable injury. ORS 656.214(5).

Here, we find no evidence that the doctors acknowledged claimant's pre-injury migraine headache condition or explained why they believe her current headaches are due to the compensable injury. See Donna S. Coliron, 42 Van Natta 2739 (1990). Under such circumstances, we conclude that claimant has not established an entitlement to a chronic condition award pursuant to OAR 436-35-320(5). We, therefore, reverse the Referee's awarded impairment value of 5 percent.

Depressive reaction

The Referee also awarded claimant an impairment value for her depressive reaction condition, pursuant to OAR 436-35-400(5)(b)(B). On review, the employer argues that claimant has never received psychological treatment for a mental condition. Furthermore, the employer argues that only one psychologist, Dr. DeVour, has examined claimant and his diagnosis does not establish that claimant's condition is permanent.

We agree with the employer that claimant must prove, by medical evidence, that her psychological condition is permanent. See James A. Rouse, 43 Van Natta 2405 (1991).

Here, Dr. DeVour, psychologist, examined claimant on June 18, 1990, and diagnosed a mild adjustment reaction, with symptoms of occasional depression and irritability. He opined that when claimant felt better with regard to her physical problems, her mild symptoms of depression and irritability would resolve. He concluded that specific treatment for claimant's symptoms was not indicated and her "mild and transitory emotional reactions will fade as her subjective experience of discomfort improves."

After reviewing Dr. DeVour's report, we find that claimant has failed to establish that her mild adjustment reaction is permanent. We, therefore, conclude that she is not entitled to an impairment value pursuant to OAR 436-35-400, and we reverse the Referee's impairment value award of 23 percent.

Accordingly, we conclude that claimant has not proven an entitlement to an award of permanent disability under the "standards." The Referee's order is, therefore, reversed.

ORDER

The Referee's order dated July 27, 1992 is reversed. The September 13, 1991 Determination Order and March 27, 1992 Order on Reconsideration are reinstated and affirmed. The Referee's out-of-compensation attorney fee award is also reversed.

April 20, 1993 Cite as 45 Van Natta 789 (1993)

In the Matter of the Compensation of
JAMES W. RIX, Claimant
WCB Case No. 91-06754
ORDER ON REVIEW
Bettis & Associates, Claimant Attorneys
Roy L. Miller (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's injury claim for a cervical condition; and (2) awarded claimant a penalty under ORS 656.262(10)(a) for SAIF's allegedly unreasonable claims processing. In his respondent's brief, claimant contests that portion of the Referee's order that declined his request for mileage and wage reimbursement. On review, the issues are compensability, penalties and reimbursement. 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

Claimant contends that his current neck condition is the result of a discrete injury. We agree. It is, therefore, claimant's burden to prove that his work was a material contributing cause of his need for treatment. Jon A. Rogers, 44 Van Natta 2313, 2315 (1992); Mark N. Wiedle, 43 Van Natta 855, 856 (1991).

The Referee found claimant's claim compensable, concluding that all of the medical evidence supported claimant's claim. SAIF contends, however, that claimant is not credible and that his injury could not have occurred in the manner that he described. We disagree.

SAIF bases its credibility argument on two grounds: (1) that claimant waited seven months after his injury to file his claim; and (2) he failed to advise his physicians of prior chiropractic treatments received for his neck.

Although claimant waited seven months to file a claim, he reported the injury to his employer within three days of its occurrence. In addition, although claimant engaged in post-injury activities that could have caused his current neck condition, the medical evidence establishes that those activities did not cause his condition. Finally, claimant's physicians also discounted his prior chiropractic treatments as indicative of a non-industrial cause of his current neck condition.

SAIF further contends that claimant's injury could not have occurred as he described. After reviewing the record, however, we agree with the Referee that the conflicts in the evidence are not so great as to defeat claimant's claim. Claimant's claim is compensable.

Penalties

The Referee concluded that SAIF's denial was unreasonable and assessed a penalty under ORS 656.262(10). We disagree.

A denial is reasonable if an employer has a legitimate doubt about the compensability of a claim at the time of the denial. Atlas Cylinder v. Epstein, 114 Or App 117, 122 (1992); Willis W. Stamm, 44 Van Natta 79, 80 (1992). Here, claimant did not seek medical treatment for seven months after the injurious incident or for some five months after he stopped working for the employer. During that interim period, he engaged in physical activity that could have caused his neck condition. The medical reports also indicated that claimant had previously received chiropractic treatments for his neck. Dr. Hermens noted that claimant had a nonwork-related mild cervical spondylosis, and acknowledged that claimant had provided him with an inconsistent medical history. (Ex 10, 12). Considering these circumstances, we conclude SAIF has a legitimate doubt regarding compensability at the time of its denial. Penalties, therefore, are not warranted.

Reimbursement

At SAIF's request, claimant traveled from Richland, Oregon, to Portland, Oregon, to attend an IME. SAIF reimbursed claimant for some, but not all, of his reported expenses. Claimant sought the remaining expenses at hearing. The Referee denied the request.

SAIF contends that we are without jurisdiction to consider claimant's request because claimant did not file a cross-request for review on that issue. We conclude, however, that because we retain jurisdiction by virtue of SAIF's appeal, we can address the issues presented in claimant's respondent's brief. Cameron D. Scott, 44 Van Natta 1723, 1724 (1992). Consequently, we proceed to the merits of claimant's contention.

The Referee declined to award claimant additional reimbursement, based on claimant's failure to prove the requested amounts. We agree.

With regard to the requested mileage, the record is silent as to the distance between Richland and Portland, the route claimant traveled or his mileage while in Portland. There is, therefore, a failure of proof with regard to mileage.

There is also a failure of proof with regard to claimant's claimed wage loss. Although claimant testified that, at the time of his IME, he was working at least eight hours per day for $6 per hour for a variety of employers on a piece-meal basis, we conclude that that testimony alone is insufficient to establish claimant's claim. The testimony is nonspecific and unaccompanied by substantiating evidence. (Tr. 19). Therefore, we agree with the Referee that claimant failed to prove that he was entitled to additional reimbursement.

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 $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. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631, 634 (1986). Finally, claimant is not entitled to a fee for services devoted to his unsuccessful "reimbursement" argument.

ORDER

The Referee's order dated July 23, 1992 is affirmed in part and reversed in part. The Referee's penalty assessment for SAIF's allegedly unreasonable denial is reversed. Claimant's attorney is awarded $700 for services on Board review, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

April 20, 1993 Cite as 45 Van Natta 791 (1993)

In the Matter of the Compensation of
PAULA L. SORIA, Claimant
WCB Case No. 91-13961
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Westerband and Kinsley.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

We affirm and adopt the Referee's order with the following supplementation on witness credibility. The Referee's order said the following:

> "If this were a straightforward credibility case, claimant would prevail. Her testimony is impugned by Mittleider, who is in turn impugned by Harris. The latter two cancel each other out; all other things being equal, claimant wins." (O&O p. 2).

We conclude, based on our review of the record, that Harris' testimony was not sufficient to impeach the credibility of Mittleider, and that Mittleider's testimony cast a serious shadow of doubt on claimant's credibility as a witness and reliability as a historian.

It is undisputed that claimant has right CTS. The question is whether her work activities were the major contributing cause of the disease or its worsening.

On the question of credibility, claimant and Mittleider have known and associated with one another on a friendly basis because they have a close friend in common. According to Mittleider's testimony, claimant told her on several occasions before the present claim arose, that she had problems (pain and numbing) with her right hand. Mittleider testified that Mittleider herself was scheduled to have surgery, and claimant made these statements while the two were discussing their respective physical problems.

In an effort to blunt the force of Mittleider's testimony, claimant called Linda Harris as a witness. Harris is an office manager for a local dentist where Mittleider had worked in the past as a bookkeeper. Harris testified that, in her opinion and based on her personal knowledge, Mittleider's reputation for truthfulness in the community was very poor.

We are not persuaded that Mittleider's detailed and pointed testimony about conversations she had with claimant should be disbelieved because of Harris' stated opinion about Mittleider's reputation for veracity. Claimant admits that she had no personal dispute with Mittleider, and there is no indication in this record that Mittleider was biased by reason of some personal animosity toward claimant or for any other reason. Claimant denied that she ever discussed arm or hand complaints with Mittleider prior to beginning work for this employer.

However, like the Referee, we find troublesome claimant's failure to offer any explanation for the markedly different accounts she has given of her off-work crocheting activities. Claimant crochets (or has crocheted) as a hobby. She told one doctor that she had not crocheted in nine months, but to another, that she had not crocheted in four years. At hearing, she testified that she had not crocheted in 10 to 12 years. Whether and to what extent claimant crocheted as a hobby was relevant to the question of causation given the opinion of Dr. Dickerman that crocheting may have been a causative factor. Dr. Dickerman also had the opinion that, given the severity of the right carpal tunnel tests, the condition had come on over a significant period of time with significant exposure. He found it unlikely, therefore, that claimant's condition was secondary to her recent exposure at work. No medical opinion rebutted this theory.

Claimant has the burden of proof. As did the Referee, we conclude that she has failed to carry the burden.

ORDER

The Referee's order dated June 4, 1992 is affirmed.

April 21, 1993 Cite as 45 Van Natta 792 (1993)

In the Matter of the Compensation of
JASON E. DONOVAN, Claimant
WCB Case No. 92-05081
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Daughtry's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's work activities, which required repetitive use of his hands, were the major contributing cause of his bilateral CTS.

The existence of claimant's bilateral CTS is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

In order to establish compensability of his occupational disease claim, claimant must show that work activities or exposures were the major contributing cause of his bilateral CTS condition or its worsening. ORS 656.802(2). "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). Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2). An "occupational disease" includes any series of traumatic events or occurrences which requires medical services or results in disability. ORS 656.802(1)(c).

Based on the conflicting opinions of Drs. Nathan and White, the Referee found the medical evidence to be in equipoise. Therefore, he concluded that claimant failed to carry his burden of proof. We disagree.

In evaluating the medical evidence concerning causation, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983); see also Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

In this case, Dr. White, treating surgeon, opined that claimant's bilateral CTS condition is work-related. (Exs. 4, 12). White's opinion concerning causation is based on claimant's detailed and accurate history concerning his hand-intensive work and his symptoms. (See Ex. 4). There is no contention that White's history is inaccurate or incomplete or that claimant did not have objective findings establishing the existence of his CTS.

Dr. Nathan, on the other hand, opined that the CTS preexisted this work exposure and that claimant's work-related hand activities were not be responsible for his median nerve conduction abnormalities. (Exs. 6-5 & 11). First, because claimant was completely asymptomatic until early 1992, Nathan's opinion that claimant's CTS preexisted his landscaping work for the employer is not particularly persuasive. Second, because Nathan failed to address the fact that claimant's symptoms improved when he was away from work, we see no reason to credit Nathan's opinion over White's. See Weiland v. SAIF, supra; Argonaut Insurance Co. v. Mageske, supra. Under these circumstances, based on the opinion of claimant's treating surgeon, we conclude that claimant has carried his burden of proving that his work activities for SAIF's insured were the major contributing cause of his bilateral CTS condition. Thus, the 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 claim 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 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 July 16, 1992 is reversed. The SAIF Corporation's denial is set aside. The claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an attorney fee of $3,000, payable by SAIF.

In the Matter of the Compensation of
MAY L. GALO-TUQUERO, Claimant
WCB Case No. 92-01835
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Hoguet's order that modified an Order on Reconsideration which found claimant medically stationary on January 4, 1992. On review, the issue is claimant's medically stationary date. 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 claimant was not medically stationary on January 4, 1991, the date designated by the Order on Reconsideration. We disagree.

It is claimant's burden to prove that she was not medically stationary on the date designated by the Order on Reconsideration. Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987); Berliner v. Weyerhaeuser, 54 Or App 624 (1981). "Medically stationary" means that "no further improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

Dr. Wagner, claimant's original treating physician, referred claimant to Dr. Lorish. Dr. Lorish reported that claimant was medically stationary as of January 4, 1991. Dr. Lorish testified that although he hoped claimant would improve with the passage of time, he did not anticipate, with any reasonable certainty, that there would be any material improvement with the passage of time. Dr. Moller, a consulting orthopedist, agreed with Dr. Lorish that claimant was medically stationary on January 4, 1991. Finally, Dr. Wagner also concurred with Dr. Lorish.

The entire medical record indicates that claimant was medically stationary as of January 4, 1991. There is no contrary medical or lay evidence. Accordingly, we conclude that claimant has not carried her burden of proving that she was not medically stationary on January 4, 1991, the medically stationary date established by the Order on Reconsideration.

At hearing, the insurer requested an offset for temporary disability benefits paid after January 4, 1991 in the amount of $731.06. Inasmuch as we have reversed the Referee and found that claimant was not entitled to temporary disability benefits after January 4, 1991, the insurer is allowed an offset of $731.06 against any future awards of permanent disability.

ORDER

The Referee's order dated September 22, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that found claimant medically stationary as of April 18, 1991 is reversed. The Order on Reconsideration award of temporary disability is reinstated and affirmed. The insurer is granted an offset of $731.06, for temporary disability benefits paid after April 4, 1991, against any future awards of permanent disability. The remainder of the order is affirmed.

In the Matter of the Compensation of
DIXIE L. TUCKER, Claimant
Own Motion No. 93-0104MM
OWN MOTION ORDER
Michael Casey, Claimant Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for her compensable low back injury. Claimant's aggravation rights expired on December 9, 1992. The employer opposes the reopening of the claim on the ground that no surgery or hospitalization has been requested. In addition, claimant contends both that she sustained a new injury on November 23, 1992 and she sustained an aggravation on that date, prior to the expiration of her aggravation rights.

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.

On February 2, 1993, Dr. Golden, M.D., agreed with Dr. Bernstein, M.D., that claimant is not a surgical candidate and that a conservative form of treatment could be helpful to her. Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim.

Own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Claimant contends she aggravated her old injury while working on November 23, 1992, prior to her aggravation rights expiring, when she suffered a "strain from replacing banding and lifting bander". She states she saw two doctors for a new aggravation on November 24, 1992 and was released from work on December 31, 1992 by Dr. Faber, M.D.

A claim for aggravation must be filed within five years after the first determination or the first notice of closure. ORS 656.273. Claimant's claim was closed by Determination Order on December 9, 1987. Therefore, her aggravation rights expired on December 9, 1992.

A physician's report may establish an aggravation claim. However, 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." Juan F. Carrizales, 43 Van Natta 2811 (1991); 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 the compensable injury. Carlson, supra at 964; Michael L. Page, 42 Van Natta 1960, 1963 (1990).

Among the medical information submitted by claimant, there are copies of two chart notes that are dated prior to December 9, 1992, the date claimant's aggravation rights expired. However, there is no evidence of when the employer received these chart notes. Furthermore, even if the employer received these chart notes before December 9, 1992, they do not meet the requirements of a claim for aggravation.

A chart note dated December 7, 1992, apparently from Dr. Bernstein, states that claimant returned for follow up, notes that the last shot "did the trick" but notes her pain is starting to return, and notes that a second shot was given on that date.

In a chart note dated December 8, 1992, Dr. Faber states:

> "REPORT from Dr. Bernstein: Visit on 11/24---he could find nothing significant with her but the question of depression certainly exists. He comments that she did break down and cry. REPORT from Dr. Potter; He feels that she probably has some anxiety syndrome contributing to everything that she has."

Neither of these chart notes establishes an aggravation claim. The return of pain noted by Dr. Bernstein is an objective finding. Suzanne Robertson, 43 Van Natta 1505 (1991). However, Dr. Bernstein neither indicates that this is a worsening of the compensable condition nor makes a causal connection between the return of pain and claimant's compensable injury. In addition, Dr. Faber's chart note indicates depression and a possible anxiety syndrome without discussing the compensable low back

condition. Dr. Faber does not indicate any worsening of the low back condition or causally relate the depression or anxiety syndrome to the compensable injury. On this record, we lack evidence that a claim for aggravation was filed prior to December 9, 1992.

In addition, we note that, if claimant is contending that a new injury occurred on November 23, 1992, the Board in its own motion authority has no jurisdiction over that contention.

Accordingly, we deny the request for own motion relief. Id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURA L. BRUMFIELD, Claimant
WCB Case No. 90-20608
ORDER ON REVIEW
Schouboe & Furniss, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Hazelett's order that: (1) declined to consider the compensability of claimant's cervical, right hip and left shoulder conditions; (2) upheld the insurer's denial of the aforementioned conditions; (3) found that claimant's back injury claim was not prematurely closed; (4) awarded no additional temporary disability compensation; (5) affirmed a Determination Order award of 21 percent (67.2 degrees) unscheduled permanent disability for a back condition; (6) awarded no scheduled permanent disability for loss of use of claimant's arm and legs; and (7) declined to award penalties for the insurer's allegedly unreasonable claim processing. In her brief, claimant argues that the Referee's $100 penalty-related attorney fee was inadequate. On review, the issues are jurisdiction (premature and/or untimely hearing requests), compensability, premature closure, temporary disability, extent of scheduled and unscheduled 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, with the following exceptions and supplementation.

We do not adopt the "Ultimate Findings of Fact" or the finding that claimant requested a hearing on the denial of benefits for cervical, left shoulder and right hip conditions on December 4, 1991. Instead, we find that claimant requested a hearing regarding these conditions when the hearing first convened before Referee Lipton on January 23, 1991. On that date, Referee Lipton expressly retained jurisdiction to address the compensability issue when the hearing reconvened. On December 5, 1991, the hearing reconvened before Referee Hazelett.

FINDING OF ULTIMATE FACT

The insurer had notice of claimant's claims for cervical, left shoulder and right hip conditions by the January 23, 1991 hearing.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

At the December 5, 1991 hearing, Referee Hazelett declined to address compensability of claimant's claims for cervical, left shoulder and right hip conditions. In reaching this conclusion, the Referee determined that he lacked authority to address the compensability of these conditions, because claimant's hearing request was initially premature, then untimely, regarding the neck and right hip and untimely regarding the left shoulder.

Claimant contends that the Referee erred in declining to consider the aforementioned compensability issues. We agree, and conclude that the compensability issues were properly before the Referee for hearing on December 5, 1991.

First, assuming that the request for hearing regarding the neck and right hip was premature on January 23, 1991, any such procedural defect was cured by the continuance granted by the Referee. See Rodney T. Buckallew, 44 Van Natta 358, 360 (1992) ("Any surprise caused by raising the compensability issue at hearing was remedied by the continuance granted by the Referee").[1]

Second, concerning the timeliness issue, the Referee reasoned that claimant's written request for hearing dated December 4, 1991 was untimely, as it was filed more than 60 days after the insurer's September 26, 1991 denial. Finding that good cause had not been shown for the untimeliness, the Referee declined to address the compensability issues. We disagree.

The hearing in this matter was first convened on January 23, 1991 before Referee Lipton. At the outset of the hearing, claimant claimed entitlement to permanent disability compensation for the accepted low back and thoracic strain/sprain conditions. However, she also claimed entitlement to a permanent disability award for right hip, neck and shoulder conditions, which she contended were compensably related to the accepted conditions. The insurer disagreed with claimant's statement of the issue. Specifically, the insurer contended that this was the first notice it had received that claims were being made for right hip, neck and shoulder conditions. To this, claimant responded that she was surprised to know that causation was being disputed, since unchallenged claims had previously been made through various medical reports. Ultimately, it became clear to the Referee that neither party was prepared to proceed on the question of compensability, if any, and the following resolution was reached:

> "REFEREE: Well, perhaps we need to get that issue clarified before we go ahead with the issues that were scheduled to be heard today, and would that be claimant's preference?
>
> "MR. SHEARER: Well, yeah. If we're going to be having to prove a causation issue, I think we need some definite report from the doctor explaining this.
>
> "REFEREE: And what's the employer's position on that, Mr. Lyons?
>
> "MR. LYONS: Am I correct in assuming that this would not have to go back into the hopper for regular - -
>
> "REFEREE: I'm going to retain jurisdiction over it and just treat it as a continued case.
>
> "MR. LYONS: Okay. Under those circumstances, then, you know, to avoid any protracted delay of it, I wouldn't have any problem with that.
>
> "REFEREE: All right. I - -
>
> "MR. SHEARER: How are you going to handle it now? Are you going to assess it and then issue a denial or acceptance before we have to go through this process of going to the expense of a report or - -
>
> "MR. LYONS: I think that would probably be the best way.
>
> "REFEREE: Well, I'll just retain jurisdiction of the file, and you keep me apprised as to your progress in processing this, and when it's ready for hearing, let me know, and we'll put it back on the docket.
>
> "MR. SHEARER: Okay.
>
> "MR. LYONS: Okay.
>
> "* * *.

[1] Because the insurer concedes that claims for these conditions were made on January 23, 1991, when the hearing first convened, (Respondent's Brief, p. 9), we need not consider claimant's contention that claims were perfected prior to that date.

REFEREE: With those matters understood, this case is in recess to be retained under my jurisdiction." (Tr. 9-11) (Emphasis supplied).

On this record, we conclude that a written request for hearing was not necessary following issuance of the insurer's written denial to give the Referee jurisdiction over the question of compensability. With the agreement of the parties, Referee Lipton had retained jurisdiction over the case and continued the hearing to include any denial of compensability, should such a denial be issued. Through correspondence, counsel kept the Referee apprised of the status of the case to the point of their ultimate disagreement on the question of causation, and they notified the Referee when they were ready to litigate the question.

Under the circumstances, a letter may have been appropriate to tell the Referee that the parties were ready to proceed. However, no new hearing request was necessary to give the Referee jurisdiction over the question of causation, since Referee Lipton had retained jurisdiction with agreement of the parties, for the purpose of deciding that question. See Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1986)(Where evidence offered was relevant to a pending hearing on a denied claim, there was no "new" claim); Vandehey v. Pumilite Glass & Building Co., 35 Or App 187, 192-93 (1978) (Where claimant's request for hearing had already raised the issue, the appeal was "already under way" and subsequent evidence was not a new claim); Kevin C. O'Brien, 44 Van Natta 2587 (1992); Tom E. Dobbs, 35 Van Natta 1332 (1983). Therefore, Referee Hazelett erred in declining to consider the compensability issues.

Inasmuch as the parties were permitted to fully develop the record on the question of causation, we proceed to the merits.

Compensability/permanent disability: left shoulder, right hip, neck, arms and legs

Claimant seeks permanent disability benefits for alleged conditions of the left shoulder, right hip, neck, arms and legs. After conducting our review, we are not persuaded that those conditions are related to claimant's low back injury.

Dr. Forgey, treating chiropractor, diagnosed claimant's condition following her December 1, 1987 compensable injury as a lumbosacral strain/sprain. Forgey's diagnosis has remained the same throughout the claim. (See Exs. 26, 38A). Dr. Bell, neurologist, who prescribed claimant's continuing conservative care since June 1989, eventually diagnosed a "ligamentous muscle problem" (Ex. 41) and a "soft tissue injury." (Ex. 54-2). There is no indication that the insurer accepted anything more than the lumbosacral strain/sprain claimed. (See Exs. 2, 3).

Claimant relies on Forgey's opinion relating claimant's constellation of symptoms to the 1987 work injury as proof that her compensable claim includes neck, left shoulder, right hip and arm and leg conditions as well as the accepted low back condition. However, there is no contention that body parts other than the low back were directly affected by the 1987 lifting incident. Rather, to the extent that the medical evidence relates claimant's need for treatment for her neck, shoulder, hip, back and extremities to the work injury, it describes these problems as indirect consequences only. (See Exs. 53, 54A). Therefore, assuming the existence of conditions involving body parts other than the low back, claimant bears the burden of proving that her 1987 lifting injury was their major contributing cause. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Due to the passage of time since the 1987 injury, the causation issue is a complex medical question which must be resolved by expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967; Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). We rely on those opinions which are well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259 (1986).

Forgey and Bell provide the primary medical evidence relating claimant's left shoulder, right hip, neck and extremity symptoms to the 1987 lifting injury. Bell opined that the injury caused sprained or strained "ligaments, nerves, muscles, and tendons. These go into spasm and affect the nerves that go to the arms and legs." (Ex. 41). In the same report, Bell related claimant's permanent physical restrictions to her "chronic pain in her back." (Id). Later, Bell issued an unexplained "check-the-box" response indicating that claimant has chronic conditions of her hip and neck. (Ex. 50-1). Considering

Bell's initial opinion that low back spasms caused symptoms elsewhere and Bell's failure to explain how this effect amounts to chronic conditions of claimant's neck and right hip, we do not find Bell's eventual "check-the-box" opinion to be persuasive. Moreover, claimant's treatment has been directed toward her low back, even when she complained of symptoms elsewhere. On this evidence, claimant has not established that the injury was the major cause of her alleged disability and/or need for treatment for her neck and right hip. See ORS 656.005(7)(a)(A).

Forgey opined that claimant's bilateral dorsal pain, including her shoulder girdle muscle problems, were "symptom[s] related to her low back pain." (Ex. 53 emphasis added; see Ex. 54A). Dr. Schultz, chiropractor, who provided the only left shoulder treatment, does not explain how or whether this treatment was related to the compensable low back strain condition. Although Forgey described the shoulder problem as a symptom of the low back condition, he did not explain this alleged causal relationship. Consequently, claimant has not proven that her December 1987 work injury was the major contributing cause of any left shoulder condition which she may have. See ORS 656.005(7)(a)(A).

Accordingly, claimant has not established the compensability of conditions affecting her neck, right hip, left shoulder, arms or legs. Therefore, none of these conditions shall be considered in rating the extent of claimant's permanent disability for her low back.

Premature closure/temporary disability/penalties/attorney fees

We adopt the Referee's "Conclusions of Law and Opinion" on these issues, contained in the sections entitled "Interim Compensation and Unreasonable Resistance to the Payment of Compensation" and "Premature closure," with the following alteration and supplementation.

The next-to-last sentence on page 7 is replaced as follows:

Because claimant's claims for neck, left shoulder and right hip conditions are not compensable, there has been no unreasonable resistance to the payment of compensation under these claims. See Ellis v. McCall, 308 Or 74 (1989); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Consequently, claimant's request for penalties and attorney fees is denied.

In addition, because the left shoulder claim is not compensable, the Referee's $100 attorney fee award (associated with the left shoulder claim) is reversed and claimant's request for a larger fee is denied. Id., see also Forney v. Western States Plywood, 296 Or 628, 632 (1984) citing Brown v. EBI Companies, 289 Or 905 (1980) (Attorney fees may only be awarded when authorized by statute).

Extent of permanent disability

We adopt the Referee's opinion and conclusions on this issue through the first full paragraph on page 11, with the following supplementation.

Claimant seeks increased permanent disability compensation for her low back condition, specifically increased impairment ratings and an adaptability factor of +10.

We note at the outset that the Referee applied the standards effective at the time of the Determination Order in rating claimant's permanent disability. See WCD Admin. Order 6-1988, renumbered 7-1988 (see WCD Admin. Order 1-1989). These are the standards we apply as well.

Considering the unexplained variations among the treating physicians' range of motion measurements and independent examiners' findings that claimant does not have reduced range of motion, we conclude that claimant has not proven entitlement to an impairment rating in addition to the 5 percent for a chronic back condition which the insurer does not dispute.

Regarding her adaptability factor, claimant argues entitlement to a +10 value. The insurer concedes that claimant is entitled to a +8 value. Because we find that Forgey's release to light work with restrictions, (see Ex. 29), supports a value no higher than +8, under former OAR 436-35-310(4), we utilize the +8 value to which the insurer agrees.

Claimant's unscheduled permanent disability award is computed pursuant to former OAR 436-35-280. The sum of her age and education values (2) is multiplied by her adaptability value (8), for a total of 16. This total is added to claimant's impairment value (5), for a total of 21 percent unscheduled permanent partial disability. In reaching this result, we reiterate that claimant has not proven entitlement to permanent disability benefits for her arms, legs, neck, left shoulder or right hip. Accordingly, we affirm the Determination Order award of 21 percent unscheduled permanent disability.

ORDER

The Referee's order dated May 15, 1992 is affirmed in part and reversed in part. That portion of the order that awarded an attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
BONNIE L. EBERHART, Claimant
WCB Case No. 91-16969
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Holtan's order which: (1) upheld the SAIF Corporation's current condition denial regarding claimant's low back condition; and (2) affirmed an Order on Reconsideration which awarded no permanent disability for a low back injury. On review, the issues are the propriety of SAIF's current condition denial, which issued prior to claim closure, compensability, and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

The second part of the November 22, 1991 denial stated that SAIF would continue to provide medical benefits related to claimant's accepted condition but that it appeared that her current need for treatment was related to the denied conditions.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that, both when the Referee listed the issues and when he discussed the merits of SAIF's November 22, 1991 denial, he incorrectly paraphrased the second part of the denial as denying responsibility for claimant's accepted July 7, 1990 low back injury. In fact, the November 22, 1991 denial: (1) denied several conditions as not related to the accepted lumbar sprain/strain (claimant contested only the denial of those conditions listed in the January 30, 1992 letter from Dr. Blake, treating physician); and (2) stated that SAIF would continue to provide medical services related to the accepted condition but that all current need for treatment was related to the denied conditions. Thus, SAIF did not deny ongoing responsibility for claimant's accepted lumbar strain/sprain. The denial raised the question of whether claimant was being treated for the strain/sprain or for noncompensable problems.

Propriety of SAIF's November 22, 1991 Denial

Both at hearing and on review claimant argues that SAIF's November 22, 1991 denial was an improper preclosure denial. We agree with the Referee's reliance on Daniel R. Bakke, 44 Van Natta 831 (1992), in determining that the denial was not an improper preclosure denial. However, even assuming that the denial was procedurally improper, on the facts of this case, the Referee was correct in reaching the merits of the denial.

In Chaffee v. Nolt, 94 Or App 83 (1988), the court noted that preclosure denials were generally improper in that they allowed insurers to circumvent the ordinary process of claim closure. Id. However, the court held that, given the insurer's prompt closure of the claim after issuance of the denial, the insurer's conduct in that case did not appear to be intended to shortcut the ordinary process of claim closure and, therefore, the Board was correct in reaching the merits of the denial. Id. at 85-86; Karl G. Rohde, 41 Van Natta 1837 (1989).

Both here and in Chaffee, supra, the insurer closed the claim three days after issuance of a denial. We find that the same reasoning applies in this case. The Referee was correct in reaching the merits of the denial.

Claimant relies on Roller v. Weyerhaeuser Co., 67 Or App 583, recon 68 Or App 743, rev den 297 Or 124 (1984), in contending that the preclosure denial of her current condition is improper. In Roller, the court found that to permit an employer to attempt to terminate future responsibility for an accepted claim by means of a preclosure partial denial was "tantamount to authorizing it to bypass a hearing on the extent of a claimant's disability and could preempt the resolution of an issue that is involved in determining the extent of disability." Id. at 67 Or App 586. In Roller, there was no prompt claim closure following the partial denial, and the court found that the employer's denial resulted in bypassing the process of claim closure and determination of extent of disability.

However, as noted above, SAIF here issued a Notice of Closure three days after issuing its current condition denial. Claimant requested reconsideration of that Notice of Closure which was affirmed by an Order on Reconsideration. Subsequently, claimant requested a hearing on the Order on Reconsideration and review of the Referee's order. At all times in this process the issue of extent of disability was at issue. Thus, unlike in Roller, the process of claim closure and determination of extent of disability was not bypassed.

Furthermore, claimant overlooks the following statement from the Roller court:

> To hold, as we do, that employer's partial denial was improper here does not preclude it from litigating the issue at the time of closure; neither does it affect employer's post-closure right to deny claims for specific medical treatments or for aggravation on the ground that they do not 'result from the injury.' Id. at 67 Or App 587. (Emphasis supplied).

Thus, finding a preclosure denial improper does not result in waiver by the insurer of the causation issue. Neither does it lead to a finding that the denied condition is compensable. Rather, it simply delays litigation of the issue until claim closure. Here, the claim was closed three days after the denial was issued. Claimant appealed from the Order on Reconsideration, and nothing precluded SAIF from asserting at hearing that the condition for which claimant sought benefits is not causally related to the accepted stain/sprain condition. Roller v. Weyerhaeuser Co., supra. In short, the question of the procedural propriety of the preclosure denial is moot since the issues of causation and extent of disability were properly and fully litigated in the extent case. Therefore, even if we apply Roller as claimant requests, the Referee was still correct in reaching the merits of the denial.

Compensability

We adopt the Referee's reasoning and conclusions regarding the compensability of claimant's current condition and the compensability of the multiple conditions denied by SAIF's November 22, 1991 denial.

We note that, at hearing, claimant contested only the denial of those conditions listed in the January 30, 1992 letter from Dr. Blake, which did not include the partial denial of "psychological factors affecting physical condition." (Ex. 29, #2Tr. p.4). However, on review, claimant argues that there is no evidence that her psychological condition is not related to the accepted lumbar strain/sprain. That is not the standard. If claimant is contending that she has developed a psychological condition as a consequence of the compensable lumbar strain/sprain, she must prove that the accepted injury is the major contributing cause of the psychological condition. ORS 656.005(7)(a)(A).

To the extent that claimant attempts to first raise on review the issue of compensability of a psychological condition, we decline to address it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, there is no evidence in the record that the accepted injury caused a psychological condition.

Extent of Scheduled and Unscheduled Permanent Disability

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

ORDER

The Referee's order dated July 24, 1992 is affirmed.

In the Matter of the Compensation of
REBECCA MARKS, Claimant
WCB Case No. 91-03417
ORDER ON REVIEW (REMANDING)
Westmoreland & Shebley, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

Claimant requests review of Referee Podnar's order that dismissed her request for hearing on the ground that her failure to retain an attorney was not an extraordinary circumstance that would justify further postponement or continuance. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

The insurer issued a denial on February 20, 1991. Claimant, then represented by counsel, timely appealed. A hearing was set for June 18, 1991. On June 11, 1991, claimant's counsel moved to postpone because he had a conflict with other proceedings on that date. The hearing was rescheduled for November 20, 1991.

On November 14, 1991, claimant's counsel again moved to postpone the hearing, as he had resigned as counsel due to a conflict of interest. The insurer did not object to the withdrawal or postponement. The hearing was rescheduled for April 24, 1992. On March 27, 1992, the Referee sent claimant a letter recommending that she retain an attorney. Because claimant had not retained an attorney at the time of hearing, the hearing was again rescheduled for June 4, 1992.

The hearing convened on June 4, 1992. Claimant, pro se, appeared and requested a postponement, as her current attorney had not yet agreed to represent her. Counsel for the insurer moved to dismiss. The Referee granted the motion.

No oral proceeding was convened and no exhibits were received.

CONCLUSIONS OF LAW AND OPINION

We first address the Referee's conclusion that claimant was not entitled to a further postponement of her requested hearing. In addressing this issue, we note that although no evidence was admitted at hearing, the record contains correspondence documenting the procedural history of this case and the prior postponements of claimant's hearing. Further, the parties have made additional representations in their arguments to the Board. Inasmuch as we consider these documents and representations to be sufficient to conduct our review of the postponement issue, we have proceeded with our evaluation.

OAR 438-06-081 provides, in relevant part:

> "A scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement."

"* * *

"(4) 'Extraordinary circumstances' shall not include incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence."

Here, claimant appeared at the time and place set for hearing and requested a postponement. The hearing had previously been postponed on three separate occasions. The most recent postponement (some three months earlier) had been granted based on claimant's inability to secure legal counsel. Noting that she had met with an attorney the day before the hearing and that the attorney was reviewing her file, claimant sought a further postponement.

Finding that claimant had ample time to retain counsel and had not done so, the Referee concluded that claimant's efforts did not constitute due diligence. Accordingly, the Referee held that claimant's continued efforts to retain legal counsel did not constitute extraordinary circumstances beyond claimant's control, sufficient to justify the postponement of the hearing. See OAR 438-06-081.

We agree with the Referee's conclusion. Claimant had the opportunity to secure legal counsel for some six months before the June 4, 1992 hearing. Moreover, an April 1992 scheduled hearing was postponed to grant claimant additional time within which to obtain an attorney. In light of such circumstances, we do not consider the basis of claimant's further postponement request (to grant her then-potential attorney time to review the file) to be sufficient to constitute extraordinary circumstances beyond claimant's control. OAR 436-06-081. At most, claimant's explanation suggests that her postponement request was based on incomplete case preparation, which could have been accomplished with the exercise of due diligence. OAR 438-06-081(4). Such a reason does not warrant the granting of a postponement.

In addition to denying the motion for postponement, the Referee dismissed claimant's hearing request. Although incomplete case preparation is a basis for denying postponement, it is not a basis for dismissing the hearing request. Inasmuch as claimant appeared at the scheduled hearing, the Referee should not have dismissed the case. See OAR 438-06-071; Mario Miranda, 42 Van Natta 405, 406 (1990). Rather, claimant should have been granted the opportunity to proceed based on the testimonial and documentary evidence available at the time of the June 4, 1992 hearing. Mario Miranda, supra.

Accordingly, we remand this matter to Referee Podnar with instructions to conduct a hearing. Since claimant has now secured legal counsel, her attorney is entitled to represent her at that hearing. However, only those witnesses who were present to testify at the June 4, 1992 hearing and only those documents which were prepared for introduction as evidence at that time shall be admitted by the Referee. Following the conclusion of the hearing, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated June 11, 1992, as amended June 15, 1992, is vacated. This case is remanded to Referee Podnar for further proceedings consistent with this order.

Board member Hooton dissenting.

This case involves an order of the Referee dismissing claimant's request for hearing. The majority concludes that the failure to obtain legal counsel is inadequate case preparation under OAR 438-06-081(4) and affirms that dismissal. I am unable to agree with that result on the present claim. Therefore, I respectfully dissent.

The order of the Referee is based on specific findings that controlled his decision. A portion of the recitations of the Referee deal specifically with the procedural history of this claim. This claim was originally set for hearing on June 18, 1991. At that time, claimant was represented by Darrell Bewley, Attorney at Law. That hearing was postponed at the request of claimant's counsel because he had a conflict in scheduling. The matter was reset for November 20, 1991. That hearing was also reset at the request of Mr. Bewley because he found himself unable to continue and requested that claimant be given an opportunity to find counsel to represent her.

The hearing was again reset to April 24, 1992, and a letter sent from the Hearings Division urging claimant to retain counsel to represent her interests. The matter was set over on the eve of that hearing because claimant had been unable to find counsel to represent her. The matter was rescheduled for June 4, 1992.

On June 4, 1992, claimant appeared pro se and again requested a postponement. She purportedly represented that she had spoken with an attorney on June 3, 1992 and that he was reviewing her claim, though he had not yet decided whether to represent her. The attorney for Liberty Northwest Insurance Corporation moved to dismiss the request for hearing, and that request was granted.

The Referee based his order on the following specific findings:

> "In the matter of the postponement of the hearing which was scheduled April 24, 1992, on the eve of the hearing claimant advised that she had just sought counsel and that he was reviewing the file, but would be unable to attend on such short notice. There is no evidence in this file that claimant actually retained counsel as stated.
>
> "On June 4, 1992, at the time of hearing counsel for Liberty Northwest moved to dismiss. I conclude that claimant has had ample time to find counsel and that on the two most recent previous hearing dates has sought counsel only the day before. I do not regard this as a reasonable effort to move the case forward and I do not regard it as due diligence. I do not find that there are any extraordinary circumstances which would justify the continuance or postponement of this case another time." (Amended O&O at 1, emphasis added.)

The Referee did not specify the statute or rule which permitted this action, but a review of the argument would suggest that the Referee reached his conclusions either under OAR 438-06-071, which permits dismissal of a hearing request if the claimant causes an unreasonable delay in the hearing of more than 60 days, or OAR 438-06-081 as cited by the majority.

While either rule would provide adequate authority for the action taken in this case, both require specific factual findings to support a dismissal order. Those findings must be made on the basis of the record, and herein lies the problem. Despite the fact that ORS 656.283(6) requires that the Referee make a record of all the proceedings before him, no record was made. No exhibits were entered into evidence and no transcript kept of any oral proceedings. Despite the fact that there are letters in the case file of the Hearings Division, those letters are primarily authored by counsel or the Referee and do not provide a basis for the specific findings made by the Referee. Where those specific findings are based on representations of the claimant at the time of argument on the motion, those representations would be part of the factual record. However, given the absence of a transcript, I am unable to conclude that claimant was even given an opportunity to speak.

The Dismissal Order, in this case, may actually be the appropriate remedy. However, there is no record on which to make the finding that claimant failed to meet the due diligence requirement of OAR 438-06-081, or from which to conclude that the delay in the hearing was unreasonable under OAR 438-06-071. Consequently, I am unable to support this order and would remand the claim to the Referee for the making of the record which ORS 656.283(6) required in the first instance.

Failure to complete statutory requirements in the conduct of a hearing, even on a motion to dismiss, is an abuse of discretion for which the Referee must be reversed. There is no reasonable alternative. Consequently, I am wholly at a loss to explain the majority reasoning, and certainly can neither accept nor condone it.

In the Matter of the Compensation of
KENNETH W. McDONALD, Claimant
WCB Case No. 91-07926
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

The insurer requests review of Referee Galton's order which: (1) set aside a July 23, 1990 Determination Order and an August 29, 1991 Order on Reconsideration as prematurely issued; and (2) directed the insurer to pay temporary disability benefits from March 10, 1988 until closure pursuant to ORS 656.268. On review, the issues are res judicata, temporary disability, and the effect of a prior order. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

Following a previous hearing, Referee Crumme, in a May 21, 1991 Opinion and Order on Reconsideration, directed the insurer to pay temporary disability compensation awarded in a July 23, 1990 Determination Order, which had not been paid by the time of the previous hearing. In addition, Referee Crumme's order found claimant's psychological condition to be compensable, and he directed the insurer to provide compensation for this condition as required by law. Referee Crumme' also found that claimant was disabled from working due to both his accepted low back condition and his psychological condition as of March 27, 1990, the date his then-treating physician, Dr. Sears, released him from work. Based on this finding, Referee Crumme' ordered the insurer to pay interim compensation from March 27, 1990 until the insurer denied the psychological claim on July 17, 1990. Referee Crumme' also assessed penalties and related attorney fees for the insurer's unreasonable resistance to the payment of this compensation. (Ex. 49).

As to issues related to the July 23, 1990 Determination Order, including premature closure and extent of permanent disability, Referee Crumme' found that he did not have jurisdiction to consider the issues, since claimant had not first requested reconsideration of the Determination Order. (Ex. 49-11, 49-12). After the hearing before Referee Crumme', claimant requested reconsideration. (Ex. 51). On reconsideration, the Director affirmed the Determination Order in all respects, thereby affirming the temporary and permanent disability awards made in the July 23, 1990 Determination Order. (Exs. 42, 53). There is no evidence that claimant challenged this August 29, 1991 Order on Reconsideration.

By the time of the current hearing, claimant still had not received the compensation, penalty and related attorney fees ordered by Referee Crumme. The insurer had requested Board review of Referee Crumme's May 21, 1991 order, but, as pertinent here, challenged only compensability of the psychological condition. Subsequently, on review, we affirmed Referee Crumme's order finding the psychological condition compensable. Kenneth W. McDonald, 44 Van Natta 692 (1992), on recon 44 Van Natta 1052 (1992).

CONCLUSIONS OF LAW AND OPINION

Applicable Law

First, we note that because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, this case is properly analyzed under the 1990 amendments to the Workers' Compensation Law. We do not find that this will produce an unjust, harsh or absurd result. See Ida M. Walker, 43 Van Natta 1402 (1991).

Finality of Determination Order/Order on Reconsideration

Referee Galton set aside and rescinded the July 23, 1990 Determination Order and August 29, 1991 Order on Reconsideration as prematurely issued because claimant's psychological condition was not then medically stationary. The insurer contends that the Referee was not authorized to do so because claimant did not seek to have the orders rescinded, and because the orders had become final by operation of law. We agree with the insurer.

Claimant did not seek to have the orders rescinded. (See Tr. 3-4). Nor did claimant request a hearing challenging the Order on Reconsideration within the time period specified in ORS 656.268(6)(b). We have previously held that referees should not decide issues not properly before them. Richard H. Long, 43 Van Natta 1309, 1310 (1991); Theodore W. Lincicum, 40 Van Natta 1760, 1762-63 (1988). Moreover, since claimant did not challenge the Order on Reconsideration, it became final by operation of law and could not be relitigated at a subsequent hearing. See Drews v. EBI Companies, 310 Or 134, 149 (1990). Under such circumstances, the Referee was without authority to set aside and rescind the Determination Order and Order on Reconsideration. Accordingly, we reinstate the August 29, 1991 Order on Reconsideration and the July 23, 1990 Determination Order.

Temporary Disability Compensation

In the current case, claimant seeks to enforce Referee Crumme's May 21, 1991 Opinion and Order on Reconsideration. (Ex. 49). Specifically, claimant seeks temporary disability compensation due to his psychological condition, which Referee Crumme' found to be compensable. In finding the condition compensable, Referee Crumme' directed the insurer to provide compensation as required by law. The insurer has paid no compensation, contending that none is due. We disagree.

When the insurer requested Board review, challenging compensability of the psychological condition, the compensation appealed was stayed, except "[t]emporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs." ORS 656.313(1)(a)(A). Thus, claimant was entitled to receive temporary disability benefits from May 21, 1991 for disability due to his psychological condition pending the insurer's appeal of the compensability of that condition. Furthermore, since we affirmed Referee Crumme's decision on review, claimant is entitled to receive all temporary disability benefits due to his compensable psychological condition until the claim is properly closed under ORS 656.268. ORS 656.313(1)(a)(A).

The insurer contends that because Referee Crumme' did not specifically order it to pay benefits for temporary disability, it is not obliged to so. This argument has no merit. We have long held that when an order directs the insurer or employer to accept and process a claim according to the law, it is the carrier's obligation to do just that. See George B. Rossman, 41 Van Natta 1839 (1989); Frank R. Gonzales, 34 Van Natta 551 (1982). Thus, Referee Crumme's directive to "provide compensation according to the law" for the psychological claim was sufficient to trigger the insurer's duty to determine whether compensation is due, and pursuant to ORS 656.313(1)(a)(A), to pay any compensation that was due after May 21, 1991, including temporary disability benefits.

The insurer next argues that no benefits for temporary disability are due because the Determination Order awarded periods of temporary disability which ended July 17, 1990, and that order is now final. (Ex. 42). Therefore, the insurer argues, claimant is precluded from claiming any additional temporary disability. We disagree.

The insurer apparently contends that claimant's claim for additional temporary disability benefits is barred by res judicata, the "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews v. EBI Companies, supra, 310 Or at 139. The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars litigation of an issue only if that issue was actually litigated and determined in a setting where the determination of the issue was essential to the final decision reached. North Clackamas School Dist. v. White, 305 Or 48 (1988). In comparison, claim preclusion bars litigation not only on every claim previously included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue; however, it does require the opportunity to litigate, whether or not used. Drews, supra.

The issue of whether claimant was entitled to temporary disability benefits as a result of a compensable psychological condition was not adjudicated at the prior hearing. The prior adjudication determined various issues, including, among others, compensability of the psychological condition, entitlement to interim compensation due to the psychological claim, and entitlement to the temporary disability benefits awarded in the Determination Order. However, it did not decide the issue of whether claimant was entitled to additional temporary disability benefits due to disability caused by his compensable psychological condition.

Nor does claim preclusion bar claimant's request for additional temporary disability benefits due to the psychological condition. Claimant's entitlement to additional temporary disability benefits arose only as a result of the prior hearing, since that is when the psychological claim was determined to be compensable and the insurer was directed to process the claim as required by law. The Determination Order, which was litigated at the prior hearing, did not address claimant's psychological condition. The insurer issued its denial of the psychological condition claim on July 17, 1990, the same day that claimant was determined to be medically stationary under the Determination Order. The Determination Order specifically stated that "[t]his is not a determination of any denials issued by the insurer." (Ex. 42).

Thus, claimant did not have an opportunity at the prior hearing to litigate his claim for additional temporary disability benefits due to his psychological condition, since that claim only arose as a result of the previous Referee's order and therefore could not have been litigated previously. Accordingly, we hold that, even though the Determination Order has become final, neither claim nor issue preclusion bars claimant's claim for additional temporary disability benefits due to his compensable psychological condition.

Finally, the insurer argues that even if the claim is not otherwise barred, claimant is not entitled to additional temporary disability benefits because time loss was not authorized by an "attending physician" as defined in the Workers' Compensation Law.

Dr. Sears, claimant's then-treating chiropractor, released him from work as of March 27, 1990. (Ex. 49-5). Referee Crumme' found that, as of March 27, 1990, the insurer had notice of claimant's disability due to both his back and psychological conditions, and therefore, ordered the insurer to pay interim compensation for the psychological condition, beginning March 27, 1990. (See Ex. 49-13). The insurer did not appeal the interim compensation issue. Subsequently, following Referee Crumme's order finding the psychological condition compensable, Dr. Beckstrom, claimant's treating physician who is licensed to practice medicine in Washington but not Oregon, authorized continuing temporary disability due to the psychological condition, retroactively for one year. (Ex. 51E). Drs. Worthington and Rountree, Ph.D., claimant's treating psychologists, also authorized continuing temporary disability. (Ex. 51B).

The insurer argues that due to the 1990 amendments to the Workers' Compensation Law, a physician who is not duly licensed to practice in Oregon cannot be an attending physician. Therefore, pursuant to ORS 656.245(3)(b)(B) and ORS 656.005(12)(b)(A), Dr. Beckstrom cannot authorize temporary disability compensation. We disagree.

When the definition of "attending physician" changed in 1990, the Department required all carriers to advise workers in writing whether their current physicians no longer qualified as an "attending physician" under the 1990 amendments to the Workers' Compensation Law. See Department of Insurance and Finance Bulletin No. 215 (June 8, 1990). The Bulletin required the worker to receive 30 days written notice before any benefits may be terminated. Id. We find no evidence in the record that the required notice was provided to claimant. Under such circumstances, we find that the insurer cannot unilaterally terminate benefits on the basis that claimant failed to comply with the new law. See Sandra L. Masters, 44 Van Natta 1870 (1992).

Claimant also seeks enforcement of the following provisions of Referee Crumme's order: (1) payment of the temporary disability compensation ordered in the July 23, 1990 Determination Order; and (2) payment of interim temporary disability compensation from March 27 to July 17, 1990 for claimant's psychological condition claim.

Because we have reinstated the Determination Order and Order on Reconsideration, we again direct the insurer to pay the compensation awarded in those orders. Indeed, the compensation should have been paid under the Determination Order long before the matter came before the present Referee, and we find that the insurer's refusal to pay the ordered compensation was unreasonable. Likewise, we again order the insurer to pay the interim compensation awarded in the previous Referee's order. We find no justification for the insurer's refusal to pay compensation under a valid, unappealed order, and we find its conduct unreasonable.

Accordingly, in lieu of Referee Galton's order, we direct the insurer to process claimant's psychological claim to closure as required by ORS 656.268. In addition, we order the insurer to pay all compensation ordered as a result of the July 23, 1990 Determination Order and Referee Crumme's May 21, 1991 order, including interim compensation and temporary disability compensation due under the

psychological claim, less any amounts already paid for the same period under the back claim. See Fischer v. SAIF, 76 Or App 656 (1985); Ernest J. Myers, 44 Van Natta 1052, 1055 (1992). In addition, we order the insurer to pay the penalty ordered by Referee Crumme' in the amount of 25 percent of the above temporary disability benefits, one-half to be paid to claimant and one-half to his attorney, pursuant to ORS 656.262(10). Finally, for the insurer's unreasonable failure to comply with Referee Crumme's order, we assess the insurer another 25 percent penalty for this separate act of misconduct, equal to 25 percent of the compensation granted by Referee Crumme's order. See Glen D. Roles, 45 Van Natta 282, 45 Van Natta 488 (1993).

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

Referee Galton's order dated October 24, 1991, as reconsidered January 15, 1992, is reversed in part, modified in part, and affirmed in part. That portion of Referee Galton's order which set aside the July 23, 1990 Determination Order and August 29, 1991 Order on Reconsideration is reversed, and those orders are reinstated. In lieu of Referee Galton's award of benefits for temporary disability, the insurer is directed to pay temporary disability compensation due under the July 23, 1990 Determination Order and Referee Crumme's May 21, 1991 Order on Reconsideration, less any amounts previously paid for the same period under the back claim. Further, the insurer is directed to pay the penalty ordered by Referee Crumme' in the amount of 25 percent of the specified temporary disability benefits (temporary disability benefits due under July 23, 1990 Determination Order and interim compensation due between March 27, 1990 and July 17, 1990), one-half to be paid to claimant and one-half to be paid to his attorney. In addition, for the insurer's unreasonable failure to comply with Referee Crumme's order, the insurer shall pay a penalty in the amount of 25 percent of the temporary disability benefits awarded by Referee Crumme's order, one-half to be paid to claimant and one-half to be paid to his attorney. That portion of Referee Galton's order which awarded claimant's attorney a fee payable from claimant's increased temporary disability compensation, not to exceed $1,050, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the insurer.

Board member Hooton dissenting.

This case involves what, at one time, would have been considered a true aberration in the area of workers' compensation litigation. Claimant's claim was closed by Determination Order following the issuance of a denial of claimant's psychological condition. Prior to the Workers' Compensation "reform" of 1990, the Determination Order and the denial would have been litigated in the same proceeding. When the denial was set aside, the Determination Order would have been set aside simultaneously because it is legally impossible to allow claim closure when there is a compensable condition which has not become medically stationary. ORS 656.268(1).

In the post "reform" period, however, it is necessary to find a means of completing the processing of a claim, within the intent of the statute, in a procedural maze which gives jurisdiction of the various components of a claim such as this to different forums. The Referee in the original hearing, had jurisdiction to resolve only the compensability of the psychological condition, and the Director has original jurisdiction over the Determination Order. As a consequence, it is now possible to produce the anomalous result which the majority embraces here. Unfortunately, I am unable to accept that result because it violates the statutory imperative at ORS 656.268(1) that claims shall not be closed until the worker is medically stationary.

In this instance, claimant was not stationary at the time of claim closure, and had demonstrated that by overturning the denial of his psychological condition at hearing. While the majority's resolution protects claimant's rights to all compensation presently due as a result of that hearing, it establishes the first closure of the claim on an inappropriate date, thereby depriving claimant of a portion of his statutory aggravation period. I, therefore, offer the following analysis as a more reasonable method of resolving the present dispute so as to preserve the statutory imperative at ORS 656.268(1) and to prevent the litigation of workers' compensation claims from becoming exercises in technicality, the only effective purpose of which is to deprive injured workers of benefits lawfully due.

When Referee Crumme determined that claimant's psychological condition was compensable as part of the original claim, the Determination Order became moot. A claim cannot be closed, nor permanent disability rated before "the workers' condition resulting from an accepted disabling injury has become medically stationary...." ORS 656.268(4)(a). Referee Crumme determined that claimant's psychological condition resulted from the accepted disabling injury. However, the psychological condition was not even considered when the Determination Order issued. Just as an aggravation denial is rendered moot when a claim is found to be prematurely closed, so a Determination Order becomes moot when a previously denied condition is determined to be compensably related to the compensable injury, if that condition was not considered at the time of claim closure.

We have determined that no particular action is required by the claimant to set aside an aggravation denial that is mooted when it is determined that a claim has been prematurely closed. That denial remains just as "null and void" if the denial became final by operation of law, as it is when claimant requests a hearing to set it aside. The denial can be given no practical effect because the law prevents the denial. Candy M. Kayler, 44 Van Natta 2424 (1992). There is no distinction between the legal analysis related to that mooted denial and the Determination Order here.

The Determination Order in the present claim was issued solely as a consequence of the psychiatric denial. Because the psychiatric condition, which was not stationary, was in a denied status, the insurer could allege that all accepted conditions of the compensable injury were medically stationary. When the denial was set aside, however, the precondition for the issuance of the Determination Order, that all accepted conditions be stationary, was no longer satisfied. Just as an aggravation denial based on the issuance of a Determination Order is void when the Determination Order is set aside as premature, the statute prohibits giving any effect to the Determination Order which issued only because of the denial of claimant's psychological claim. Thus, I would conclude that Referee Galton's order setting aside the Determination Order and Order on Reconsideration, though unnecessary because both are null and void as moot, is consistent with and follows from Referee Crumme's order finding that the psychological condition is compensable as part of the original claim.

Even if the Determination Order is not rendered moot when the denial of claimant's psychiatric condition is set aside, I still disagree with the insurer's contention that the Referee was not authorized to set aside the Determination Order and Order on Reconsideration because they had become final by operation of law. I would find that the insurer had agreed to hold the issue in an open and pending case status when it agreed to permit Referee Crumme to enter an order remanding the premature closure issue to the Department. A referee may not remand a claim to the Director. Mickey L. Platz, 44 Van Natta 1056 (1992). Nevertheless, the Referee's order must be given some effect. Therefore, I would treat Referee Crumme's action as an abeyance of the issues related to the Determination Order, with the consent of the insurer. By requesting a hearing to enforce Referee Crumme's Order, claimant, in effect, reactivated the issues held in abeyance by Referee Crumme, thereby raising the issues related to the Determination Order before Referee Galton. Because these issues can be deemed in abeyance, no finality could attach to the Determination Order and Order on Reconsideration. Accordingly, I would conclude that Referee Galton was authorized to set aside the Determination Order and Order on Reconsideration.

Finally, I would note that the insurer should not be allowed to benefit by permitting an action that it knew to be legally incorrect. ORS 656.262 establishes that the insurer has the principle obligation for processing workers' compensation claims. When Referee Crumme issued an order inconsistent with the issuance of the Determination Order in the present claim, the insurer, and not claimant, had the primary responsibility to notify the Director of the issuance of that order and to seek the reversal of the Determination Order as a normal part of claims processing. To permit the Director to continue the reconsideration proceeding as if the Determination Order had any legal effect is tantamount to misrepresentation by silence. The Workers' Compensation Law does not recognize the basic adversarial nature of the relationship between the employer/insurer and the claimant. The statute requires that the insurer subsume its own interest, and process the claim in a manner consistent with the law and claimant's legitimate needs. While the practical reality of the situation is adversarial, a referee cannot achieve substantial justice in any proceeding in which his discretion is shackled by technical rules and requirements. Consequently, in resolving issues such as those presented here, any referee must be able to rely on the processing requirements of ORS 656.262 as though the appropriate legal interests of claimants are the insurer's sole concern.

In the Matter of the Compensation of
RICHARD R. MILLUS, Claimant
WCB Case No. C3-00554
DISPOSITION AGREEMENT ORDER ON RECONSIDERATION APPROVING CLAIM
Davis, Gilstrap, et al., Claimant Attorneys
Carolyn Ladd (Saif), Defense Attorney

On March 3, 1993, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

By order dated April 9, 1993, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement provided for an extraordinary attorney fee, yet the services listed by claimant's counsel were not services directly related to obtaining the CDA. See David D. Buchanan, 43 Van Natta 1187 (1991). Accordingly, because extraordinary circumstances did not exist to justify a fee greater than provided under normal circumstances, the CDA was found unreasonable as a matter of law.

Claimant has requested reconsideration of our order by submitting a modified disposition that no longer requests approval of an extraordinary attorney fee. Here, the disapproval order was mailed on April 9, 1993, and claimant's request for reconsideration was filed on April 14, 1993. Thus, we find claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2). Moreover, upon review of the addendum, we find good cause for allowing the additional submission. Accordingly, we will consider this information on reconsideration. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

In a prior case, we declined to approve a CDA on reconsideration where the parties' amendment increased the amount of consideration to be paid to claimant and reduced claimant's counsel's attorney fee. See David L. Harris, 43 Van Natta 1209 (1991). In Harris, we reasoned that the parties' revision of the CDA constituted new evidence, which is not permitted without a showing of good cause. Additionally, we concluded that the revision affected a significant part of the parties' agreement, in that the amount of proceeds to claimant had been changed.

After further consideration, we disagree with the reasoning expressed in Harris. We conclude that, where claimant's actual monetary recovery has been increased upon reconsideration, due to a proportionate decrease in his counsel's attorney fee, the total consideration for the CDA remains the same. Consequently, we do not find that the revised distribution of the proceeds constitutes "additional information" regarding the agreement. Moreover, we do not find that such a revision affects a significant part of the parties' agreement, as the total consideration for the agreement upon reconsideration is identical to the total consideration initially provided for in the parties' agreement. In essence, the revised CDA represents a redistribution of funds, which is not only in accordance with all parties' expressed wishes, but results in an additional recovery to the claimant. Therefore, to the extent that the Harris case is inconsistent with this order, it is disavowed.

Accordingly, we grant the motion for reconsideration. On reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition is approved for a total consideration of $22,500, with $18,375 of the proceeds to be paid to claimant. An attorney fee of $4,125, payable to claimant's counsel according to the terms of the revised agreement, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARLENE E. PARKS, Claimant
WCB Case Nos. 90-21018 & 91-08460
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Westerband.

The self-insured employer requests review of that portion of Referee Mongrain's order that set aside its disclaimer of responsibility for claimant's benign paroxysmal positional vertigo (BPPV) condition. Claimant cross-requests review of those portions of the Referee's order that: (1) upheld the employer's partial denial of her claim for endolymphatic hydrops and perilymph fistula; (2) declined to award temporary total disability benefits for the period from November 6, 1989 through October 18, 1990; and (3) declined to assess a penalty and related attorney fee for the employer's allegedly unreasonable refusal to pay temporary total disability benefits. Claimant also contends that the Referee erred in admitting Dr. Grimm's deposition (Ex. 28A) without allowing her an opportunity to cross-examine Grimm regarding the deposition. On review, the issues are responsibility, evidence, compensability, temporary total disability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt the Referee's conclusions and opinion concerning this issue, with the following supplementation.

The issue of the employer's responsibility for claimant's BPPV condition following the September 29, 1989 incident with a subsequent employer (Marten Transport) was previously litigated before Referee Michael Johnson in WCB Case No. 89-22855. In that case, claimant requested a hearing regarding the employer's denial letter dated November 6, 1989, which stated in relevant part:

> "You have a[n accepted] non-disabling claim which by September, 1989 was fully resolved. You have suffered a subsequent, independent, intervening injury while employed by another employer. This injury is a new workers' comp claim and is the cause of your current disability and need for medical services. If this September 29, 1989 incident while [sic] was in the employ of an Oregon employer, we deny responsibility for your current condition; if this incident occurred while employed by a non-Oregon employer, we deny compensability under Oregon law, of your current condition." (Ex. 6)

Claimant filed a claim against Marten in Wisconsin. Marten denied the claim, and claimant requested a hearing. That hearing request was pending at the time claimant's Oregon claim against the employer went to hearing. Claimant did not file a claim against Marten in Oregon, and Marten was not joined as a party in WCB Case No. 89-22855.

Following the hearing in WCB Case No. 89-22855, Referee Johnson issued his order on October 18, 1990, finding the employer to be responsible for claimant's BPPV condition. (Ex. 11). The Referee found that claimant's accepted January 1989 injury with the employer was a material contributing cause of the BPPV condition. The Referee also found that the September 1989 incident with Marten independently contributed to a worsening of the condition. However, because the Wisconsin claim against Marten had been denied, the Referee concluded that the employer remains responsible for claimant's condition. The employer requested Board review.

By Order on Review dated June 28, 1991, the Board vacated Referee Johnson's order and remanded the case for further evidence taking regarding the final determination of the Wisconsin claim. Darlene E. Parks, 43 Van Natta 1523 (1991). The Board also denied the employer's request to remand for further evidence taking regarding Marten's status as a subject employer in Oregon, reasoning that such evidence was obtainable with due diligence prior to hearing.

On remand, Referee Johnson issued an order on October 2, 1991, finding that the Wisconsin claim against Marten had been determined not to be compensable and that the decision had not been appealed. Accordingly, the Referee concluded that the employer remains responsible for claimant's condition. (Ex. 40). That decision was not appealed.

Meanwhile, on May 8, 1991, the employer issued a Notice of Intent to Disclaim Responsibility for Compensation which alleged, in relevant part, that "due to an intervening injury on September 29, 1989, [claimant's] Benign Paroxysmal Positional Vertigo condition (BPPV) is presently the responsibility of Marten Transportation, an employer covered under the Oregon workers' compensation law." (Ex. 26). Claimant requested a hearing regarding that notice, which is the subject of the current proceeding.

The doctrine of "preclusion by former adjudication," or res judicata, precludes relitigation of claims and issues previously adjudicated. Drews v. EBI Companies, 310 Or 134, 139-140 (1990). Under the res judicata doctrine of "claim preclusion," litigation of a claim 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). Thus, a plaintiff who has prosecuted an action against a defendant through to a final judgment is barred from prosecuting another action against the same defendant where the second action is based on the same claim that was at issue in the first. Drews v. EBI Companies, supra, 310 Or at 140. Claim preclusion applies equally to a defendant's defense; that is, the defendant cannot avail himself of any defense in the second action which he raised or could have raised in the original action. Id.; see Restatement (Second) of Judgments § 18.

Here, claimant had successfully prosecuted the BPPV claim against the employer in WCB Case No. 89-22855. The employer was determined to be responsible for that condition, and that determination is final. The employer's subsequent disclaimer of responsibility for the same condition, issued on the basis that Marten was a subject employer in Oregon at the time of the intervening injury in September 1989, is an impermissible attempt to raise a defense which could have been raised in the previous action.

When the employer denied the BPPV claim in November 1989, it was aware that the condition was arguably related to claimant's employment with Marten and that Marten was the potentially responsible employer. At that time, the employer was required to engage in "immediate priority investigation to determine responsibility." See former OAR 436-60-180(4), (5) (WCD Admin. Order 4-1987, effective January 1, 1988). Following the investigation, the employer could have joined Marten to the proceeding, see Runft v. SAIF, 303 Or 493, 504 (1987), and asserted its status as an Oregon employer in a responsibility defense. The employer failed to do so and was determined to be responsible. The employer later requested remand to take evidence regarding Marten's status as an Oregon employer, but the motion was denied on the basis that the evidence was obtainable at hearing.

Because the employer failed to join Marten to the prior proceeding and raise the responsibility defense at that time, it is now precluded by res judicata from raising that defense in this proceeding.

The employer argues that equitable or judicial estoppel applies to permit the assertion of its responsibility defense. See Marshall v. Korpa, 118 Or App 144 (1993). The employer notes that, in claimant's respondent's brief to the Board in WCB Case No. 89-22855, claimant contested the employer's motion for remand on the basis that the employer could still request an arbitration on the responsibility issue and present evidence on Marten's status as an Oregon employer. (See Ex. 14-2). Therefore, the employer argues, by asserting that position in the prior proceeding, claimant is now estopped from asserting that the employer is precluded from raising the responsibility defense in this proceeding. We disagree.

There is no indication in the record that the Board denied the employer's motion for remand on the basis asserted by claimant in her brief. Rather, the Board denied the motion on the basis that the evidence sought by the employer was obtainable at the time of hearing. (See Ex. 36A-2). Thus, although claimant's position in this proceeding may be inconsistent with the position she asserted in the prior proceeding, we are not persuaded that the employer was prejudiced in any way by claimant's prior position. Indeed, it appears that claimant merely took a position on a question of law, i.e., that the employer would not be precluded from seeking arbitration on the responsibility issue, which the

Board ultimately did not adopt. Inasmuch as the employer was not prejudiced by claimant's prior position, we find no basis for applying estoppel in these circumstances. See Marshall v. Korpa, supra; see also 28 Am Jur 2d, Estoppel and Waiver § 70. The cases cited by the employer are not sufficiently analogous to the facts of this case to be controlling authority.

Evidence

Claimant argues that the Referee erred in admitting the entire deposition of Dr. Grimm for impeachment purposes (Ex. 28A), without allowing her an opportunity to cross-examine Grimm regarding the deposition. We review the Referee's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). We do not find the Referee abused his discretion.

At hearing, the employer's counsel requested permission to offer into evidence selected pages from the transcript of Grimm's deposition. (Tr. 14). The partial transcript was offered to rebut medical reports authored by Grimm three days before hearing, which were admitted into evidence. (See Exs. 38, 39). The Referee granted counsel's request, but also ruled that claimant would be allowed to cross-examine Grimm regarding the deposition. (Tr. 22-23, 27, 30).

Following the hearing, by cover letter dated October 1, 1991, the employer's counsel submitted to the Referee the partial transcript of Grimm's deposition, noting that it was "offered for impeachment purposes." By letter dated October 11, 1991, claimant's counsel responded, in relevant part:

> "* * * I am in possession of [the employer's counsel's] proposed impeachment exhibit, which is a transcript of the deposition of Robert Grimm, M.D. I understand that [the employer's counsel] is submitting this exhibit for impeachment purposes only and on that basis would request that I not be given the opportunity to cross-examine Dr. Grimm. If indeed [the employer's counsel] is offering it only for impeachment purposes, I would request that, were you to allow the deposition in solely for impeachment purposes, I be allowed to offer the remainder of the deposition to rebut the employer's claim of Dr. Grimm's shifting testimony. I have enclosed a copy of the entire deposition for your convenience."

In his order, the Referee admitted the entire transcript of Grimm's testimony for the "limited purpose of potential impeachment of Dr. Grimm's later stated opinion [in exhibits 38 and 39]." (O&O p. 1). The Referee added that admission of the entire deposition is a more reasonable alternative to the cumbersome procedure of cross-examination of Grimm. (Id.)

After reviewing the record, we are persuaded that claimant withdrew her request to cross-examine Grimm. The right of cross-examination was granted by the Referee as a means by which claimant could respond to the partial transcript of Grimm's deposition, which was first disclosed at hearing. However, when the partial transcript was subsequently submitted to the Referee for admission into evidence, claimant's counsel did not pursue cross-examination, but instead, requested permission to offer the entire deposition into evidence. In so doing, claimant's counsel implicitly waived the right of cross-examination. Accordingly, we do not find that the Referee erred in admitting Grimm's deposition without cross-examination.

Compensability

We adopt the Referee's conclusions and opinion regarding this issue, with the following supplementation.

We agree with the Referee that Dr. Grimm's various opinions regarding the causation of claimant's endolymphatic hydrops (EH) and perilymph fistula (PLF) are inconsistent, (Compare Exs. 28-3, 28A-20, 38 and 39), and that the inconsistencies are not adequately explained. Inasmuch as Grimm provided the only medical opinions which support compensability, claimant has not sustained her burden of proving that the compensable injury in January 1989 was a material contributing cause of the EH and PLF conditions.

Temporary Total Disability

We adopt the Referee's conclusions and opinion regarding this issue, with the following supplementation.

Claimant seeks enforcement of the employer's claim processing obligation pursuant to Referee Johnson's October 18, 1990 order in WCB Case No. 89-22855. (See Ex. 11). Specifically, claimant seeks the payment of temporary total disability benefits for the period from November 6, 1989 through October 18, 1990.

The payment of temporary disability benefits pursuant to Referee Johnson's order was not a matter "in litigation" until claimant filed her hearing request in the present case. Inasmuch as the hearing request was filed after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is subject to the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch 2, § 54; Bird v. Bohemia, Inc., 118 Or App 201 (1993); Raymond J. Seebach, 43 Van Natta 2687 (1991).

In Walden J. Beebe, 43 Van Natta 2430 (1991), we held that the filing of a request for review of a Referee's order by a carrier within 30 days stays the payment of compensation appealed without any limitation or exception as to when, within the 30 day period, the carrier's appeal is filed. ORS 656.313(1)(a)(A). We also acknowledged that former OAR 436-60-150(3)(e) (renumbered OAR 436-60-150(4)(f)) provided that timely payment of temporary disability benefits is made when paid no later than the 14th day after the date of any litigation order which orders temporary disability. However, we concluded that, in the event that there was a conflict between the administrative rule and the statute, as amended, it is the statute rather than the rule which controls.

Accordingly, inasmuch as Referee Johnson's order was timely appealed and ultimately vacated on Board review, the employer was under no obligation to pay the aforementioned temporary total disability benefits pursuant to that order.

Penalties and Attorney Fees

The employer's refusal to pay temporary total disability benefits pursuant to Referee Johnson's order was not unreasonable. Accordingly, penalties and related attorney fees may not be assessed.

Assessed Attorney Fee

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 BPPV issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

In assessing a fee, we are mindful of our prior decisions holding that an assessed attorney fee may not be awarded for services rendered in obtaining a rescission of a disclaimer of responsibility. See Joseph L. Gamble, 44 Van Natta 2131 (1992); David Jones, 44 Van Natta 1752 (1992). Gamble and Jones are distinguishable from this case, however, because the attorney fees in those cases were sought under ORS 656.386(1), which requires that the claimant prevail over a denial of compensation. See Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992). In this case, on the other hand, ORS 656.382(2) authorizes an assessed attorney fee because the request for review was initiated by the employer, and we found that the compensation awarded to claimant should not be disallowed or reduced.

Furthermore, it is not clear from our reading of Gamble and Jones whether the claimants' compensation was at risk in those cases. Here, although the employer merely disclaimed responsibility for the claim, the procedural posture of this case clearly placed claimant's compensation at risk for disallowance. Claimant filed an out-of-state claim against another employer, which she lost on the merits. The out-of-state employer was not a party to this proceeding. Thus, if the present employer had prevailed on Board review, claimant's compensation would have been effectively disallowed. Inasmuch as the employer did not prevail, ORS 656.382(2) authorizes an assessed fee for defending against the employer's appeal.

ORDER

The Referee's order dated January 22, 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
MARIE R. BREWER, Claimant
WCB Case No. 92-03275
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of those portions of Referee Mills' order that: (1) awarded claimant additional temporary total disability benefits (TTD) from September 12, 1991 through February 6, 1992; and (2) found that the Hearings Division had jurisdiction to award penalties and associated attorney fees based on unpaid and untimely paid TTD. On review, the issues are jurisdiction, temporary total disability benefits, and penalties and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

The Referee found that he lacked jurisdiction to consider claimant's substantive entitlement to TTD benefits because the Determination Order had not yet been through the reconsideration process. Finding, however, that the employer improperly terminated claimant's TTD benefits prior to claim closure on February 6, 1992, the Referee concluded that claimant was procedurally entitled to TTD benefits through February 6, 1992.

Subsequent to the Referee's order, we 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. See Mindi M. Miller, 44 Van Natta 2144 (1992). We found that because the claimant had filed her request for hearing after the issuance of the Determination Order, we had jurisdiction to enforce the award of temporary disability despite the absence of reconsideration of the Determination Order by the Department. We found, however, if a 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.

Here, as in Miller, claimant filed her request for hearing after the issuance of the Determination Order. At hearing, claimant raised three issues: substantive entitlement to the time loss payments ordered by the Determination Order; entitlement to procedural TTD benefits through the date of claim closure; and penalties and related attorney fees for the employer's allegedly unreasonable resistance to and untimely payment of TTD. (Tr. 6). To the extent that claimant is not seeking to modify the Determination Order's award of TTD, but rather is objecting to the termination of such benefits while the claim was in open status, the Referee had jurisdiction to enforce the award of TTD benefits as authorized by that order.

On review, the employer challenges the Referee's order concerning TTD benefits insofar as it awarded claimant procedural TTD benefits past the date authorized by the Determination Order. Citing the recent Court of Appeals decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the employer argues that the Referee did not have authority to order an additional procedural temporary total disability award which creates an overpayment of benefits. Claimant concedes that under Seiber, the Board should not order procedural time loss if it creates an overpayment.

We note that this case is distinguishable from Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992), wherein we declined to apply Seiber. In Yoakum, the claimant filed his request for hearing before the issuance of the Determination Order, challenging the insurer's unilateral

termination of TTD which occurred before the Determination Order issued. Finding that none of the statutory conditions occurred that would permit an insurer to terminate TTD prior to the claimant becoming medically stationary, we concluded that the insurer lacked authority to terminate claimant's procedural entitlement to temporary disability. On reconsideration, we explained that because the order did not impose a requirement on the insurer to pay a greater amount of procedural temporary disability than claimant's substantive entitlement, Seiber was inapplicable.

The instant claim has been closed by Determination Order, finding claimant medically stationary on September 11, 1991. Pursuant to Seiber, supra, claimant is not entitled to the payment of benefits past the medically stationary date. Because the Referee had no authority to impose payment of time loss benefits past the date authorized by the Determination Order, we modify the Referee's order to award claimant time loss benefits from December 12, 1989 through September 11, 1991.

Penalties and Attorney Fees

On review, the employer argues that the Referee lacked jurisdiction to enforce procedural entitlement to time loss benefits. Thus, it contends, the sole issue before the Referee was the assessment of penalties and attorney fees pursuant to ORS 656.262(10), a matter which is within the exclusive jurisdiction of the Director. See Ronald A. Stock, 43 Van Natta 1889 (1991). We disagree.

Here, claimant also sought enforcement of a Determination Order's award of TTD benefits. Because the Referee had jurisdiction to enforce the Determination Order, he also had jurisdiction to award penalties and attorney fees related to unpaid and untimely paid TTD benefits. We adopt the Referee's reasoning and conclusion that the employer improperly terminated claimant's temporary disability benefits prior to claim closure, and affirm his assessment of a penalty. However, we modify the Referee's order to award claimant a penalty equal to 25 percent of the unpaid and untimely paid temporary disability benefits accruing from December 12, 1989 through September 11, 1991. Claimant's attorney is awarded one-half of the penalty assessed by this order, in lieu of an attorney fee. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Claimant's attorney is not entitled to a fee for his services on review because the compensation awarded at hearing has been reduced and he did not successfully defend against the employer's appeal. See ORS 656.382(2). Moreover, inasmuch as penalties are not considered compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for services on review concerning the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated June 24, 1992 is affirmed in part, modified in part, and reversed in part. That portion of the Referee's order that awarded claimant temporary disability benefits in addition to those authorized by the Determination Order is reversed. The self-insured employer is directed to pay time loss benefits from December 12, 1989 through September 11, 1991, less amounts already paid. That portion of the Referee's order that awarded an out-of-compensation attorney fee is modified consistent with this order. That portion of the Referee's order that awarded a penalty is modified to assess a penalty equal to 25 percent of the unpaid and untimely paid temporary disability benefits accruing from December 12, 1989 through September 11, 1991, less amounts already paid, to be equally divided between claimant and her attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
FRED W. DASEN, Claimant
WCB Case No. 91-14446
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a left index trigger finger. On review, the issue is compensability.

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

On review, claimant contends that this case is analogous to Rodney T. Buckallew, 44 Van Natta 358 (1992), where we held that, for purposes of determining whether a claimant has met the major contributing cause standard for establishing an occupational disease, we do not consider the claimant's susceptibility or predisposition to the disease. See Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991). In Buckallew, we relied on medical evidence to find that the claimant's preexisting diabetic condition predisposed him to development of a joint disease in the foot secondary to mechanical trauma.

In this case, however, there is insufficient medical evidence to support a finding that claimant's diabetes condition predisposed him to development of the trigger finger condition. The persuasive weight of the medical evidence shows, instead, that claimant's diabetes was the major cause of the finger condition. Contrary to claimant's contention, the fact that there is an increased incidence of trigger finger conditions in diabetic patients does not, in and of itself, establish a predisposition, as opposed to a causal relationship. Therefore, given the medical record in this case, Buckallew is distinguishable.

ORDER

The Referee's order dated January 23, 1992 is affirmed.

In the Matter of the Compensation of
ERNEST W. GAYMAN, Claimant
WCB Case No. 92-02582
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Menashe's order which upheld the insurer's denial of his current low back condition. On review, the issue is compensability.

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

In upholding the insurer's denial, the Referee reasoned that claimant had failed to prove his December 11, 1989 injury was a material contributing cause of his current disability or need for treatment. We agree that claimant's current condition is not compensable. However, because claimant's compensable injury has combined with his preexisting condition, we conclude that the requisite standard of proof for compensability of the resultant condition is "major contributing cause."

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); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

There is no dispute that claimant suffers from preexisting degenerative disease of the low back. (Ex. 4; App. Br. 2). Claimant argues that we should rely on Dr. Vu's opinion that his "current needs for treatment of his lower back problem are mostly related to his 1989 injury." (Ex. 44). Dr. Vu, claimant's family practice physician, recently treated claimant for hernia and diabetic conditions. However, Dr. Vu acknowledged that Dr. Rosenbaum was claimant's treating physician for his back condition. (Ex. 44).

We share the Referee's reliance on the opinion offered by Dr. Rosenbaum. From the outset, Dr. Rosenbaum noted that claimant has had "periodic lumbar symptoms through the years with chronic pain in the low back as well as left lower extremity pain." (Ex. 6). After reviewing the results of a lumbar MRI and myelogram, Dr. Rosenbaum concluded that claimant would not be benefitted by surgery. (Ex. 31). He diagnosed a lumbar strain and stated that claimant's symptoms appeared to be musculoskeletal in nature, superimposed upon degenerative disc disease. (Ex. 33). From Rosenbaum's reports, we conclude that claimant's degenerative condition "combined" with his strain to cause additional disability and need for treatment.

Furthermore, considering claimant's degenerative disease, the Orthopaedic Consultants expected the development of both back and leg symptomatology, even in the absence of a work-related exposure. (Ex. 40-6). They concluded that claimant's employment was not the major contributing cause of claimant's condition. (Ex. 40-7). Dr. Rosenbaum "basically concur[red]" with the Consultants' report. (Ex. 42).

In light of such circumstances, we are not persuaded that claimant's December 1989 compensable injury is the major contributing cause of his current disability and need for treatment. Consequently, we agree with the Referee that the insurer's denial must be upheld.

ORDER

The Referee's order dated July 24, 1992 is affirmed.

April 23, 1993 Cite as 45 Van Natta 818 (1993)

In the Matter of the Compensation of
SUSAN L. HALL, Claimant
WCB Case No. 91-15241
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

The self-insured employer requests review of Referee Howell's order that set aside its denial of claimant's spinal stenosis and/or degenerative spinal condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee limited his analysis of compensability to the issue of whether or not claimant had proved that her compensable injury was a material contributing cause of the production of symptoms of L5-S1 degenerative disk disease and spinal stenosis. See ORS 656.005(7)(a). Finding that claimant had satisfied this burden, the Referee concluded that the claim was compensable. The Referee's analysis was consistent with the Board's order in Bahman M. Nazari, 43 Van Natta 2368 (1991), which required a two-step determination under ORS 656.005(7)(a)(B) in which the claimant first had to show that the industrial accident was a material contributing cause of disability or need for treatment. Because that reasoning was overturned by the Court of Appeals, we now analyze compensability as set out by the court in Tektronix, Inc. v. Nazari, 117 Or App 409, 412-13 (1992).

The employer asserts that this claim should be analyzed under ORS 656.005(7)(a)(A) or 656.005(7)(a)(B) while claimant contends that ORS 656.005(7)(a) is the applicable statute for determining compensability. Based on the following medical evidence, we find that ORS 656.005(7)(a)(B) is the proper statute to determine this issue.

The record contains two opinions regarding causation. Dr. Thompson, orthopedic surgeon and claimant's treating physician, stated that claimant's symptoms were caused by the compensable lumbar strain that was superimposed on a preexisting degenerative disc and that claimant also had demonstrated severe functional interference. (Ex. 34-8, 34-9). In specifically discussing the degenerative condition, Dr. Thompson reported that claimant's industrial accident "aggravated" the condition, causing it to become symptomatic. (Id. at 11). Furthermore, he reported that "the most significant component" with regard to claimant's symptoms was functional overlay. (Id).

Dr. Struckman, orthopedist, conducted an independent medical examination. He reported that claimant had sustained a "low back strain" but that the "degenerative change could well be the cause for most of [claimant's] persistent symptoms" since the strain would have resolved by the time of the examination. (Ex. 24-3). Although Dr. Struckman indicated that the degenerative change was not work-related, he did not explain why the preexisting condition was symptomatic. (Id. at 4).

When a compensable injury combines with a preexisting disease or condition, the resultant condition is compensable only if the work-related injury is the major contributing cause of claimant's disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra. Relying on the opinion of Dr. Thompson as the treating physician, see Weiland v. SAIF, 64 Or App 810 (1983), we conclude that claimant's compensable back strain combined with her preexisting degenerative condition. Therefore, we conclude that the claim properly is analyzed under ORS 656.005(7)(a)(B). Furthermore, we find that this resultant condition, along with functional overlay, caused a need for treatment. However, because Dr. Thompson also reported that functional overlay, and not the compensable injury, was the major contributing cause of claimant's symptoms, we conclude that she failed to carry her burden of proof. Accordingly, she did not prove compensability.

ORDER

The Referee's order dated August 6, 1992 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

April 23, 1993 Cite as 45 Van Natta 819 (1993)

In the Matter of the Compensation of
JAN L. JACKMAN, Claimant
WCB Case No. 91-14654
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 30, 1993 Order on Review that affirmed Referee Holtan's order which, in part, directed that the scheduled permanent disability awards be paid at the rate of $145 per degree. Specifically, SAIF contends that, because the date of injury in this case is March 13, 1986, the scheduled permanent disability award should be paid at $125 per degree. We agree that the scheduled permanent disability award should be paid at the rate in effect at the time of the compensable injury.

We note that, although both parties requested review of Referee Holtan's order, neither party submitted briefs to explain their respective positions on review. After "de novo" review, we affirmed Referee Holtan's order which relied on SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992), in determining that the proper rate of scheduled permanent disability was $145.

In SAIF v. Herron, supra, the court determined that the increased rate of compensation for scheduled disabilities of $305, as provided in amended ORS 656.214(2), applies only 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). Here, that rate is $125 per degree.

Accordingly, our March 30, 1993 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our March 30, 1993 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSALYN A. MASSEY, Claimant
WCB Case No. 92-06370
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of Referee Mills' order that set aside its denial of claimant's occupational disease claim for her bilateral carpal tunnel syndrome condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the opinion of Dr. Layman, claimant's attending physician, was more persuasive than that of Dr. Nathan. Accordingly, he found that claimant had established compensability of her bilateral carpal tunnel syndrome. We adopt the Referee's Conclusions of Law and Opinion, with the following supplementation.

On review, the insurer argues that in discounting Dr. Nathan's opinion, the Referee should not have relied upon prior Board or court cases that also found Dr. Nathan nonpersuasive. The insurer contends that each case and the accompanying medical opinions should be reviewed on its own merits. See, e.g., SAIF v. Carter, 73 Or App 416 (1985).

We agree with the insurer that it is not relevant that the doctor found to be not persuasive in the prior Board and court cases was Dr. Nathan. However, the Referee also cited the cases for the legal proposition that, in certain circumstances, the medical evidence can support a conclusion that the symptoms for which compensation is sought are the disease. See Georgia-Pacific Corp. v. Warren, 103 Or App 275 (1990).

We agree with the Referee's conclusion that this case is similar to Georgia-Pacific Corp. v. Warren, supra. Dr. Nathan reported that claimant has an underlying median neuropathy condition, which is idiopathic. However, Dr. Nathan also opined that claimant's work activities contributed to the onset of her carpal tunnel symptoms. Moreover, Dr. Layman also believed that claimant's symptoms were caused by her work activity, and he made no distinction between her carpal tunnel syndrome and an underlying carpal tunnel disease. Furthermore, he attributed no part of her syndrome to a preexisting condition. Accordingly, we conclude that the syndrome is the compensable disease, and we agree with the Referee's conclusion that Dr. Nathan's opinion is consistent with a theory of compensability.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of compensability, to be paid by the insurer. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,200 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 and statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated August 31, 1992 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

April 23, 1993 Cite as 45 Van Natta 821 (1993)

In the Matter of the Compensation of
WILLIE G. MOSS, Claimant
WCB Case No. 91-08585
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) dismissed its cross-request for hearing for failure to request reconsideration of a Determination Order that reclassified claimant's tinnitus condition as disabling; and (2) affirmed an Order on Reconsideration that found that claimant's condition should remain classified as disabling. On review, the issues are the propriety of the Referee's dismissal and classification. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following exception. We do not adopt the Referee's first "Finding of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The employer did not seek reconsideration of the Determination Order reclassifying claimant's tinnitus condition as disabling. When an Order on Reconsideration affirmed the Determination Order, the employer requested a hearing. In reliance upon ORS 656.268(5) and OAR 436-30-045(7) (WCD Admin. Order 5-1992), the Referee concluded that the employer was precluded from challenging the disabling status of claimant's condition at hearing because it had not sought reconsideration of the Determination Order. Thus, the Referee dismissed the employer's cross-request as untimely. We agree with the Referee's ultimate conclusion, but base our decision on the following reasoning.

On review, the employer contends that the cited rule impermissibly exceeds ORS 656.268. The Determination Order in this case issued on August 9, 1991 and the Order on Reconsideration on February 12, 1992. However, WCD Admin. Order 5-1992, which added subsection (7) to OAR 436-30-045, did not become effective until February 26, 1992. Therefore, OAR 436-30-045(7) is inapplicable to this claim. Consequently, although the rule does not provide an independent basis for the Referee's finding that the employer "has no standing to challenge" the Order on Reconsideration, we need not address the employer's argument that the rule conflicts with the statute.

Subsequent to the Referee's order, we held that where an employer neglected to first seek reconsideration of a Determination Order, it was precluded from later requesting a hearing on a Reconsideration Order affirming that order. See Todd M. Brodigan, 45 Van Natta 438 (1993). In that case, an employer did not seek reconsideration of an unscheduled permanent disability award granted by a Determination Order. When an Order on Reconsideration affirmed that award, the employer

requested a hearing. A referee concluded that the employer was precluded from seeking elimination or reduction of the award because it had not sought reconsideration of the Determination Order and, thus, dismissed the employer's cross-request as untimely. On review, we agreed, and found that although the employer had requested a hearing within the requisite 180-day period from the Determination Order, because it had neglected to first seek reconsideration of that order as mandated by ORS 656.268(5), the employer was prohibited from contesting that portion of the Order on Reconsideration permanent disability award which adhered to the Determination Order award. Id. at 439.

We find that the same reasoning applies here. ORS 656.268(5) provides in relevant part that "[if] the worker . . . or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." (Emphasis supplied). Here, the Determination Order reclassifying claimant's tinnitus condition as disabling issued on August 9, 1991. Claimant requested reconsideration of the order pursuant to ORS 656.268(5). The Department received claimant's request for reconsideration on February 3, 1992. The employer did not request reconsideration of the order. The Order on Reconsideration issued on February 12, 1992, affirming the Determination Order. Claimant requested a hearing objecting to the Order on Reconsideration, insofar as it failed to rate extent of permanent disability. The employer filed a cross-request for hearing, objecting to the reclassification of claimant's condition as disabling. Both hearing requests were filed within 180 days after the Determination Order was mailed.

We find that claimant was the only party who sought reconsideration of the Determination Order. Although the employer requested a hearing within the requisite 180-day period from the Determination Order, it neglected to first seek reconsideration of that order as mandated by ORS 656.268(5). Consequently, the employer is prohibited from contesting the disabling status of claimant's tinnitus condition. Brodigan, supra.

Finally, we note that our discussion in Brodigan answers the employer's concerns that a party who does not seek reconsideration of a Determination Order that is later changed in a manner consistent with the objecting party's request would be forestalled from requesting a hearing on the Reconsideration Order. We explained that under such circumstances, the party who did not request reconsideration could request a hearing to contest that portion of the award altered by the Order on Reconsideration. However, that party could not seek a modification beyond that granted by the Determination Order, which that party had previously chosen not to dispute.

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 counsel's services on review is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest to claimant.

ORDER

The Referee's order dated July 27, 1992 is affirmed. For services on review, claimant is awarded a reasonable attorney fee of $800, payable by the self-insured employer.

In the Matter of the Compensation of
ARLISS J. KING, Claimant
WCB Case No. 92-02542
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Paul Roess, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of Referee Brown's order that awarded claimant 38 percent (121.6 degrees) unscheduled permanent disability (PPD) for a right neck/shoulder/upper back condition, whereas an Order on Reconsideration awarded 13 percent (41.6 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings," as clarified. We do not adopt his "Ultimate Findings of Fact."

Finding (2) - Claimant became medically stationary and was released for light work with no overhead use of her arms on July 16, 1991, rather than July 16, 1992.

Finding (3) - Claimant's at-injury job was as a Forestry Seedling Puller (DOT 451.687-018), which has a strength category of medium. As of the date of the Notice of Closure, claimant had returned to modified work for the employer.

CONCLUSIONS OF LAW AND OPINION

As did the Referee, we rate claimant's unscheduled PPD under the standards set out in WCD Administrative Order 2-1991.

We adopt the values and reasoning related to those values assigned by the Referee to impairment (13 percent), age (0), and education (5), and discuss only the adaptability value.

Finding that claimant's at-injury job was that of Nursery Laborer (DOT 405.687-014) (a job requiring heavy physical exertion) and that claimant was released to perform light duty work, the Referee assigned an adaptability value of +5. Therefore, whereas an Order on Reconsideration awarded PPD based on impairment alone, the Referee awarded an additional 25 percent (5 x 5).

On review, the employer contends that claimant returned to her "regular work," and that the PPD award should, therefore, be based on impairment alone. We agree with the Referee that claimant was released to and returned to modified work. Therefore, we find that claimant's age, education, and adaptability factors should be considered. We do not, however, agree with the adaptability value used by the Referee.

We acknowledge that the Dictionary of Occupational Titles (DOT) contains several job titles that arguably could be used to describe claimant's job at injury. However, because claimant works in a forestry occupation (which includes jobs concerned with developing, cultivating, maintaining and harvesting forests and their products), rather than a horticultural occupation (which includes jobs cultivating ornamental trees, shrubs and flowers), we conclude that the DOT's in Division 45 more accurately describe her work. See Ex. 1.

Accordingly, after reviewing the record and claimant's testimony regarding her job duties, we conclude that the DOT that most closely describes her prior work (which includes root pruning, transplanting, weeding, packing and grading) is Forestry Seedling Puller (DOT 451.687-018). That job requires the physical capacity to perform medium work.

Here, following her injury, claimant was released and returned to modified work consistent with her light duty restrictions. (Ex. 5A, 7A). We find, therefore, that the appropriate adaptability value is +3. OAR 436-35-310(3).

Multiplying the adaptability factor (3) times the sum of the age and education factors (5), the product is 15. When this is added to claimant's impairment value of 13 percent, claimant's unscheduled permanent disability under the "standards" is 28 percent.

ORDER

The Referee's order dated July 22, 1992 is modified. In lieu of the Referee's award and in addition to the Order on Reconsideration award of 13 percent (41.6 degrees), claimant is awarded an additional 15 percent (48 degrees) unscheduled permanent disability, for a total award to date of 28 percent (89.6 degrees) unscheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee award shall be adjusted accordingly.

In the Matter of the Compensation of
JULIETTE A. BOCK, Claimant
WCB Case No. 91-11059
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Nichols' order that: (1) upheld the self-insured employer's denial of her claim for a bilateral wrist condition; and (2) upheld the employer's denial of her claim for a psychological condition. Claimant also contends that the Referee erred in admitting Exhibits 24A and 24B into evidence. On review, the issues are evidence and compensability.

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

Exhibits 24A and 24B are chart notes by Dr. Fried, claimant's treating psychiatrist. Claimant argues that those exhibits were improperly admitted and considered by the Referee. We disagree.

OAR 438-07-015 sets forth the general rule for full disclosure of claims information. Section (4) of that rule requires that documents acquired after the initial exchanges must be provided to the other parties within seven days after the disclosing party's receipt of the documents. In addition, OAR 438-07-018(4) grants the referee discretion to allow admission of additional medical reports not disclosed in accordance with OAR 438-07-015. In exercising this discretion, the referee must determine whether material prejudice has resulted from the timing of the disclosure.

Here, Exhibits 24A and 24B are date stamped to indicate that the employer's counsel first received them on December 2, 1991. The employer's counsel represented to the Referee by letter dated March 3, 1992, that he had offered the documents into evidence on December 6, 1991, and mailed copies to claimant's counsel by certified mail. Claimant does not deny those representations. Accordingly, we find that the employer provided the chart notes to claimant within seven days after receiving them, in compliance with OAR 438-07-015(4).

Furthermore, we find that, in admitting the chart notes, the Referee properly exercised her discretion under OAR 438-07-018(4). Claimant, objected to the admission of the chart notes, but did not allege any basis for a finding that material prejudice had resulted from the timing of the disclosure. Neither did claimant request continuance of the hearing to gather further evidence in response to the chart notes, nor has claimant requested remand to accomplish that same purpose. Consequently, the Referee properly admitted the chart notes prior to closing the record on March 4, 1992.

ORDER

The Referee's order dated April 2, 1992 is affirmed.

In the Matter of the Compensation of
BILLY D. DAVIDSON, Claimant
WCB Case Nos. 92-00688, 92-03838 & 92-00179
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Mongrain's order which declined to award claimant a carrier-paid attorney fee for prevailing against Liberty Northwest Insurance Corporation's (Liberty) responsibility denial of claimant's occupational disease claim for hearing loss. Liberty cross-requests review of those portions of the Referee's order which: (1) set aside its denial of claimant's hearing loss claim; and (2) upheld the SAIF Corporation's denial of claimant's hearing loss claim. In its brief, SAIF contests the Referee's attorney fee award, payable by SAIF, based on the rescission of SAIF's compensability denial prior to the hearing. On review, the issues are responsibility 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

Responsibility

Applying the last injurious exposure rule, the Referee assigned responsibility to Liberty as the last potentially responsible insurer. Because claimant missed no time from work, the Referee found that the "onset of disability" was the date claimant first sought medical treatment in October 1991, when Liberty was on the risk. The Referee further found that Liberty failed to shift responsibility to the earlier employer, SAIF's insured. We agree.

The parties do not dispute that the last injurious exposure rule applies. We agree that the rule is applicable. See Fred A. Nutter, 44 Van Natta 854 (1992). Under the rule, responsibility is assigned to the last potentially liable employer whose work could have contributed to claimant's disability. Boise Cascade Corp. v. Starbuck, 296 Or 283 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 238, 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 Ap 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990).

Liberty contends that to shift responsibility to SAIF, it must show that claimant's employment during its coverage did not contribute to the cause of, aggravate, or exacerbate the underlying disease. Liberty relies on Starbuck, supra, where the Supreme Court stated:

> "(2) In an occupational disease context, if a disease is contracted and disability occurs during one employment as a result of conditions of that employment, even though work conditions of a later employment could have caused that disease, the earlier employer is liable if the later employment 'did not contribute to the cause of, aggravate, or exacerbate the underlying disease.'" Starbuck, 296 Or at 243.

The Court in Starbuck used Bracke, supra, as an example of that situation. In situation (2) quoted above, as in Bracke, initial responsibility was placed on the earlier employment because the "onset of disability" occurred while the earlier employer was on the risk. In this case, initial responsibility was assigned to Liberty, the later employment. Thus, this case is similar to situation (1) in Starbuck, in which the Court explained:

> "[I]f a worker's disability results from exposure to potentially causal conditions in multiple employment and the onset of the disability is during a later employment or thereafter, the last employment providing such conditions is deemed proved to have

caused the disease even though the claimant has not proved that the conditions of the last employment were the actual cause of the disease and even though a previous employment also possibly caused the disease." Starbuck, 296 Or at 243.

Claimant missed no time from work and first sought medical treatment in October 1991. Thus, the onset of disability occurred when Liberty was on the risk. See Gregory A. Wilson, 45 Van Natta 235 (1993). Therefore, in order to shift responsibility to an earlier employment, Liberty must establish that the work conditions while SAIF was on the risk were the sole cause or that it was impossible for claimant's exposure during Liberty's coverage to have caused claimant's hearing loss. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984). For the reasons expressed by the Referee, we are not persuaded that Liberty has met either standard necessary to shift responsibility to SAIF. Consequently, Liberty remains responsible for claimant's hearing loss claim.

In the alternative, Liberty argues that responsibility for claimant's hearing loss should be apportioned according to the amount of permanent hearing loss which occurred during the different periods of coverage. We disagree.

Liberty relies on Robert A. Lusk, 42 Van Natta 1584 (1990), in which we found that application of the last injurious exposure rule was unnecessary because claimant established the degree to which the two potentially liable insurers were responsible for causing his hearing loss. In Lusk, we held each insurer responsible for its period of exposure. The court reversed on the ground that the claimant had never become an employee of the first employer because he had failed a pre-employment test. BBC Brown Boveri v. Lusk, 108 Or App 623 (1991).

Thus, our holding in Lusk is of no precedential value. Moreover, the Lusk reasoning is inconsistent with the court's subsequent holding in UAC/KPTV Oregon TV, Inc. v. Hacke, 101 Or App 598, 604 (1990) (Oregon law does not provide for apportionment of responsibility according to causation). Finally, this disapproval of apportionment in favor of the last injurious exposure rule is a longstanding policy. See Bracke, 293 Or at 245; Jack Spinks, 43 Van Natta 1350 (1991).

Responsibility (rather than compensability) was at issue at hearing and on review. Furthermore, the record does not establish that the rate of claimant's temporary total disability would be reduced if SAIF, rather than Liberty, was found responsible for the claim. Under such circumstances, we are unable to find that claimant's compensation was at risk of disallowance or reduction. Thus, his counsel would not be entitled to an attorney fee for services on review. See International Paper Company v. Riggs, 114 Or App 197 (1992); David D. Shamberger, 45 Van Natta 295 (1993). In any event, since claimant's attorney did not file a brief on Board review regarding the responsibility issue, no attorney fee is awardable. See Shirley M. Brown, 40 Van Natta 879 (1988).

Attorney Fees

The Referee concluded that claimant's attorney was entitled to an assessed fee under ORS 656.386(1) for "obtaining compensation" based on SAIF's rescission of its denial of compensability prior to hearing. He therefore assessed a $1,200 fee, payable by SAIF.

In John L. Law, 44 Van Natta 1091 (1992), we held that, under amended ORS 656.386(1), claimant's counsel was entitled to an assessed fee for his prehearing services in obtaining compensation for claimant through rescission of SAIF's denial of compensability. There, although CIGNA was responsible for the claim, we ordered SAIF to pay the assessed attorney fee because its denial of compensability put claimant's entitlement to compensation at risk. Id. at 1095.

Subsequent to the Referee's order, we reversed our prior decision in Law and on reconsideration held that, pursuant to the court's holding in Multnomah County School District v. Tigner, 113 Or App 405 (1992), the claimant's counsel was not entitled to an attorney fee under amended ORS 656.386(1) for services rendered in obtaining rescission of SAIF's denial of compensability. John L. Law, 44 Van Natta 1618 (1992).[1] We reasoned that, as in Tigner, since a hearing had been held and compensability was not

[1] Although a signatory to this order, Member Gunn would direct the parties to his dissent in Law, supra.

at issue at the hearing, ORS 656.386(1) was not applicable. Here, as in Law, SAIF rescinded its compensability denial prior to hearing and a hearing has been held.

Therefore, in accordance with Tigner and Law, we reverse the Referee's award of a $1,200 assessed attorney fee, payable by SAIF, for obtaining the pre-hearing rescission of the compensability portion of its denial.

Finally, claimant contends that he is entitled to an assessed fee, under either ORS 656.386(1) or 656.307(5), payable by Liberty, for prevailing on Liberty's denial of responsibility. We disagree.

Attorney fees may be awarded only as authorized by statute. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.386(1) authorizes a fee only if an insurer denies the claim for compensation. Because Liberty denied responsibility only, it did not deny a claim for compensation. Claimant is therefore not entitled to an assessed fee, payable by Liberty, for the responsibility hearing. Tigner, 113 Or App at 408-409; John L. Law, 44 Van Natta at 1619; see Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985) rev den 300 Or 722 (1986).

ORDER

The Referee's order dated July 13, 1992, as amended on July 28, 1992, is reversed in part and affirmed in part. The Referee's award of an assessed attorney fee, payable by SAIF, is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
LINDA J. HUGHES-SMITH, Claimant
WCB Case No. 91-04981
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Michael V. Johnson's order that upheld the SAIF Corporation's denial of her aggravation claim for a fibrositis 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

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 low back 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).

The Referee concluded that claimant had established a symptomatic worsening of her condition, but had failed to establish that the worsening was more than a waxing and waning of symptoms contemplated by the last award of compensation. ORS 656.273(8). The last award of compensation was the June 1990 hearing before Referee Baker.

Although there was no medical evidence in existence at the time of the last award of compensation that predicted future waxing and waning of the fibrositis condition, the Referee "related back" a November 1991 statement from Dr. May, the attending physician, that fibrositis can wax and wane of its own accord. In reaching his decision, the Referee reasoned that the fibrositis condition had not changed much in the past several years. On this basis, the Referee concluded that it was appropriate to relate the attending physician's November 1991 statement concerning the potential for future waxing and waning of the fibrositis symptoms back to the time of the last award of compensation.

On review, claimant argues that no evidence in existence at the last arrangement of compensation predicted future waxing and waning of her condition. Therefore, claimant contends, the Referee incorrectly concluded that the last award of compensation contemplated such periods of waxing and waning. We agree.

A history of past flare-ups alone is insufficient evidence on which to base a finding that waxing and waning of symptoms was contemplated by the previous award of permanent disability. Lucas v. Clark, supra; Gary D. Gunter, Jr., 44 Van Natta 2198 (1992). There must also be medical evidence predicting such flare ups. Id.

Here, the attending physician's statement could not have been contemplated by Referee Baker when he awarded claimant 60 percent unscheduled permanent partial disability, because the statement was not in existence at the time of the June 28, 1990 hearing. Even assuming that the fibrositis condition has not changed appreciably in the past several years, the medical evidence in existence at the last arrangement of compensation does not support a finding that the parties and the Referee "contemplated" future waxing and waning of the fibrositis at that time. See John L. Will, 44 Van Natta 1209, 1210 (1992). Accordingly, because we conclude that the last arrangement of compensation did not contemplate future waxing and waning of the compensable condition, we address the other elements necessary to establish an aggravation.

We agree with the Referee that claimant has established a symptomatic worsening of her condition based on Dr. May's November 7, 1990 chart note. Dr. May notes objective findings which include increased muscle tone and active trigger points. Finally, we conclude that claimant has established that her worsened condition resulted in diminished earning capacity as compared to the date of the last arrangement of compensation. In this regard, Dr. May opined that the increased fibrositis symptoms have reduced her lifting capacity and her ability to engage in repetitive activities at least temporarily below what it had been at the time of the last arrangement of compensation in June 1990. Based on Dr. May's opinion, which is uncontroverted, we conclude that claimant has established that she is less able to work due to her worsened condition.

SAIF argues that based on a comparison of her testimony at hearing here and at the June 1990 hearing, claimant experiences the same level of disability currently as she did at the time of the last arrangement of compensation. However, there is no medical evidence in the record which challenges Dr. May's conclusions that claimant is more disabled now as a result of her worsening than she was at the last arrangement of compensation in June 1990. In the absence of any contrary evidence, we conclude that claimant has established that her worsened condition has rendered her less able to work and has resulted in diminished earning capacity below the level fixed at the last arrangement of compensation. Accordingly, based on this record, we conclude that claimant has established a compensable aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $4,174, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 11, 1992 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,174, payable by SAIF.

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case No. 91-18171
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 29, 1993 Order on Review. In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn.

Claimant is allowed 14 days from the date of this order in which to respond to the motion. Thereafter, the Board shall proceed with its review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURIE A. BENNION, Claimant
WCB Case No. 91-18461
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) assessed a penalty for its allegedly unreasonable denial of claimant's neck and left arm condition; (2) assessed an attorney fee for its allegedly unreasonable failure to pay medical bills and time loss compensation; and (3) awarded a $5,000 attorney fee for prevailing on the compensability issue. On review, the issues are penalties and attorney fees.

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

The Referee assessed a penalty based on SAIF's unreasonable "back-up" denial of claimant's neck and left arm condition. In reaching this result, the Referee reasoned that the only evidence arguably supporting the denial was equivocal and, consequently, SAIF did not have legitimate doubt concerning its liability for the claim. We reach the same result, based on the following reasoning.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc., v. Porras, 103 Or App (1990)).

Here, SAIF initially accepted claimant's claim at an August 1991 hearing. Subsequently, in December 1991, SAIF denied the claim. To prevail on the merits of its "back-up" denial, SAIF must prove by "clear and convincing evidence" that the claim is not compensable. ORS 656.262(6). Comparing that standard of proof to the "preponderance" standard required of a claimant to prove the compensability of an unaccepted claim, we conclude that the evidence necessary to establish legitimate doubt supporting a reasonable "back-up" denial is more demanding than that required to support the reasonableness of a denial of an unaccepted claim.

In this case, SAIF issued a "back-up" denial (Ex. 12) on December 17, 1991, apparently based on the opinion of Drs. Peterson and Fuller, independent examiners. (See Ex. 9). Peterson and Fuller reviewed claimant's history and examined her on September 18, 1991. They opined that claimant was

not medically stationary, but they "could see no reason why a healthy 26 year old should not be returned to a functional level of activity." (Ex. 9-4-5). In addition, they explained:

> "[N]either [claimant's work activity nor hitting her head on the roof of a car] seems to constitute a sufficient mechanism of injury for the current symptomatic state. It is unlikely that bumping one's head on the roof of a car would result in such widespread symptoms that one were [sic] unable to work for six months. It is similarly unlikely that typing at a computer terminal would render such symptoms. Therefore, we wonder whether there might not be some other underlying problem.
>
> "In the opinion of this panel [claimant's] sleep disorder is of paramount importance in the generation and maintenance of [claimant's] pain complaints. As in many other cases of myofascial pain disorders, we suspect there may be psychosocial factors at play that affect both her ability to sleep and her pain level.
>
> "There are minor inconsistencies on this examination, as well as tendency toward symptom magnification. The objective findings are minimal and do not support the degree of subjective complaints present.
>
> In addition to the neck and shoulder symptoms, a prominent complaint is that of headache. [Claimant] has previously been treated for TMJ syndrome. We feel it is possible that her TMJ syndrome has again become symptomatic and may very well be the cause of her ongoing headaches. * * * Therefore, we cannot attribute the remaining symptoms to her work activities." (Ex. 9-5-6).

In our view, Peterson's and Fuller's opinion that claimant's current widespread symptoms are an "unlikely" result of her work activity and their mere suspicion that psychosocial factors were contributors, as well as the doctors' unsubstantiated suspicion regarding claimant's prior TMJ condition and their reference to other myofascial disorders do not persuade us that SAIF had legitimate doubt regarding its liability for the claim. In summary, considering SAIF's ultimate burden on the merits to prove noncompensability by clear and convincing evidence and our finding that SAIF's evidence does not reasonably approach this standard, we further conclude that SAIF did not have a legitimate doubt about its liability for claimant's injury claim. Consequently, we agree with the Referee's conclusion that SAIF's "back-up" denial was not reasonable.

In addition, we agree with the Referee's assessment of an attorney fee under ORS 656.382, based on SAIF's unreasonable failure to pay medical bills and time loss compensation following acceptance of the claim in August 1991 and prior to its "back up" denial. In reaching this conclusion, we note that only one 25 percent penalty may be assessed against claimant's unpaid compensation, which includes unpaid time loss and medical bills. See Conagra, Inc., v. Jeffries, 118 Or App 373, 376 (March 3, 1993); see also Kim L. Haragan, 42 Van Natta 311, 313 (1990). However, SAIF's unreasonable failure to pay time loss and medical bills while the claim was in an accepted status are instances of unreasonable conduct separate and distinct from its subsequent unreasonable denial. See Ernest J. Meyers, 44 Van Natta 1054 (1992). Under these circumstances, claimant is entitled to an attorney fee for SAIF's unreasonable failure to pay this compensation, as well as a penalty for its unreasonable denial. See Oliver v. Norstar, Inc., 116 Or App 333 (1992); see also Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Finally, 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 July 9, 1992 is affirmed.

In the Matter of the Compensation of
FRANCISCO D. IBARRA, Claimant
WCB Case No. 91-08811
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Davis' order that dismissed, for lack of jurisdiction, that portion of his hearing request that raised the issue of extent of scheduled permanent disability. The insurer 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 dismissal 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

Dismissal

In his request for reconsideration of the November 13, 1990 Determination Order, claimant raised the issues of temporary partial disability and rate of scheduled permanent disability. (Ex. 11). The Referee concluded that claimant was precluded from raising the extent of his scheduled permanent disability. The Referee reasoned that, because claimant had not raised the issue of extent of scheduled permanent disability in his request for reconsideration, he could not first raise that issue at hearing. Citing ORS 656.268(5), the Referee noted that the reconsideration procedure was a prerequisite to appeal to the Hearings Division. ORS 656.268(5). Because claimant did not include in his request for reconsideration the issue of extent of scheduled disability, he did not exhaust the prerequisite procedure and could not proceed to the Hearings Division on that issue. We agree with the Referee's conclusion that claimant is precluded from contesting the extent of scheduled permanent disability issue.[1] See Raymond L. Mackey, 45 Van Natta 776 (1993)(a party may not raise new issues at hearing relating to a determination order or notice of closure which were not raised at the reconsideration proceeding).

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 26, 1990 compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated December 2, 1991 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 is reversed. The award of an out-of-compensation fee to claimant's counsel payable from that increased compensation is reversed. The remainder of the order is affirmed.

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[1] Although a signatory to this order, Board Member Gunn directs the parties to his dissent in Raymond L. Mackey, supra.

In the Matter of the Compensation of
LILLIAN D. THOMPSON, Claimant
WCB Case No. 92-04976
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Garaventa's order that upheld the SAIF Corporation's denial of claimant's new occupational disease claim for a left wrist carpal tunnel syndrome (CTS) condition. On review, the issue is claim processing (whether the claim should be processed as an aggravation or as a new occupational disease). We reverse.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's recent work activities were the major contributing cause of her current left CTS condition.

CONCLUSIONS OF LAW AND OPINION

In this case, SAIF has already reopened claimant's accepted left wrist claim, processing it as an aggravation. The sole question on review is whether the claim is properly processed as an aggravation or as a new occupational disease.

The Referee found that, although claimant's repetitive work activities were a contributing cause of her current left CTS, they were not the major contributing cause of a worsening in the preexisting CTS condition. Therefore, she concluded that SAIF properly processed the claim as an aggravation.

Subsequent to the Referee's order, we issued our order in Peggy Holmes, 45 Van Natta 278 (1993). There we stated that a worker suffers a "new" occupational disease, in a case involving one employer/insurer, only if her later work exposure is the major contributing cause of her current condition. 45 Van Natta at 279. That is the standard we apply on review.

The primary medical evidence concerning the causation of claimant's current left CTS condition is provided by Drs. Carter, treating surgeon, Radecki, independent examiner, and Struckel, SAIF's medical adviser. Radecki identified numerous possible causes for claimant's condition, including obesity, scarring from multiple prior surgeries, residual nerve injury and psychological factors. Because claimant's left median motor nerve conduction did not change after surgery, Radecki reasoned that claimant's symptoms likely reflect nothing more than waxing and waning symptoms of her preexisting nerve compromise. He further concluded that claimant's repetitive work activities were not the major cause of her current left CTS. (Ex. 50-4-5). Considering claimant's history of repetitive work activities involving her wrists, we are not persuaded by Radecki's reasoning, which rules out the work contribution summarily.

Struckel reviewed claimant's records and opined that claimant's scar tissue from prior surgeries, rather than from continued work activities, caused her recent need for repeat surgery. Reasoning that activity-related scar damage would cause decreased finger motion, which Struckel believed claimant did not have, Struckel concluded that claimant's recent need for treatment resulted from her old injury (via the surgeries), rather than her more recent exposures. (Ex. 49-6)

Carter, who performed claimant's April 1992 left CTS surgery, noted that claimant's fingers were stiff and clumsy before the operation and more flexible thereafter. (Ex. 51-1). Based on his surgical findings of "dense synovial tissue surrounding the flexor tendons and also impinging against and encasing the median nerve," Carter concluded that the synovial tissue, rather than surgery-related scar tissue, was the primary cause of claimant's recently worsened left CTS problems. (Id). Carter further opined that "claimant's repetitive work locking, unlocking, moving and pulling of gates and doors, and doing inmate searches with her left hand and arm for the approximately one year prior to 03-25-92 at the Department of Corrections, was a major contributing cause of her left hand condition for which she required medical services and incurred disability." (Ex. 48; see Exs. 51, 52).

Considering Carter's special advantage as claimant's treating surgeon and his well-reasoned opinion based on his own surgical findings, we find no reason to rely on medical conclusions other than Carter's. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). We acknowledge that Carter did not expressly conclude that claimant's work activities were the major contributing cause of claimant's worsened left hand condition. Nevertheless "magic words" are not required. When viewed in its entirety, particularly considering his familiarity with claimant's medical and work history, we are persuaded that Dr. Carter's opinion satisfies the statutory prerequisite for a compensable occupational disease. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Accordingly, based on Carter's opinion, we conclude that claimant has proven that her recent work activities were the major contributing cause of her need for the April 1992 left CTS surgery. Thus, she has established that her claim is properly processed as a "new" occupational disease.

SAIF denied claimant's "new" occupational disease claim on causation grounds. (Ex. 43). Because claimant prevailed on this denial, she is entitled to an assessed attorney fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the new occupational disease claim 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 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 July 30, 1992 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for left wrist CTS is reversed. The claim is remanded to SAIF for processing consistent with this order. For his services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,000, payable by SAIF. The remainder of the order is affirmed.

April 28, 1993 Cite as 45 Van Natta 833 (1993)

In the Matter of the Compensation of
TODD M. BRODIGAN, Claimant
WCB Case No. 91-12483
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our March 11, 1993 order which: (1) reduced claimant's unscheduled permanent disability award for an integumentary condition from 50 percent to 41 percent; (2) reduced claimant's scheduled permanent disability for loss of use or function of his right leg from 66 percent to 5 percent; (3) declined claimant's request to set aside the Director's temporary standards as invalid; and (4) directed the self-insured employer to pay claimant's scheduled permanent disability at a rate of $145 per degree. On April 8, 1993, we withdrew our order for further consideration. Having received the employer's response to claimant's motion, we proceed with our reconsideration.

For the reasons expressed in our prior order, we adhere to our conclusions that we lack authority to declare the Director's temporary standards to be invalid. See Eileen N. Ferguson, 44 Van Natta 1811 (1992). Likewise, we continue to hold that claimant's scheduled permanent disability award must be paid at a rate of $145 per degree. See SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992). In response to claimant's contentions regarding our decisions concerning the extent of his unscheduled and scheduled permanent disability awards, we supplement our decision in the following manner.

Concerning his unscheduled permanent disability award, claimant seeks an increase beyond the 41 percent granted by the Order on Reconsideration. In support of his request, claimant asserts that the "specific vocational pursuit" (SVP) value used in the Evaluation Section's determination of his 41 percent

unscheduled permanent disability award was inaccurate. Specifically, he contends that the appropriate SVP should be 2, rather than 7, as calculated by the Evaluation Section. Such SVP figures represent a value of +4 under former OAR 436-35-300(4), rather than the +1 value used by the Evaluation Section.

In our prior order, we found that claimant's integumentary impairment was either classified under Class II or Class I impairment, rather than the Class III impairment used by the Evaluation Section. For the reason expressed in our previous decision (Dr. Parshley's opinion that claimant does not require continuous treatment), we continue to conclude that claimant's impairment does not qualify as Class III. See former OAR 436-35-440(2).

Considering the impairment values for Class II and Class I (15 percent and 3 percent) in relation to the value for Class III (38 percent) and in light of the fact that the employer was precluded from seeking a reduction of claimant's award below the 41 percent granted by the reconsideration order, we declined to resolve the specific impairment value. In other words, we essentially reasoned that even if claimant's impairment value was Class II (15 percent), his unscheduled permanent disability award would not exceed the 41 percent award.

We use similar reasoning in responding to claimant's contention that his SVP value should be +4, rather than +1. That is, even if claimant's SVP value is +4 and his impairment Class II (15 percent), his unscheduled permanent disability would total 25 percent (4 * 2.5 (adaptability value) = 10 + 15 = 25). Since this total would not exceed the 41 percent award granted by the reconsideration order, claimant would not have established entitlement to an additional unscheduled permanent disability award.

Turning to the scheduled permanent disability issue, claimant seeks reinstatement of the Referee's 66 percent award for the right leg rather than the 5 percent award granted in our order. In support of this request, claimant relies on his testimony and the opinion of Dr. Parshley.

As noted in our prior order, Dr. Parshley recorded reduced range of motion findings for claimant's right lower extremity. Nevertheless, Parshley further recognized that, in light of claimant's preexisting deformity and surgeries, it was "impossible for me to assess how much change in range of motion in the right ankle" is attributable to the compensable injury. Referring to "pre-injury measurements," claimant argues that Dr. Parshley's "post-injury" range of motion findings establish a quantifiable loss attributable to claimant's compensable injury.

We decline to follow claimant's method for resolving this issue. To begin, a scheduled permanent disability award is rated on the permanent loss of use or function of a body part due to an on-the-job injury. Former OAR 436-35-010(2)(a). Secondly, these losses are based on permanent impairment as measured by a physician according to particular rating methods. See former OAR 436-35-005(1), (2); former OAR 436-35-010(2). Considering such rules, we are not prepared to make the mathematical calculations suggested by claimant, particularly in light of Dr. Parshley's specific reservations regarding attributing any of claimant's limitations to his compensable injury.

We also reject claimant's contention that he is entitled to a 50 percent value for Class III dermatological condition under former OAR 436-35-230(7)(c). To receive such an impairment value, claimant must require continuous treatment. As discussed above, Dr. Parshley does not support such a conclusion. Nonetheless, Dr. Parshley does recognize claimant's occasional skin problems, as well as the "significant alteration" in claimant's life-style and "major disability" the injury has caused. (Ex 50-1; 70-8).

In light of such circumstances, we are persuaded that claimant has sustained a Class II dermatological condition under former OAR 436-35-230(7)(b). In other words, we find that there are signs and symptoms of a skin disorder, which require treatment from time to time and have resulted in limitations in function of his right leg. After further considering Dr. Parshley's aforementioned references to "significant alterations" and "major disability," we rate claimant's impairment at 20 percent.

Consequently, we increase claimant's scheduled permanent disability for loss of use or function of his right leg from the 5 percent, as found by our prior order, to 25 percent. Inasmuch as this award

continues to represent a reduction in claimant's award from that granted by the Referee, claimant's counsel is not entitled to an additional attorney fee for services on review. Nevertheless, claimant's counsel is entitled to 25 percent of the increase in scheduled permanent disability compensation between the 5 percent reconsideration order award and this 25 percent award. (25 percent - 5 percent = 20 percent). This fee shall not exceed $2,800. OAR 438-15-040(1).

Accordingly, we withdraw our March 11, 1993 order. On reconsideration, as supplemented and modified herein, we republish our March 11, 1993 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 28, 1993 Cite as 45 Van Natta 835 (1993)

In the Matter of the Compensation of
EUL G. MOODY, Claimant
WCB Case No. 91-14333
ORDER ON REVIEW
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant, pro se, requests review of Referee Holtan's order that dismissed claimant's hearing request. On review, the issue is the propriety of the Referee's dismissal order.

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

In October 1991, claimant, through his then-attorney of record, requested a hearing. In December 1991, claimant, again through his then-counsel, filed a supplemental hearing request.

A hearing was eventually scheduled for August 11, 1992. The day before the scheduled hearing, the Hearings Division was notified by claimant's then-attorney's firm that the hearing request was being withdrawn. Based on this announcement, the hearing was cancelled.

On August 14, 1992, claimant's then-attorney of record submitted a letter to the Referee providing notification that claimant was withdrawing his hearing request. On August 19, 1992, the Referee dismissed claimant's hearing request.

On September 10, 1992, the Board received a letter from claimant. Expressing dissatisfaction with the processing of his claim, claimant, without benefit of legal representation, requested review of the Referee's order.

On review, claimant discusses his condition and prior events during the processing of his claim, as well as his experiences with several physicians and attorneys. We acknowledge claimant's frustrations with the system and its participants. Nevertheless, the record establishes that his hearing request was dismissed in response to his then-attorney's express withdrawal of the request. Inasmuch as there is no evidence to contradict our appraisal of the circumstances surrounding the dismissal of claimant's request, we affirm the Referee's order. Verita A. Ware, 44 Van Natta 2163 (1992).

ORDER

The Referee's order dated August 19, 1992 is affirmed.

In the Matter of the Compensation of
EVELIO ACOSTA, Claimant
WCB Case No. 92-03244
ORDER ON REVIEW
Ann B. Witte, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Lipton's order which found that claimant was medically stationary on January 3, 1992, rather than November 15, 1991, as found by a Notice of Closure and Order on Reconsideration. On review, the issue is medically stationary date. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that from November 15, 1991 through January 3, 1992, further material improvement in claimant's condition was reasonably expected with medical treatment or the passage of time. Accordingly, he found that claimant was medically stationary on January 3, 1992, rather than November 15, 1991 as found by the January 14, 1992 Notice of Closure and February 21, 1992 Order on Reconsideration. We disagree.

"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 term "medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Since claimant is objecting to the medically stationary date found by the closure orders, he bears the burden of proving that he was not medically stationary as found by those orders. See 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).

In 1983, claimant injured his left elbow using a planting device and subsequently falling and hitting his elbow. The left elbow injury resolved within five months with no permanent disability. Claimant continued to work until 1991. In May 1991, claimant's left arm/elbow was struck by a patient at the group home where claimant was employed. In July 1991, SAIF accepted claimant's claim for a contusion left forearm condition.

On August 19, 1991, Dr. Hardin, claimant's attending physician, reported that claimant had not shown improvement. (Ex. 12A). Thereafter, Dr. Hardin referred claimant to Dr. Grossenbacher, orthopedist. Dr. Grossenbacher prescribed a TENS unit. (Ex. 13B).

On November 15, 1991, claimant was examined by Drs. Dinneen and Bellville of Western Medical Consultants. (Ex. 14). The Consultants found no valid objective findings to support claimant's subjective complaints. Consequently, they declared him medically stationary. (Ex. 14-3).

In December 1991, Drs. Hardin and Grossenbacher concurred with the independent medical examiners' findings. (Exs. 16; 17). On January124, 1992, SAIF issued a Notice of Closure, finding claimant medically stationary as of November 15, 1991. On January 16, 1992, Dr. Grossenbacher reported that due to claimant's cultural and language barriers, further diagnostic tests should be conducted before a final determination was made. (Ex. 25).

Claimant was referred by Dr. Grossenbacher to Dr. Gibbs, neurologist. In January 1992, Dr. Gibbs recommended further imaging studies. (Ex. 18). A March 1992 MRI indicated mild C-6 radiculopathy. (Ex. 23A). On March 31, 1992, Dr. Gibbs reported that claimant had not shown improvement since January 3, 1992 and no further treatment was indicated. (Ex. 24).

Under the circumstances, we conclude that claimant has failed to establish that further material improvement in his condition could reasonably be expected as of November 15, 1991. Specifically, 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). Accordingly, the fact that Dr. Gibbs recommended further imaging studies does not establish that claimant was not medically stationary.

Furthermore, we are not persuaded that Dr. Grossenbacher retracted his earlier opinion that claimant was medically stationary on November 15, 1991. Although further diagnostic testing was conducted after November 15, 1991, the medical evidence fails to establish that claimant's condition was not medically stationary as of the date found by the claim closure orders.

Accordingly, we reverse the Referee on the issue of medically stationary date. We find, instead, that claimant was medically stationary as of November 15, 1991. Consequently, we reinstate and affirm the January 14, 1992 Notice of Closure as reconsidered on February 21, 1992. In light of this conclusion, we also authorize SAIF to offset the temporary disability it paid subsequent to November 15, 1991 and before its January 14, 1992 Notice of Closure against claimant's future permanent disability awards on this claim.

ORDER

The Referee's order dated July 21, 1992 is reversed. That portion of the Referee's order that awarded additional temporary total disability benefits from November 15, 1991 through January 3, 1992 and an "out-of-compensation" attorney fee from this increased compensation is reversed. The January 14, 1992 Notice of Closure and February 21, 1992 Order on Reconsideration are reinstated and affirmed. SAIF is authorized to offset against claimant's future permanent disability awards on this claim, its temporary disability benefits paid between November 15, 1991 and January 14, 1992.

April 29, 1993 Cite as 45 Van Natta 837 (1993)

In the Matter of the Compensation of
LYNETTE D. BARNES, Claimant
WCB Case Nos. 90-18152, 90-14715,90-17215 & 90-18151
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Steven Cotton (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Liberty Northwest Insurance Corporation requests review of Arbitrator Spangler's decision tht: (1) set aside its denial of claimant's "new injury" claim for a left knee condition; and (2) upheld the SAIF Corporation's denial of claimant's medical services claim for the same condition. On review, the issue is responsibility.

Enclosing a copy of a referee-approved March 1993 disputed claim settlement (DCS) between Liberty and claimant, Liberty asserts that the agreement has resolved this dispute which is currently pending before the Board. Claimant responds that the DCS has no effect on this present dispute. We agree with claimant.

The DCS resolved compensability issues regarding claimant's left knee condition subsequent to September 25, 1990, her low back condition, and a right foot/ankle condition. The agreement further provides that claimant's current left knee condition preexisted her minor injury of April 11, 1990. In accordance with OAR 438-09-010, the settlement acknowledges that claimant retains her rights to benefits under ORS 656.245, 656.273, 656.278 and 656.340 insofar as those rights may be related to her original left knee strain claim.

The dispute presently before us pertains to whether claimant suffered a "new injury" on April 11, 1990 while working for Liberty's insured or whether her need for medical services is related to her 1984 compensable injury with SAIF. On the other hand, the DCS pertains to claimant's left knee condition subsequent to September 25, 1990 (a time after the purported "new injury"). Although the

agreement acknowledges that claimant's current left knee condition preexisted the April 11, 1990 injury, the settlement does recognize that claimant sustained an injury (albeit a minor one) on that date for which Liberty is responsible.

In light of such circumstances, we conclude that the DCS did not and could not (without our approval) resolve the dispute presently pending review. The provisions of the DCS will unquestionably have a significant impact on the future processing of claimant's "new injury" claim with Liberty. Nevertheless, the agreement does not terminate our review authority regarding the responsibility dispute arising from that alleged April 11, 1990 "new injury."

Turning to the merits of Liberty's appeal, our review is limited to questions of law. ORS 656.307(2). Finding no errors of law, we affirm the decision of the Arbitrator.

In reaching this conclusion, we note that, on April 19, 1993, we approved Liberty and claimant's Claim Disposition Agreement (CDA), in which claimant released her rights to all workers' compensation benefits, except medical services, for her compensable injury. WCB Case No. C3-00695. Considering our approval of the CDA and the Referee's approval of the parties' DCS, this order regarding the Arbitrator's decision is limited to medical services resulting from the April 11, 1990 "new injury" to claimant's left knee condition prior to September 25, 1990.

ORDER

The Arbitrator's decision dated July 28, 1992 is affirmed.

April 29, 1993 Cite as 45 Van Natta 838 (1993)

In the Matter of the Compensation of
GEOFFREY A. BEALS, Claimant
WCB Case No. 92-06223
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of that portion of Referee Schultz's order that awarded claimant a $1,625 assessed attorney fee for his counsel's services prior to hearing in obtaining the rescission of the insurer's denial of claimant's "current conditions." On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On March 17, 1992, the insurer issued a partial denial of claimant's "current conditions" as unrelated to a compensable 1989 cervical and thoracic condition. Along with the denial, the insurer sent claimant a proposed Claim Disposition Agreement (CDA), concerning the 1989 accepted claim, and a Disputed Claim Settlement (DCS), regarding the "current conditions" partial denial.

On May 6, 1992, claimant's counsel requested a hearing on the March 17, 1992 denial. On May 13, 1992, the insurer rescinded its denial and accepted the claim. The hearing convened on July 28, 1992.

ORS 656.386(1) provides that, if an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, a reasonable attorney fee shall be allowed. In Michael A. Dipolito, 44 Van Natta 981, 982 (1992), we held that ORS 656.386(1) has "no application when the hearing request did not pertain to a denial (written or 'de facto') and, thus, there was no denial to withdraw after the hearing request and before the hearing." At the hearing, the insurer argued that claimant requested a

hearing before it denied claimant's claim, because the March 17, 1992 denial was not a real denial. In the insurer's view, its denial was contingent upon claimant accepting the DCS, and did not become effective because claimant rejected the DCS. We disagree.

An insurer must deny a claim before it can resolve a case by a DCS. ORS 656.289(4); OAR 438-09-010(2)(b). However, no statute or rule requires or permits an insurer to issue a contingent denial as part of the DCS negotiating process. Consequently, we agree with the Referee that claimant's counsel requested a hearing on a denied claim.

After filing the request for hearing, claimant's counsel conferred with claimant's physicians, reviewed claimant's medical file, prepared and obtained responses to interrogatories directed to those physicians and corresponded with the insurer. Under those circumstances, we also conclude that claimant's counsel was instrumental in obtaining claimant compensation prior to hearing.

In determining the appropriate attorney fee, the Referee relied on claimant's counsel's statement of services. Claimant's counsel rendered some of the stated services subsequent to the insurer's May 13, 1992 rescission. Claimant's counsel is not entitled to an assessed fee under ORS 656.386(1) for those post-rescission services. Amador Mendez, 44 Van Natta 736, 737 (1992).

For purposes of determining a reasonable assessed fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee for claimant's counsel's efforts in obtaining compensation for claimant's "current conditions" prior to hearing and before the rescission of the insurer's denial is $1,218.75, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by claimant's counsel's statement of services) the value of the interests involved, the complexity of the issues, and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated August 11, 1992 is modified. In lieu of the Referee's attorney fee award, claimant's counsel is awarded an assessed attorney fee of $1,218.75 for his services prior to hearing, to be paid by the insurer. The Referee's order is otherwise affirmed.

April 29, 1993 Cite as 45 Van Natta 839 (1993)

In the Matter of the Compensation of
CAROLYN S. FARMER, Claimant
WCB Case No. 92-07307
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Nielsen's order that: (1) awarded a penalty for its unreasonable delay in paying claimant's physical therapy bills; and (2) awarded a $750 attorney fee for claimant's counsel's efforts in obtaining compensation for claimant without a hearing. On review, the issues are penalties and attorney fees.

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

The Referee assessed a penalty based on the insurer's unreasonble delay in paying claimant's physical therapy bills. We agree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's delay or refusal must be gauged based upon the information available to the carrier at the time of the conduct. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc., v. Porras, 103 Or App (1990).

Here, we find that the insurer did not have a legitimate doubt concerning its liability for claimant's physical therapy bills. In reaching this conclusion, we are persuaded that the insurer's purported reliance on the rules regarding claimant's choice of physicians did not supply a legitimate doubt, since as the Referee noted, the insurer did not comply with the requirements of those rules. Moreover, the insurer cannot have a legitimate doubt for lacking knowledge of facts that would have been disclosed by a reasonable investigation. See Kenneth A. Foster, 44 Van Natta 148 (1992). Here, such an investigation would have disclosed that claimant had not changed her attending physician.

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 September 1, 1992 is affirmed.

April 29, 1993 Cite as 45 Van Natta 840 (1993)

In the Matter of the Compensation of
JOHN R. HEATH, Claimant
WCB Case Nos. 91-14829 & 91-02296
ORDER ON RECONSIDERATION
Bottini, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

On March 25, 1993, we abated our March 12, 1993 order, which reversed the Referee's award of additional temporary disability benefits from the date of claim closure until the date of the Referee's order reinstating the January 3, 1991 Determination Order. Taking this action on our own motion, we asked the parties to submit supplemental briefs addressing the applicability of Glen D. Roles, 45 Van Natta 282 (1993) on recon 45 Van Natta 488 (1993), to this case. Having received the parties' briefs, we proceed with our review.

We republish that portion of our order which pertained to the premature claim closure issue. We turn to the temporary disability issue.

The Referee found that the claim had not been prematurely closed. Therefore, the May 17, 1991 Order on Reconsideration (which had set aside the January 3, 1991 Determination Order) was reversed. The Referee also awarded temporary disability benefits from January 3, 1991 through the Referee's December 2, 1991 order.

In our prior order, we affirmed the Referee's decision that the claim had not been prematurely closed. Nevertheless, although we reasoned that claimant was procedurally entitled to temporary disability benefits that accrued from the date of the May 17, 1991 Order on Reconsideration until the Referee's December 2, 1991 order, we held that claimant was not substantively entitled to additional temporary disability benefits beyond the January 3, 1991 medically stationary date. Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), we concluded that we had no authority to impose payment of benefits beyond the medically stationary date.

After further considering this temporary disability issue in light of ORS 656.313(1)(a)(A) and Glen D. Roles, supra, we find that claimant is entitled to the temporary disability benefits awarded by the Referee. We base our conclusion on the following reasoning.

In Seiber, a carrier had not paid temporary disability benefits prior to claim closure. Although we agreed that the claimant was not substantively entitled to temporary disability benefits, we awarded temporary disability benefits because had the carrier begun paying the benefits it would not have been authorized to terminate the claimant's compensation until claim closure. Therefore, we ordered the carrier to pay the benefits and also authorized an offset of this administrative overpayment against the claimant's future compensation.

The Seiber court held that we lacked authority to impose a procedural overpayment of temporary disability benefits when the claimant was not substantively entitled to such benefits. The court reasoned that the procedural overpayment created by our order resulted from the payment of temporary disability benefits beyond the medically stationary date, and, as such, was a consequence of the administrative process of claim closure, not a substantive entitlement to temporary disability benefits. Id. at 654.

Here, the insurer contends that the "substantive versus procedural" entitlement issue ends the inquiry and that, therefore, this case is indistinguishable from Georgia-Pacific v. Hughes, 305 Or 286 (1988). In Hughes, the Supreme Court held that a carrier was not required to pay a portion of interim compensation granted by a Referee's order pending review of that order. Noting that the claimant was working during a period for which the interim compensation had been granted, the Court reasoned that the compensation was never due. Analogizing this case to Hughes, the insurer contends that since claimant was not ultimately found to be substantively entitled to such benefits, it was not required to pay them. We disagree.

In reaching our conclusion, we draw support from the court's decision in Roseburg Forest Products v. McDonald, 116 Or App 448 (1992). In McDonald, the employer refused to pay temporary disability benefits granted by a determination order pending its appeal of that order. The employer contended that the claimant had withdrawn from the work force. Relying on Hughes, the employer argued that although the claimant was procedurally entitled to temporary disability benefits awarded by determination order, the time loss was not "compensation" for purposes of ORS 656.313 because claimant did not have a substantive right to compensation. The McDonald court disagreed, reasoning that the determinative issue was not whether the claimant was procedurally or substantively entitled to temporary disability benefits, but whether the employer was required to pay temporary disability benefits under a determination order pending an appeal of that order. Citing Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the court concluded 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." McDonald, 116 Or App at 452.

The above quoted language from Piwowar closely resembles the current language in ORS 656.313(1)(a)(A), which provides:

> "Filing by an employer or the insurer of a request for hearing on a reconsideration order . . . stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs." (emphasis added)

In Glen D. Roles, 45 Van Natta 282, 284 (1993) aff'd on recon 45 Van Natta 488 (1993), we distinguished Seiber to find that a referee's award of temporary total disability benefits granted by Determination Orders were not merely procedural benefits. Relying on McDonald, we reasoned that the temporary total disability benefits were compensation which was not stayed under former ORS 656.313(1) pending a carrier's appeal of the referee's order. We concluded that, "rather than creating an 'administrative overpayment' as was disapproved in Seiber, we [were] simply requiring [the carrier] to comply with its statutory obligation under former ORS 656.313 to pay compensation awarded by an appealed referee's order." Roles, 45 Van Natta at 284.

The exception created by subsection (A) of ORS 656.313(1)(a), likewise, does not create a "procedural overpayment." Rather, it creates a statutory obligation to pay temporary disability compensation awarded by an appealed order on reconsideration. See McDonald, 116 Or App at 452; Roles, 45 Van Natta at 283.

Although Roles involved an insurer appeal of a Referee's order, the language of amended ORS 656.313(1)(a)(A) makes clear that temporary total disability benefits awarded by an order on reconsideration remain substantive compensation which is not stayed pending appeal and creates a statutory obligation to continue payment of such compensation until claim closure or the order is reversed. This obligation reflects a legislative intent to provide injured workers with a means of support pending an employer or insurer appeal of an adverse order. Therefore, we hold that the insurer was required, pursuant to amended ORS 656.313(1)(a)(A), to pay temporary disability benefits awarded by the order on reconsideration pending its appeal of that order.

We have previously found that, under amended ORS 656.313, the filing by the insurer stays the payment of the compensation appealed when the insurer's appeal is filed within 30 days as provided by statute. Walden J. Beebe, 43 Van Natta 2430, 2431 (1991)(the insurer was not required to file its request

for review within 14 days of the referee's order in order to avail itself of the stay provisions). The time for filing a request for hearing on a reconsideration order is governed by ORS 656.268(6)(b), which provides that the objecting party may file a request for hearing within 180 days after the notice of closure or determination order is mailed.

Here, on October 14, 1991, the insurer timely appealed the May 17, 1991 Order on Reconsideration. The insurer, therefore, was not obligated to pay temporary disability benefits owing prior to May 17, 1991, while the claim was deemed to be in open status. In other words, any temporary disability benefits owing from November 29, 1990 to May 16, 1991 were properly stayed. However, pursuant to amended ORS 656.313(1)(a)(A), the insurer is required to pay temporary disability benefits that accrued from the date of the May 17, 1991 Order on Reconsideration until the Referee's December 2, 1991 order reversing the Order on Reconsideration.

Notwithstanding this modification of our prior order, the temporary disability benefits granted by the Referee's order has been reduced. (The Referee granted temporary disability benefits from January 3, 1991 through December 2, 1991, whereas we have awarded temporary disability benefits from May 17, 1991 through December 2, 1991). Because our decision results in a reduction of claimant's compensation award, claimant's counsel is not entitled to an attorney fee for services on review. See ORS 656.382(2).

Finally, we continue to adhere to our prior holding that the insurer's failure to commence payment of temporary disability benefits which were due within 14 days of the May 17, 1991 Order on Reconsideration amounted to an unreasonable resistance to the payment of compensation. We, therefore, do not disturb our prior penalty assessment.

Accordingly, we withdraw our March 12, 1993 order. On reconsideration, we affirm in part and modify in part the Referee's December 2, 1991 order. That portion of the Referee's order that awarded temporary disability benefits is modified to award temporary disability benefits from May 17, 1991 through December 2, 1991. In lieu of the Referee's attorney fee award, claimant is awarded 25 percent of this compensation, not to exceed $1,050. That portion of the order that assessed a penalty is modified to assess a penalty equal to 25 percent of temporary disability benefits accruing from May 17, 1991 through December 2, 1991, to be equally divided between claimant and his attorney. The remainder of the order is affirmed. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES F. HERRON, Claimant
WCB Case Nos. 91-18372, 92-03965 & 92-05951
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Mitchell, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

Liberty Northwest Insurance Corporation requests review of Referee Livesley's order that: (1) set aside its denial of compensability and responsibility for claimant's "new occupational disease" claim for a right elbow condition; (2) upheld American Hardware Mutual Insurance's and American States Insurance's denials of the same condition; and (3) awarded claimant an assessed attorney fee, payable by Liberty Northwest rather than by American States. In its brief, American States argues that claimant is not entitled to an assessed attorney fee payable by any of the insurers. On review, the issues are compensability, responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

We adopt the Referee's opinion concerning the compensability and responsibility issues. See Donald C. Moon, 43 Van Natta 2595 (1991).

Assessed Attorney Fee

The Referee awarded claimant an assessed attorney fee for services at hearing, payable by Liberty Northwest. On review, Liberty Northwest contends that, because only American States continued to contest compensability at hearing, the assessed attorney fee should be paid by American States, rather than Liberty Northwest. American States argues that no assessed fee may be awarded here. We agree with the Referee that an assessed fee is appropriate; however, we conclude that the fee is payable by American States rather than Liberty Northwest.

American States argues that no fee is assessable against it because claimant has not prevailed against its aggravation denial. At hearing, American States continued to contest compensability. Claimant received a favorable determination on the question of compensability. Therefore, claimant is entitled to insurer-paid attorney fees under ORS 656.386(1) for services performed at the hearing level. Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993); SAIF v. Bates, 94 Or App 666 (1989).

That assessed fee is payable by American States. Only American States contested compensability of the claim at hearing. Therefore, American States, as the insurer that created the need for claimant to establish the compensability of the claim, is responsible for payment of the attorney fee at hearing. Id.

Although compensability was not raised as an issue on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Accordingly, claimant would be entitled to a reasonable assessed attorney fee under ORS 656.382(2) for legal representation on review. However, because claimant's attorney filed a brief concerning only the attorney fee issue, we decline to award an assessed attorney fee on review. State of Oregon v. Hendershott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986); Shirley M. Brown, 40 Van Natta 879 (1992).

ORDER

The Referee's order dated August 11, 1992 is affirmed in part and modified in part. That portion of the Referee's order that awarded claimant an assessed attorney fee payable by Liberty Northwest Insurance Corporation is modified. The assessed attorney fee for services at hearing is to be paid by American States Insurance rather than Liberty Northwest. The remainder of the Referee's order is affirmed.

April 29, 1993 Cite as 45 Van Natta 843 (1993)

In the Matter of the Compensation of
EVERY MENDENHALL, Claimant
WCB Case Nos. 91-10150, 89-24635 & 91-05946
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Montgomery W. Cobb, Defense Attorney

The insurer requests reconsideration of our March 31, 1993 Order on Review. In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn.

Claimant is allowed 14 days from the date of this order in which to respond to the motion. Thereafter, the Board shall proceed with its review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM TOWNE, Claimant
WCB Case No. 90-14645
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband, Neidig, and Gunn.

Claimant requests review of Referee Hazelett's order that upheld the insurer's denial of claimant's injury claim for a sprained left ankle and a fractured right ankle. On review, the issue is compensability.

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

Assuming, without deciding, that claimant successfully ruled out idiopathic causes for his fall on work premises, we nevertheless conclude that the claim is not compensable because claimant has not affirmatively proven that his injury was, in fact, related to his working environment. See ORS 656.266; Ruben G. Rothe, 45 Van Natta 369 (1993).

ORDER

The Referee's order dated April 7, 1992 is affirmed.

Board Member Gunn dissenting.

The majority finds that claimant has not successfully ruled out idiopathic causes for his worksite fall, or in the alternative, his claim is not compensable because he has not affirmatively proven that his injury is, in fact, related to his working environment. See Ruben G. Rothe, supra. I differ with the majority on both counts.

Assuming that the cause of claimant's fall was idiopathic, claimant may establish compensability if his injury was caused by "the increased risk" presented by his working environment. Ruben G. Rothe, supra; Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991).

In the present case, claimant's injury occurred at the worksite. Further, I find that claimant's work environment presented inherent risks different from those encountered by any person walking on the concrete/tile area.

Claimant was an instructor and was required to carrying such classroom materials as exams and book and papers to class. He was also required to be on time for his class to proceed for the day. Claimant testified that his hands were full and he was running late. He testified that he was aware that he was potentially late for class, he hastened his pace, looked at his watch and then fell.

Witness Schmidt verified that claimant was overloaded with the items he was carrying. (Tr. 38). She testified that before he fell, she noticed that he was off balance because of what he was carrying. (Tr. 38-39). She also testified that even after claimant had fallen, fracturing one ankle and spraining the other, he was still "very worried about getting to class." (Tr. 43).

Public Safety Officer Johnson also testified that when he arrived at the scene of the "code three" (red light and siren), claimant refused medical assistance and was instead, "very adamant about getting to class. He had to get to class." (Tr. 70). In fact, Johnson testified that when they tried to find out if claimant was hurt, all he would talk about was getting to class. (Tr. 71). Thereafter, claimant taught the class, in a wheelchair, before he would accept medical aid.

The evidence supports, therefore, that "getting to class" was imperative to claimant's job. The evidence shows that in an attempt to guarantee his promptness, claimant was rushing to work while 844

overburdened with class materials. In fact, getting to class was so important that after claimant fell and injured his ankles, he fulfilled his job assignment for the day before seeking necessary medical care. Perhaps there are very few of us as diligent as claimant here, but nevertheless, he ought not be punished for his exemplar work ethics.

Accordingly, even assuming that claimant did have an idiopathic fainting spell, the risk of injury from fainting would be greatly increased by the fact that claimant was carrying an overabundance of class materials and rushing to get to class on time for his employer's benefit. Thus, under the analyses of Marshall and Rothe, I find that claimant has met his burden of showing that the fall was work-related and not caused solely by a condition personal to claimant.

As a final comment, I note that in the present case, as in my dissent in Ruben G. Rothe, 45 Van Natta 369 (1993), I disagree that ORS 656.266 effectively overruled the Supreme Court's decision in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983). For that reason, I provide the following analysis under the Russ standard.

In Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), the Court held that where a fall on the job is unexplained, the law assumes that it was related to work, provided that the worker proves that the cause of the fall was not "idiopathic," i.e., "peculiar to the individual." Id at 27. To do so, the worker must establish that the injury was more likely work-related than idiopathic. Id at 30.

Here, as in Russ, claimant unaccountably fell while walking on the job. Therefore, by way of the medical evidence, claimant must prove that his injury did not result from any cause "peculiar" to himself. Phil A. Livesley Co. v. Russ, supra.

In an attempt to provide an explanation for claimant's fall, the medical evidence hypothesizes about a "possible syncope" or, in layperson terms, a fainting spell. However, in conclusion, Dr. Shawler reported that the "[e]xact etiology [is] unknown." (Ex. A1-3). There is no contrary medical evidence.

Furthermore, the lay evidence supports the same conclusion. Claimant did not report experiencing any sensation of fainting. Claimant reported that he did not know why he fell. Witness Schmidt testified that she observed claimant for approximately 15 seconds, "like he was going off balance," before he fell. (Tr. 38-39). This observation does not suggest that claimant suddenly fainted. Moreover, claimant, every lay witness and the medical evidence all reported that claimant did not hit his head when he fell. If claimant had fainted, it would be very atypical for claimant not to have hit his head. Further, I note that there is no supporting evidence that any left leg injury due to claimant's Vietnam experience contributed to his fall, so I do not entertain discussion in regard to that contention.

Accordingly, I find under the Russ standard that claimant has ruled out the suggested idiopathic cause of his fall. Thus, I would find claimant's claim compensable under such an analysis, as well as the Rothe analysis as discussed above.

Therefore, I respectfully dissent.

In the Matter of the Compensation of
JOSE CASTILLO, Claimant
WCB Case Nos. 90-14529, 90-12027 & 90-12098
And, In the Matter of the Complying Status of
WARREN & LOUIS SWENSON, Employer
WCB Case No. 89-21501
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Walter Barnes, Attorney
Roberts, et al., Defense Attorneys
Jonathon Liss, Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Timothy R. and Terry R. Jones, dba Ace Tree Company, request review of Referee T. Lavere Johnson's order which: (1) set aside the Director's order finding Warren and Louis Swenson to be noncomplying employers; and (2) set aside the SAIF Corporation's denial of claimant's hernia and low back conditions issued on behalf of Timothy R. and Terry R. Jones. In their brief on review, Warren and Louis Swenson request an award of attorney fees pursuant to ORS 656.740(5) for their attorney's services at hearing. On review, the issues are joinder, responsibility under ORS 656.029, and attorney fees under ORS 656.740(5).

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

The Jones brothers contend the Referee had no jurisdiction to join them in this proceeding. We disagree. Claimant's injury claim was originally processed against the Jones brothers, dba Ace Tree Company. They were determined to be noncomplying employers, and the claim was referred to SAIF for processing; SAIF accepted the claim. Subsequently, the noncompliance order was rescinded, and SAIF denied claimant's claim on behalf of the Jones brothers. (Ex. A-46). Claimant requested a hearing on this denial which, together with the noncomplying status of Warren and Louis Swenson, is the subject of this proceeding. Under these circumstances, we find that, in order to achieve substantial justice and full litigation of the issues among the parties, the Referee had jurisdiction to join Timothy R. and Terry R. Jones in this proceeding. Wilfred L. Speckman, 40 Van Natta 2076 (1988); see also Ferland v. McMurtry Video Productions, 116 Or App 405 (1992).

We affirm the Referee's order finding claimant's claim to be compensable and Timothy R. and Terry R. Jones, dba Ace Tree Company, to be the responsible employer under ORS 656.029(1). However, we modify that portion of the Referee's order which remanded the claim to SAIF for processing as a compensable claim under the noncomplying employer statutes of the Oregon Workers' Compensation Law.

We have recently held that there is no statutory authority for referring a claim to SAIF for processing in the absence of an Order of Noncompliance. Adam H. Berkey, 45 Van Natta 237, 239 (1993); Jerry M. Banks, 44 Van Natta 2561 (1992); see also James L. Guyton, 41 Van Natta 1277 (1989) (ORS 656.054 is the sole statutory authority for referring a noncomplying employer claim to SAIF for processing).

Here, although the Department initially referred the claim against Timothy R. and Terry R. Jones to SAIF for processing pursuant to an Order of Noncompliance, the Department subsequently rescinded the noncompliance order when it issued an Order of Noncompliance against Warren and Louis Swenson. Since there is no noncompliance order with respect to the Joneses at this time, responsibility for directing the processing of the claim against the Joneses remains with the Department. The claim may only be properly referred to SAIF for processing if the Department issues a noncompliance order. Adam H. Berkey, supra. Accordingly, we modify that portion of the Referee's order which remanded the claim to SAIF.

Here, when the Department rescinded its noncompliance order with respect to the Joneses, it also rescinded its February 1, 1989 referral to SAIF and advised SAIF to deny further processing under ORS 656.054. (See Exs. A-33, A-42A). SAIF issued a denial on March 15, 1990, as instructed by the

Department. (Ex. A-46). Under these circumstances, we find that SAIF issued its denial of claimant's claim acting under the color of its authority under former OAR 436-80-060(2)(WCD Admin. Order 7-1987, effective January 1, 1988). Jerry M. Banks, supra.

We conclude, therefore, as we did in Berkey and Banks, that SAIF's denial raised a matter concerning a claim which required claimant to request a hearing to protect his rights. ORS 656.283(1); ORS 656.704(1). Thus, the Referee properly proceeded to determine the subjectivity issue. The subjectivity issue has been fully litigated with all parties present. Therefore, our decision will likely have a preclusive effect on the Department's future decisions regarding the issuance of a subsequent noncompliance order concerning the Joneses and eventually, SAIF's future processing of the claim. Id.

Warren and Louis Swenson are entitled to a reasonable attorney fee for prevailing at hearing against the Director's proposed order declaring them to be noncomplying employers. ORS 656.740(5). After considering counsel's petition for attorney fees and supporting affidavit (and in light of the lack of an objection to the requested amount), we find that a reasonable fee for counsel's services at hearing is $13,695, to be paid by the Director from the Insurance and Finance Fund. In reaching this conclusion, we note that no award for costs is authorized under ORS 656.740(5).

ORDER

The Referee's order dated February 28, 1992 is affirmed in part and modified in part. That portion of the Referee's order which remanded the claim to SAIF for processing as a compensable claim for the Joneses is modified. Responsibility for the further processing of this claim currently rests with the Compliance Section, which will determine whether the issuance of an order finding Timothy R. and Terry R. Jones to be a noncomplying employer under ORS 656.054 is warranted. The remainder of the Referee's order is affirmed. The attorney for Warren and Louis Swenson is awarded $13,695 for services at hearing, to be paid by the Director from the Insurance and Finance Fund.

In the Matter of the Compensation of
RICHARD J. GUILLEN, Claimant
WCB Case No. 91-11137
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of that portion of Referee Hoguet's order that upheld the SAIF Corporation's "de facto" 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 exception of his "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that, although claimant proved an increase in symptoms and diminished earning capacity, he failed to show that the diminished earning capacity exceeded that contemplated by an April 1989 Opinion and Order. Therefore, the Referee concluded that claimant had failed to prove a compensable aggravation. We disagree.

To establish an aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning

capacity, claimant's diminished earning capacity exceeded that contemplated at the time of the last arrangement. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989); rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991).

Claimant was awarded 14 percent unscheduled permanent disability for his low back by a December 7, 1988 Determination Order. An April 1989 Opinion and Order affirmed the Determination Order award of unscheduled permanent disability for claimant's low back and also awarded 10 percent scheduled permanent disability for the left knee. (Ex. 46). On review, claimant contends that the December 1988 Determination Order, rather than the April 1989 Opinion and Order, constitutes the "last award or arrangement of compensation."

We have held that claimant's last opportunity to present evidence of his current condition constitutes the last arrangement of compensation. See Frank L. Stevens, 44 Van Natta 60, 61 (1992). In this case, claimant's last opportunity to present evidence of his current condition was at the time of the March 27, 1989 hearing, which resulted in the April 1989 Opinion and Order. See Larry H. Erbs, 42 Van Natta 98, 100 (1990). Therefore, we agree with the Referee's conclusion that the April 1989 Opinion and Order, which affirmed the Determination Order award of 14 percent unscheduled permanent disability for claimant's low back and also awarded 10 percent scheduled permanent disability for the left knee, constitutes claimant's last arrangement of compensation.

Prior to the April 1989 Opinion and Order, claimant was released to full-time work at the modified position of cabinet salesman. Dr. Krupa, chiropractor, reported that claimant would continue "to require palliative care approximately two to three times a month in order to control the symptoms he experiences." (Ex. 40-1). Dr. Baldwin, claimant's treating physician, concurred with Dr. Krupa's opinion. (Ex. 41).

In November 1991, claimant experienced increased back stiffness and pain. (Ex. 59-1). On December 4, 1991, claimant was examined by Dr. Proano, his current treating physician, who reported that claimant had "virtually no degree of back extension at all." Dr. Proano noted that claimant had very limited flexion range of motion in his low back. He prescribed chiropractic treatment with Dr. Hall at the rate of three times a week. (Id). Subsequently, Dr. Proano released claimant from work from December 5, 1991 to December 16, 1991. (Ex. 59-2). Dr. Proano also prescribed anti-inflammatory medication. (Id).

On December 16, 1991, Dr. Proano noted improvement in claimant's low back range of motion. (Ex. 59-2). Thereafter, he released claimant to return to work, restricted to four hours per day. He prescribed anti-inflammatory medication and daily chiropractic treatments. (Id).

On December 30, 1991, Dr. Proano noted continuing limitations and spasms. He recommended that claimant continue four-hour work days and chiropractic treatments. (Ex. 59-3). On January 15, 1992, Dr. Proano noted gradual improvement with three times per week chiropractic care. He, therefore, released claimant to full-time work without restrictions on January 16, 1992. (Id).

Under the circumstances, we find that Dr. Proano's reports establish that, since claimant's last arrangement of compensation, he has experienced a symptomatic worsening (established by medical evidence supported by objective findings), resulting from his original injury. Moreover, as a consequence of this worsened condition, his earning capacity was diminished below the level of the April 1989 Opinion and Order. Specifically, we find that claimant's two weeks off work and one month of restricted part-time work establishes that his earning capacity was diminished below that existing at the time of the March 1989 hearing which resulted in the April 1989 Opinion and Order affirming the Determination Order's 14 percent unscheduled permanent disability award.

Because claimant has previously been awarded unscheduled permanent disability by the Determination Order, 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). Here, we agree with the Referee that the April 1989 order contemplated future periods of increased symptoms accompanied by diminished earning capacity. The April 1989 order and the medical evidence predating that order mention that claimant "will most likely continue in the same pattern of low level symptomology punctuated by periodic exacerbations." (Ex. 40-1; 46). However, we conclude that the

need for medication coupled with chiropractic treatments ranging from three to seven times per week in combination with claimant's release from work and subsequent work restrictions is more than a limitation of "normal daily functions" during exacerbations as predicted by Drs. Krupa and Baldwin. Accordingly, we conclude that claimant has established a compensable aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board review is $3,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and appellate briefs on review), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated August 28, 1992 is reversed. The SAIF Corporation's "de facto" aggravation denial of claimant's condition as of November 23, 1991 is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded an assessed attorney fee of $3,500, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

April 30, 1993 Cite as 45 Van Natta 849 (1993)

In the Matter of the Compensation of
MICHAEL R. HOLT, Claimant
WCB Case No. 92-01709
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of Referee Bethlahmy's order which set aside its denial of claimant's claim for a neck injury. On review, the issue is compensability.

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

Claimant sustained a neck injury on January 21, 1991, while working in Arizona. His claim was accepted on behalf of the Arizona employer. (Ex. 20-14). After our review of the record, we find that claimant sustained a new injury while working for an Oregon employer on January 13, 1992. The new injury caused a herniated disc at C6-7 and required surgery.

The insurer contends, based on inconsistencies in the record, that claimant is not credible and, therefore, has failed to establish that he sustained a work injury on January 13, 1992. We disagree. The Referee made no credibility findings based on claimant's demeanor at the hearing, and we may independently evaluate credibility based on the record. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our review of the record, we find that the inconsistencies between claimant's testimony and the testimony of his co-workers and supervisor are minor and collateral to the question of whether claimant sustained a work injury. Likewise, we find no significant discrepancy between claimant's testimony and the history he gave to medical providers. Accordingly, we find that any inconsistencies in the record are outweighed by the evidence as a whole, which establishes that claimant sustained a work injury on January 13, 1992. See Peterson v. Eugene F. Burrill Lumber, 57 Or App 476, 480 (1982), aff'd 292 Or 537 (1983).

After reviewing the record, we agree with the Referee's evaluation of the medical evidence. In addition to the reasons cited by the Referee, we find Dr. Brett's opinion to be more persuasive than Dr. Kaesche's opinion for the following reasons.

Dr. Kaesche, an orthopedist who was claimant's treating physician from 1988 until January 1992 when he referred claimant to Dr. Brett, recorded in his chart notes that claimant had no radicular symptoms prior to the January 1992 incident. He also recorded neck pain of the type normally ascribed to muscular origin, which had essentially resolved by June 1991, except for a flare-up on October 23, 1991. (Ex. 1-2 to 1-4). These findings are consistent with the opinion of Dr. Schroeder, the Arizona consulting neurosurgeon, who felt that claimant's pain following the January 1991 injury was musculotendinous. (Ex. 8-2). However, Dr. Kaesche's chart notes are inconsistent with his later opinion that the C6-7 herniated disc developed progressively from the January 1991 injury, and he fails to explain how his opinion can be reconciled with his chart notes.

Furthermore, Dr. Kaesche fails to explain how the January 1991 injury, which did not cause any abnormalities at the C6-7 level, was the major contributing cause of a large disc herniation at that level in 1992. (See Exs. 7, 11). For these reasons, we find Dr. Kaesche's opinion less persuasive.

On the other hand, Dr. Brett assumed that claimant had some annular pathology due to the January 1991 injury, but because of the large size of the disc herniation, he did not believe it developed progressively over a year. Instead, he opined that claimant's work activities on January 13, 1992 were the major contributing cause of his current neck condition, which represents a "definite pathological worsening" of his neck condition since the original annular injury in January 1991. (Ex. 13-2). We find Dr. Brett's opinion to be well-reasoned and based on an accurate medical history. Accordingly, we find Dr. Brett's opinion to be more persuasive, and we affirm the Referee's determination that claimant's C6-7 herniated disc and resultant surgery are compensable.

The insurer argues that claimant's out-of-state injury represents a "preexisting condition" and that claimant must, therefore, prove that his Oregon injury is the major contributing cause of his disability or need for treatment. Assuming, without deciding, that ORS 656.005(7)(a)(B) is applicable, we would still find claimant's current condition to be compensable, based on Dr. Brett's opinion. We conclude that claimant has established the compensability of his current neck condition under either the material or major contributing cause standard.

Finally, we agree with the Referee that Miville v. SAIF, 76 Or App 603 (1985) is not applicable here, since the present case does not involve an intervening out-of-state injury which would prevent responsibility from remaining with the original Oregon carrier. Furthermore, because we find that claimant sustained a new injury in Oregon in January 1992, it follows that his current condition is not an aggravation of his compensable Arizona injury.

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

ORDER

The Referee's order dated May 28, 1992 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
DEAN M. HUNSAKER, Claimant
WCB Case Nos. 92-03563 & 92-03562
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Brown's order that: (1) set aside its denial of claimant's occupational disease claim for hearing loss and held it responsible for 90.85 percent of the claim; and (2) set aside Medford Corporation's (Medco) denial of claimant's occupational disease claim for the same condition and held it responsible for 9.15 percent of the claim. On review, the issue is responsibility. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings," except for his first and second "Ultimate Findings of Fact," as supplemented herein.

Regular testing of claimant's hearing by the employer since 1971 reveals progressive hearing loss. Claimant did not become disabled from work or seek medical treatment due to his hearing loss while SAIF was on the risk.

Claimant filed an 801 form concerning his hearing loss on October 31, 1991.

Noise exposure while SAIF was on the risk was not the sole cause of claimant's hearing loss. Noise exposure while Medco was on the risk actually contributed to claimant's hearing loss.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has two separately definable hearing losses, one occurring before July 1, 1988, while SAIF was on the risk, and the other after Medco became self-insured. Relying on Cascade Corporation v. Rose, 92 Or App 663 (1988), the Referee concluded, therefore, that both SAIF and Medco are responsible for a portion of claimant's hearing loss.

On review, SAIF contends that under the last injurious exposure rule, full responsibility should be assigned to Medco. Medco responds that because claimant has "two distinct" claims for hearing loss, the Referee properly found each carrier responsible for a portion of claimant's condition. Alternatively, Medco contends that because SAIF conceded compensability, as the first insurer on the risk, it, rather than Medco, is responsible; thus, application of the last injurious exposure is not appropriate. Finally, Medco renews its argument that ORS 656.308 and OAR 436-35-250(2) permit allocation of responsibility.

Addressing Medco's allocation argument first, we adopt the Referee's reasoning and conclusion that neither ORS 656.308 nor OAR 436-35-250(2) were intended to modify the law to provide for the allocation of responsibility for a single claim in cases of successive employers or carriers, or to modify the last injurious exposure rule.

We disagree, however, with the Referee's reliance on Cascade Corporation v. Rose, supra, to hold both carriers responsible. The claimant in Rose sustained a compensable knee injury in 1982, followed by a second knee injury in 1984 while working for another insured. Because the two injuries were distinct, the court found that they could be segregated for purposes of allocating responsibility. Id. at 667.

In the instant case, however, claimant did not have two separate injuries involving two separate conditions. Rather, he has sustained progressive hearing loss over a period of many years while working for the same employer. While claimant lost a portion of hearing while each carrier was on the risk, it arose from an ongoing exposure. Moreover, unlike the claimant in Rose, claimant does not have a previously accepted claim. Thus, Rose is distinguishable and does not control.

Medco also contends that because SAIF conceded compensability before the hearing, compensability has been actually determined against SAIF, "with the first actually compensable exposure occurring during the period of SAIF's coverage." Therefore, Medco argues, initial responsibility rests with SAIF, and the last injurious exposure rule does not apply. We disagree. In Castle & Cooke v. Alcantar, 112 Or App 392 (1992), the court noted that "[a] concession of compensability only admits that a claimant's condition resulted from a work exposure. It does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment." Id. at 395. Thus, although SAIF conceded the compensability of claimant's hearing loss, it did not concede that claimant's condition was the responsibility of SAIF.

We conclude that in this case, the last injurious exposure rule, Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), governs the initial assignment of responsibility, for successive insurers of a single employer have contested responsibility for an occupational disease which has not been previously accepted. UAC/KPTV Oregon TV, Inc. v. Hacke, 101 Or App 598, rev den 310 Or 393 (1990); see Fred A. Nutter, 44 Van Natta 854 (1992). Accordingly, we apply the rule.

Under the rule, where a worker proves that an occupational disease is caused by work conditions covered by successive carriers, the last potentially causal employment exposure is deemed responsible for the disease. Boise Cascade Corporation v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which period of employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

In order to shift responsibility to an earlier carrier, the carrier on the risk when claimant became disabled or sought medical treatment must establish that the prior work conditions were the sole cause or that it was impossible for work conditions during the last period of employment to have caused the disease. FMC Corporation v. Liberty Mutual Insurance Co., 70 or App 370 (1984), clarified 73 Or App 223 (1985). If work conditions actually contributed to a claimant's disease while the last insurer was on the risk, however, that insurer cannot avoid responsibility. Multnomah County School District v. Tigner, 113 Or App 405 (1992).

Claimant did not become disabled nor did he seek treatment while SAIF, the first insurer, was on the risk. Claimant filed an 801 form alleging work-related hearing loss on October 31, 1991 and first received medical treatment on November 26, 1991, after Medco came on the risk. Accordingly, responsibility is initially assigned to Medco. See Starbuck, supra. Medco has conceded that noise exposure after it became self-insured was an actual cause of a portion of claimant's hearing loss. We conclude, therefore, that Medco cannot avoid liability under the last injurious exposure rule. See Tigner, supra. Consequently, we find that Medco is solely responsible for claimant's hearing loss, see FMC Corporation v. Liberty Mutual, supra, as well as the attorney fee awarded claimant at hearing.

ORDER

The Referee's order dated August 7, 1992 is affirmed in part and reversed in part. The SAIF Corporation's denial is reinstated and upheld in its entirety. Medco's denial is set aside in its entirety, and the claim is remanded to Medco for processing in accordance with this order. Medco is solely responsible for the Referee's $2,800 attorney fee award. The remainder of the order is affirmed.

In the Matter of the Compensation of
PRESTON E. JONES, Claimant
WCB Case No. 91-13579
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Menashe's order which dismissed his request for hearing from a Director's palliative care order for lack of jurisdiction. On review, the issue is jurisdiction.

We affirm and adopt the Referee's order with the following supplementation. See B.D. Schlepp, 44 Van Natta 1637 (1992); Rexi L. Nicholson, 44 Van Natta 1546 (1992). We decline claimant's invitation to reverse our decision in Rexi L. Nicholson, supra.

Claimant contends that ORS 656.245(1)(b) is unconstitutional because it deprives claimant of a constitutionally protected property interest in palliative care without due process of law. However, claimant's constitutional argument is not adequately developed for our review. Accordingly, we decline to address the issue. See Ronald B. Olson, 44 Van Natta 100, 101 (1992).

ORDER

The Referee's order dated June 26, 1992 is affirmed.

Board member Hooton specially concurring.

Claimant argues that the Board should overrule its prior decision in Rexi L. Nicholson, 44 Van Natta 1546 (1992), because the scheme for review envisioned by that case violates the basic purpose and intent of the workers' compensation system, and renders meaningless the provisions of ORS 656.245(1)(b). As a member of the dissent in that case, I am sympathetic to the claimant's argument, and fervently hope that the court will reverse the Board's error on review.

Claimant further argues that Nicholson should be reversed, because, in light of the Director's rule at OAR 436-10-008(6), the hearing and review scheme of ORS 656.245(1)(b) denies claimant due process of law. While I find the argument satisfactorily developed, the Nicholson majority noted that any constitutional difficulties could be avoided by construing ORS 656.245 to permit the claimant a hearing before the Director.

In Nicholson, the majority concluded that the Board has no jurisdiction to review an order of the Director in a palliative care matter. Consequently, until Nicholson is overturned on review, claimant should address his constitutional argument directly to the Court of Appeals, as an argument that the statute is unconstitutional as applied by the Director, or that the rule is invalid. We have already decided that we are without jurisdiction to consider the argument.

I am fully aware that, in this case, the claimant has not received an order of the Director which is an order in a contested case. Rather, the Director has advised claimant that he is without authority to hold a hearing on a palliative care matter if the hearing is requested by the claimant. However, the Director's letter declining review, would appear to be an appealable order under the provisions of Forelaws on Bd. v. Energy Fac. Siting Council, 303 Or 541 (1987).

In the Matter of the Compensation of
WILLIAM L. KNOX, Claimant
WCB Case No. 92-03832
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Hooton and Lipton.

The SAIF Corporation requests review of that portion of Referee Mongrain's order that increased claimant's unscheduled permanent disability award for a low back condition from 28 percent (89.6 degrees), as awarded by an Order on Reconsideration, to 37 percent (118.4 degrees). On review, the issue is extent of unscheduled permanent disability.

We affirm and adopt the Referee's order, with the following supplementation concerning the value assigned for the adaptability factor, which is the sole issue in dispute.

Claimant became medically stationary on July 17, 1991, and his claim was closed by Notice of Closure on July 31, 1991. The standards in effect on the date of the Notice of Closure or Determination Order control. Thus, the standards that became effective April 1, 1991 apply.

In determining the extent of unscheduled permanent disability, the adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1). Former OAR 436-35-270(3)(h) provides that "'[s]trength' means the physical demands of each job as described by the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT). Prior strength is determined based on the strength category assigned in the SCODDOT for the worker's job at injury." Former OAR 436-35-270(3)(h).

Here, the Referee concluded that "significant elements" of claimant's job at injury included work as a "material handler," which is classified as "very heavy" work by the SCODDOT.[1] SAIF contends that the Referee erred, because the job of "production machine tender" most closely matches claimant's regular work activities prior to his injuries. See DOT #609.685-018. We disagree.

The SCODDOT description of the production machine tender job referred to by SAIF, includes work tasks such as starting the machine, engaging feed, and observing the operation. The production machine tender job falls within the category of medium work. DOT #609.685-018. The material handler job lists a worker's duties as loading, unloading and moving materials. The material handler job falls within the category of heavy work. DOT #929.687-034.

Claimant testified that, approximately 15 times per day, his at-injury job required him to lift 135 pound sacks of dowel pins off the floor. Claimant then carried the sack to the machine, climbed up to the top and emptied the contents of the sack into the machine. Additionally, claimant's prior job also required him to constantly lift 35 to 60 pounds of door parts throughout the workday as he fed the machine's hopper.

Accordingly, even though claimant's job involved some work in the "medium" category as he operated a machine, we conclude that claimant's "regular" job also entailed handling and lifting materials throughout the workday, which constituted work in the "heavy" category. After reviewing the record and claimant's testimony, we therefore disagree with SAIF's contention that lifting and handling materials was an "incidental" part of claimant's job at injury.

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[1] Although the Referee described the material handler job as "very heavy" work, we find that the SCODDOT actually describes the material handler job as falling within the "heavy" category. See DOT #929.687-034. Nonetheless, claimant's adaptability value (from "heavy" to "medium") remains the same. Accordingly, we agree with the Referee's assigned adaptability value of +3. OAR 436-35-310(3).

Furthermore, we have previously noted that there may be more than one DOT that arguably describes a claimant's work, as the DOT's obviously cannot anticipate the variety of duties performed by different workers. See, e.g., Arliss J. King, 45 Van Natta 823 (1993). In the present case, claimant performs aspects of both the machine operator and material handler jobs provided for in the SCODDOT. However, to adopt SAIF's suggested DOT would be to ignore the heavy duties required by claimant's job, as the machine operator position described by the DOT does not include the type of heavy lifting work that is required of this claimant. Moreover, SAIF's approach of placing more importance upon an artificial job title (and the accompanying work capacity), rather than claimant's actual duties and lifting requirements, would result in an inaccurate assessment of claimant's lost earning capacity.

Accordingly, because the adaptability factor is based upon strength demands, we find it reasonable to consider both claimant's job duties and the physical demands of his job in determining a proper DOT to be assigned to his job. Consequently, in the present case, we agree with the Referee's conclusion that "material handler" (DOT #929.687-030) appropriately describes claimant's job at injury. We, therefore, concur with the Referee's adaptability finding.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of claimant's unscheduled permanent disability is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 26, 1992, as reconsidered on August 28, 1992, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by SAIF.

April 30, 1993 Cite as 45 Van Natta 855 (1993)

In the Matter of the Compensation of
MORRIS W. SALTEKOFF, Claimant
Own Motion No. 91-0141M
ORDER DENYING FOURTH RECONSIDERATION OF OWN MOTION ORDER OF DISMISSAL
Martin McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's November 18, 1992 Own Motion Order of Dismissal, our January 7, 1993 Own Motion Order on Reconsideration, and our March 12, 1993 Second Own Motion Order on Reconsideration all of which dismissed as untimely claimant's request for Board review of the SAIF Corporation's September 4, 1992 Notice of Closure. Claimant also requests reconsideration of our March 25, 1993 Order Denying Third Reconsideration. Claimant contends that his October 1992 telephone call to the Board's Own Motion Specialist established a timely request for review of SAIF's Notice of Closure. In the alternative, claimant contends that he has established good cause for his untimely request for review because he relied on his attorney to timely request review of the closure.

After review of claimant's motion, we find no basis to alter our prior conclusions. His contentions were adequately addressed by our prior orders. Accordingly, claimant's request for reconsideration is denied. In any event, we note that our March 25, 1993 Order Denying Third Reconsideration stated that the parties rights of reconsideration and appeal continued to run from the date of our prior order, which was our March 12, 1993 Second Own Motion Order on Reconsideration. Therefore, the parties rights of reconsideration and appeal have expired, and we will not consider further requests for reconsideration of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALTON H. SHOTWELL, Claimant
WCB Case No. 91-04183
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

Claimant requests review of Referee Nichols' order that dismissed claimant's request for hearing on the issue of the reasonableness and necessity of surgery. On review, the issue is jurisdiction and attorney fees. We affirm.

FINDINGS OF FACT

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

By a January 23, 1991 Opinion and Order, a prior referee set aside the January 2, 1990 Determination Order as premature and found the July 25, 1990 aggravation denial to be moot. (Ex. 47A).

On February 7, 1991, claimant's attorney submitted Dr. Berkeley's request for surgery authorization to the insurer. (Ex. 47B).

On February 26, 1991, Drs. Morton and Ellis provided a second opinion on the reasonableness and necessity of surgery. They opined that claimant was not a good surgical risk, concurring with Dr. Franks. They left the question of whether to go forward with the surgery to claimant. (Exs. 48 and 49). Dr. Berkeley did not agree with their report. (Exs. 49A and 50).

On March 22, 1991, claimant again requested authorization of the surgery from the insurer. (Ex. 50A).

On March 29, 1991, the insurer denied the proposed surgery as not being reasonable and/or necessary. The denial included standard language instructing claimant to request a hearing if he disagreed with the denial. (Ex. 51).

On April 5, 1991, claimant's attorney filed a request for hearing on the March 29, 1991 denial letter.

On April 12, 1991, the Medical Review and Abuse Section (MRAS) wrote to Dr. Berkeley, with copies to the parties, as follows:

> "With regard to pre-authorization for surgery:
>
> "If a claimant has an open, accepted claim (which is the case with [claimant]), pursuant to OAR 436-10-070, an attending physician is required to provide the insurer with actual notice at least 7 days prior to the surgery. The insurer then has 7 days to notify the attending physician if a consultation is desired. When requested, the consultation shall be completed within 21 days after notice to the attending physician. Within 7 days of the consultation, the insurer shall notify the surgeon [attending physician] of the consultant's findings. If the attending physician and consultant disagree about the need for surgery, the insurer may inform the claimant of the consultant's opinion. However, the decision as to whether or not to proceed with surgery remains with the attending physician and the claimant. That care does not require pre-authorization or approval from the insurer. When the insurer receives the bill, they have one of three options:
>
> "1) Pay the bill; or
> 2) deny the treatment as being not related to the compensable injury (in which case the denial could be an issue at hearing); or

3) request Director review pursuant to OAR 436-10-046. In this case, the insurer would have to be able to support their position.

"OAR 436-10-046 also provides that either the insurer or the injured worker may request review of the proposed treatment. The insurer can only deny the surgery on the grounds of compensability and they can only challenge the medical necessity through this office." (Ex. 51B).

On April 21, 1991, claimant requested review by MRAS, pursuant to OAR 436-10-046, stating:

"My attending physician Dr. Edward Berkeley has requested the need for surgery which has been denied by [the insurer]." (Ex. 51BB).

On April 23, 1991, claimant's attorney also requested that MRAS review the matter and authorize the surgery. Claimant's attorney noted that the insurer had issued a formal denial on March 29, 1991, indicating that the proposed surgery was not reasonable and/or necessary. (Ex. 51C).

On July 9, 1991, MRAS notified the parties that claimant had requested a hearing on the insurer's partial denial, and stated that, if the Hearings Division determined the denial inappropriate based upon ORS 656.327 and OAR 436-10-046, the issue would be referred to MRAS to determine the appropriateness of treatment. (Ex. 53A).

On August 20, 1991, MRAS notified the parties that it had received a notice of intent to request a medical review of the treatment provided by Dr. Berkeley, and requested the insurer and medical provider to submit to the Director any information they wished to have considered in this review. (Ex. 56). On the same date, MRAS notified the parties that the insurer could not now deny the claim for medical services and gave instructions for the provision and exchange of documents, including a request for a copy of the insurer's denial and identification of the issues being litigated before the Hearings Division. (Ex. 57).

On September 10, 1991, claimant wrote to MRAS, referring to its prior refusal to review the matter and notifying it that the issue of the denial was before the Hearings Division. (Ex. 58).

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing, on the basis that the Director, not the Hearings Division, has jurisdiction over the issue of the reasonableness and necessity of the surgery. On reconsideration, the Referee declined to award claimant's attorney an assessed attorney fee pursuant to ORS 656.386(1) because he had not been instrumental in obtaining compensation for claimant.

On review, claimant argues that the Hearings Division has jurisdiction over the denial and that claimant's counsel should be awarded an attorney fee under ORS 656.386(1) for preventing the denial from becoming final. Alternatively, claimant argues that, if the Director has exclusive jurisdiction, then the insurer's issuance of a denial letter constituted an unreasonable resistance to payment of compensation pursuant to ORS 656.382, and claimant's counsel should be awarded an attorney fee pursuant to that statute.

Jurisdiction

We affirm the Referee's opinion on this issue with the following supplementation. Subsequent to the Referee's order, we concluded in Stanley Meyers, 43 Van Natta 2463 (1991), that a denial of medical treatment subject to the Director's jurisdiction under ORS 656.327(1) is "null and void as a matter of law" and the Hearings Division is without authority to hold a hearing concerning that null and void denial.

Attorney Fees

We affirm the Referee's order declining to award an assessed fee under ORS 656.386(1), with the following supplementation. Subsequent to the Referee's order, we also decided that, where a denial of

a claim is legally without effect, a declaration of invalidity by a referee is unnecessary. Thus, claimant is not entitled to an assessed attorney fee pursuant to ORS 656.386(1). See Candy M. Kayler, 44 Van Natta 2424 (1992). Moreover, at the time of the Referee's order, the appropriateness of the surgery (and, thus, claimant's entitlement to it) had not yet been determined by MRAS.

Claimant argues that his counsel is entitled to an attorney fee pursuant to ORS 656.382(1) for services reasonably necessary to obtain the invalidation of the illegal denial, on the basis that, by issuing such a denial, the insurer has unreasonably resisted the payment of compensation. We disagree.

Claimant has not requested a penalty under ORS 656.262(10). Nevertheless, where there is "unreasonable resistance to the payment of compensation" under ORS 656.382(1), an attorney fee may be awarded to claimant's attorney. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Here, the insurer issued its partial denial on March 29, 1991, and claimant requested Director review on April 21, 1991. On those dates, the issue was unsettled as to whether a carrier should issue a denial of the reasonableness and necessity of treatment and go to hearing, or request Director review, or both. The record indicates that, prior to hearing, there was a discussion between the Referee and the parties regarding whether or not the Referee had jurisdiction to hear the matter or whether the Director had exclusive jurisdiction under ORS 656.327. The Referee determined at that time that she did have jurisdiction to hear the matter and the hearing went forward on the merits. Although the Referee decided in her October 18, 1991 order that she did not have jurisdiction over the matter after all, the jurisdictional issue was not settled until we issued Stanley Meyers, supra, on December 6, 1991. In Meyers, we rejected the contention that concurrent jurisdiction lay with the Hearings Division and the Director and concluded that the Director had exclusive jurisdiction over the reasonableness and necessity of medical treatment.

For this reason, we do not believe that the insurer's issuance of a denial of the reasonableness and necessity of the requested surgery, or its failure to withdraw its denial after Director review was requested, was unreasonable resistance to the payment of compensation. Further, inasmuch as claimant's entitlement to the surgery had not yet been established by MRAS, there is no basis for finding an unreasonable resistance to compensation. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991). Accordingly, we decline to award claimant an attorney fee pursuant to ORS 656.382(1).

ORDER

The Referee's order dated October 18, 1991, as reconsidered November 20, 1991, is affirmed.

Board member Hooton concurring and dissenting.

I agree with the majority resolution of the issue whether the Board or the Hearings Division has jurisdiction to decide whether claimant's proposed surgery is reasonable and necessary. The majority also determines that claimant is not entitled to an attorney fee pursuant to ORS 656.386(1). I agree that claimant is not so entitled, since he has not finally established a right to the medical services at issue. I disagree, however, with the majority's conclusion that claimant is not entitled to an attorney fee pursuant to ORS 656.382(1).

In his Appellant's Brief claimant argued as follows:

> "If it is held that the Medical Director has exclusive jurisdiction, issuance of a denial letter constitutes an unreasonable resistance to payment of compensation pursuant to ORS 656.382. An attorney fee is also awardable under the terms of that statute for unreasonable denial to the extent the denial issued without jurisdiction and in violation of law." (App. Br. at 5).

The insurer did not respond to this argument, or to any argument regarding claimant's entitlement to attorney fees. I find the argument especially persuasive, and offer the following analysis.

ORS 656.327 controls any action for the determination of whether proposed medical services are reasonable and necessary. ORS 656.327(1)(c) provides specifically that "[t]he insurer or self-insured employer shall not deny the claim for medical services." ORS 656.262(6), however, requires written notice of acceptance or denial within 90 days. These two provisions can be reconciled only by requiring the insurer either to authorize or pay for medical services within 90 days of the receipt of a claim, or to request Director review pursuant to ORS 656.327 within that same period. A denial may issue only if the insurer asserts that the claim for medical services is not related to the injury, an issue over which the Board continues to retain jurisdiction. See Michael A. Jaquay, 44 Van Natta 173 (1992).

The language of the statute is not ambiguous, and the insurer's conduct must be held to its terms. If the insurer took the position that the Director did not have jurisdiction, as in Stanley Meyers, 43 Van Natta 2463 (1991), the question would then become whether it had a reasonable doubt that jurisdiction, in fact, lies with the Director. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). That is not the case here, where it is the insurer who asserted at hearing that the Referee lacked jurisdiction to try the case. (O&O at 2).

The Board has determined that a denial of reasonableness and necessity is invalid where claimant requests a hearing on that denial within the time allowed by law. The Board has not yet decided what effect to give to a denial of the reasonableness and necessity of medical services when the denial has become final as a matter of law. At this point in time, due diligence requires that claimants obtain representation and invalidate those illegal denials when they occur.

The majority cites Candy M. Kayler, 44 Van Natta 2424 (1992), for the proposition that an invalid denial can have no effect as a matter of law, and that claimant's attorney has provided no benefit to his client in setting it aside. However, Kayler is limited to its own facts, and relates only to an attorney fee pursuant to ORS 656.386(1). No fee was awarded because there was no evidence that the insurer relied or intended to rely on the invalid denial. Here, the insurer issued a denial in violation of law, in and of itself an act that provides strong evidence of unreasonable resistance to the payment of compensation, and then, while denying the jurisdiction of the Hearings Division to hear the claim, failed to withdraw the denial. Its continued failure to comply with the law at a point at which it asserted a defense based on ORS 656.327, which it sought to apply, is irrefutable evidence that the insurer continued to assert the appropriateness of its actions, despite the applicable statute. The insurer did not withdraw the denial. Neither was the denial rendered null or invalid by an act subsequent to issuance. It was an illegal denial at the time of issuance and at all times subsequent thereto.

Claimant is entitled to an attorney fee pursuant to ORS 656.382(1) in an amount sufficient to compensate his attorney for services reasonably necessary to obtain the invalidation of the illegal denial issued by Liberty Northwest. Neither the majority, nor the Referee, address this issue raised by claimant. By failing to address the issue, the majority errs. By failing to compensate claimant's attorney for his effort in invalidating the illegal conduct of the insurer, the majority further delays the day when insurers regularly and efficiently meet the requirements of the statute, and, in so doing, deprive claimants of the assurance of timely and appropriate processing of their claims.

In the Matter of the Compensation of
RICK L. WATSON, Claimant
WCB Case No. 91-17345
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Hooton and Lipton.

The SAIF Corporation requests review of Referee Galton's order which awarded claimant an assessed attorney fee for his counsel's services in obtaining a pre-hearing rescission of a "de facto" denial of medical services (transportation). On review, the issue is attorney fees.

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

Subsequent to the Referee's order, we held that attorney fees under ORS 656.386(1) are available only if causation is in dispute; that is, if the causation issue was actually raised by a party. Gloria J. Shelton, 44 Van Natta 2232 (1992); see also O'Neal v. Tewell, 119 Or App 329 (1993).

Here, we agree with the Referee's determination that the causal relationship between claimant's compensable injury and his request for repair or replacement of his van was in dispute until June 12, 1992, when SAIF's counsel specifically advised in writing that "compensability" was not an issue. (See Ex. 45). Initially, SAIF had taken the position it was no longer responsible for repair or replacement of claimant's van, and claimant requested the Department's Medical Review and Abuse Unit (MRAU) to resolve the issue. (Ex. 42). MRAU concluded that SAIF was contesting "compensability" and advised claimant's counsel that the Board's Hearings Division has jurisdiction over the dispute. (Ex. 43). Claimant requested a hearing from SAIF's "de facto" denial of the compensability of medical services. Under these circumstances, we conclude that causation was actually in dispute and assessed attorney fees may be awarded under ORS 656.386(1). See Gloria J. Shelton, supra; O'Neal v. Tewell, supra.

SAIF also contends that claimant's hearing request should have been dismissed for lack of jurisdiction because it was premature. We disagree. Even if claimant's original hearing request was premature, SAIF did not move to dismiss claimant's request for hearing on that basis. (Rather, it contended that jurisdiction rested with the Director). We conclude that SAIF waived any procedural error regarding claimant's premature request for hearing. Therefore, the Hearings Division had jurisdiction over this matter. See Thomas v. SAIF, 64 Or App 193 (1983).

Since attorney fees do not constitute compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 22, 1992, as reconsidered July 27, 1992, is affirmed.

In the Matter of the Compensation of
JULIE K. GASPERINO, Claimant
WCB Case Nos. C3-00387 & C3-00621
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

On February 16, 1993, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Here, the proposed agreement involved two claims with one date of injury, however, the parties provided only one summary page. The rules provide that, when two claims are being disposed of, each claim disposition must consist of a summary page containing all the information required by the rule for each claim, including the total amount due to the attorney and the total due claimant. See OAR 436-60-045 (1) and (3).

Consequently, by letter of March 11, 1993, we requested an addendum to correct this matter. The parties have not submitted the addendum within the 21-day time period, as required by OAR 438-09-020(2)(a). Under the circumstances, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2)(b). Accordingly, we decline to approve the agreement and we therefore return it to the parties.

Finally, we note that on April 8, 1993, claimant's letter requesting disapproval of the CDA was filed with the Board. The statute provides, however, that a claimant may request disapproval within 30 days of submitting the disposition for approval. ORS 656.236(1)(c). Here, claimant's request for disapproval is well beyond the 30-day period provided for by the statute. Accordingly, we find that we have no authority to grant claimant's request for disapproval under such circumstances. Nonetheless, because the requested addendum has not been submitted by the parties, we disapprove the CDA for the reasons mentioned above.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD C. EARL, Claimant
WCB Case Nos. 92-02579, 92-02578 & 92-00714
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Lipton.

Claimant requests review of those portions of Referee Mills' order that: (1) upheld Argonaut Insurance's denial, on behalf of Air Freight Services, of claimant's claim for a current psychological condition as related to an accepted 1981 back injury claim; and (2) did not award penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are compensability, penalties and attorney fees.

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

Claimant's noncompensable personality disorder preexisted his compensable knee and back injuries, which occurred in 1978 and 1981, respectively. Following the work injuries, claimant suffered several temporary symptomatic exacerbations of the preexisting psychological disorder. On several occasions prior to the present claim, such worsenings resulted in hospitalization and treatment for drug or alcohol addiction. Claimant sought Workers' Compensation benefits and two exacerbations were found to be compensable consequences of one or both of the work injuries under the "material contributing cause" standard. See Ronald C. Earl, 42 Van Natta 892 (1990), aff'd mem 105 Or App 635 (1991); Ronald C. Earl 42 Van Natta 5 (1990); Ronald C. Earl, 41 Van Natta 530 (1989). However, no such claim was found to be causally related to a prior exacerbation. In each instance, the temporary worsening resolved.

Claimant's current claim is similar to his prior claims. Again, he claims a worsened psychological condition, characterized by a need for treatment for addiction. Again, the claimed consequential worsening is factually disconnected from prior, albeit similar, exacerbations. Specifically, claimant now argues that his 1991 attempted return-to-work caused low back pain, which in turn caused him to self-medicate with heroin. Once again, claimant's allegedly consequential drug usage caused him to need treatment for addiction. Under these circumstances, we agree with the Referee that the "major contributing cause" standard applies to the present case. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

On the merits, we acknowledge that Dr. Turco's opinion may be understood to suggest that the compensable back injury is a material contributing cause of claimant's recently worsened psychological problems. However, Turco also clearly opined that the preexisting personality disorder is the major contributing cause of these problems. On this evidence, we agree with the Referee that claimant did not carry his burden of proof.

ORDER

The Referee's order dated June 19, 1992 is affirmed.

In the Matter of the Compensation of
KATHY M. ARCHER, Claimant
WCB Case No. 91-04167
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our March 12, 1993 Order on Review that: (1) reversed a Referee's order that found that res judicata barred litigation of the issues of reclassification and aggravation; (2) found that medical reports received by the SAIF Corporation within one year from the date of claimant's injury constituted a claim for reclassification; (3) remanded the matter to SAIF to be reported to the Director for purposes of classification; and (4) awarded claimant an out-of-compensation attorney fee.

Specifically, claimant contends on reconsideration that SAIF's failure to process the claim was an unreasonable resistance to the payment of compensation, which entitles her to an attorney fee pursuant to ORS 656.382(1). Furthermore, claimant's accompanying "Petition for Attorney Fees" asserts an entitlement to an assessed attorney fee pursuant to ORS 656.386(1).

In order to further consider claimant's motion, we withdrew our March 12, 1993 order. Having received SAIF's response, we proceed with our reconsideration.

Claimant first contends that she is entitled to an assessed attorney fee pursuant to ORS 656.382(1) because SAIF unreasonably failed to report her claim to the Director for classification pursuant to ORS 656.277(1). Claimant argues that, even if SAIF was relying upon a July 11, 1990 stipulation which barred claimant's request for hearing, SAIF's failure to act prior to July 11, 1990 was unreasonable.

SAIF contends that prior Board cases suggested that notice from a physician is not sufficient notice of a request for reclassification to obligate the insurer to report the claim to the Director. See Timothy Schroeder, 41 Van Natta 568 (1989). SAIF argues that, even though it received Dr. Cummings' reports, based upon Schroeder, supra, it was not unreasonable for SAIF to believe that it had no obligation to report claimant's claim to the Director. SAIF contends that the Schroeder case implied that it was claimant's duty to request a determination of the proper classification.

We agree that, although the Schroeder rationale was subsequently disavowed in Linda Warner, 43 Van Natta 159 (1991), at the time SAIF received Dr. Cummings' reports, it was not unreasonable for SAIF to decline to report claimant's claim to the Director, based upon Schroeder. Accordingly, because we find that SAIF had a legitimate doubt as to its duty to refer claimant's claim, we conclude that its actions were not unreasonable, and there is no basis for an attorney fee pursuant to ORS 656.382(1).

Claimant next contends that she is entitled to an assessed attorney fee pursuant to ORS 656.386(1). However, in Mindi M. Miller, 44 Van Natta 1671 on recon 2144 (1992), we held that we are not authorized to award attorney fees to a claimant's counsel who is instrumental in obtaining claim reclassification by the Director. We conclude that Miller is applicable in the present case, and no insurer-paid attorney fee is available for claimant's counsel's services pursuant to ORS 656.386(1).

Accordingly, we withdraw our March 12, 1993 order. On reconsideration, as supplemented herein, we adhere to and republish our March 12, 1993 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
PATRICIA A. BURNS, Claimant
WCB Case No. 92-05591
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Baker's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issues are compensability and responsibility. We vacate the Referee's order and remand.

Prior to the hearing, claimant filed a federal workers' compensation claim for bilateral carpal tunnel syndrome arising out of her work with the U.S. Forest Service. Subsequent to the hearing, on January 21, 1993, the federal claim was accepted.

The insurer has filed a Motion to Remand to the Referee on the basis that claimant's claim for bilateral carpal tunnel syndrome has now been accepted by the Federal Office of Workers' Compensation Programs. With the motion, the insurer has submitted additional materials concerning claimant's federal claim. All of the submitted materials were generated subsequent to the date of the hearing. Claimant has no objection to the insurer's motion.

We may remand for further evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Oregon Workers' Compensation law provides that if a current state claim is covered by federal workers' compensation law, claimant is a nonsubject worker for purposes of Oregon law. ORS 656.027(4); Mann v. SAIF, 91 Or App 715. Here, the Referee was aware that a federal claim was pending, but it had not been accepted or denied at the time of hearing. Because of that status, the Referee concluded that the federal claim was not a bar to the Oregon claim. Subsequent to the issuance of the Referee's order, the insurer has submitted materials which indicate that the federal claim was accepted.

In light of these circumstances, we consider the current record to be incompletely and insufficiently developed. See ORS 656.295(5). Moreover, we conclude that the proferred evidence was not obtainable at the time of hearing and is reasonably likely to affect the outcome of the case. Finally, considering that the proferred evidence pertains to claimant's status as a subject worker, we conclude that there are compelling reasons to remand the case to the Referee.

Accordingly, we vacate the Referee's order and remand the case to Referee Baker. The Referee is instructed to admit any additional documentary or testimonial evidence the parties wish to offer which the Referee considers relevant to the issues raised in this case. The proceedings to admit this evidence shall be conducted in any manner that the Referee finds achieves substantial justice and will insure a complete and accurate record of all exhibits, examination and/or testimony. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated December 29, 1992 is vacated. This matter is remanded to Referee Baker for further proceedings consistent with this order.

In the Matter of the Compensation of
DARRELL R. EVANS, Claimant
WCB Case No. 91-10991
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee Gruber's order that found claimant's claim for a psychological condition was prematurely closed. Claimant cross-requests review of that portion of the Referee's order which awarded an approved attorney fee, not to exceed $1,050. Claimant contends his counsel is entitled to an extraordinary approved attorney fee. On review, the issues are premature closure and attorney fees.

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

In support of his contention that his counsel is entitled to an extraordinary fee, claimant relies on OAR 438-15-025. However, that provision applies only to approved attorney fees granted in settlement of disputed claims or claim disposition agreements and in cases under third party law. It does not apply in situations such as the present case where claimant has requested a hearing and has been successful in overturning a closure order as premature. OAR 438-15-045; Dianne M. Bacon, 43 Van Natta 1930 (1991); Earl F. Childers, 40 Van Natta 481, 485 (1988). Accordingly, we decline to grant claimant's request.

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 $975, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 31, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $975, payable by the self-insured employer.

In the Matter of the Compensation of
MARCIA R. LEONARD, Claimant
WCB Case No. 92-04867
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Daughtry's order which affirmed the January 22, 1992 Order on Reconsideration that awarded no scheduled permanent disability for claimant's right ring finger and left middle finger injuries. On review, the issue is extent of scheduled permanent disability.

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

Here, claimant explicitly did not object to the impairment findings used in rating her disability at the time of claim closure. (Ex. 12). Therefore, no medical arbiter was appointed.

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). 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); Kathy Bott, 44 Van Natta 2366 (1992).

Here, Dr. Warren, M.D., was claimant's attending physician at claim closure. On August 28, 1991, Dr. Warren found claimant medically stationary without permanent partial disability. (Ex. 8). On December 17, 1991, claimant was examined by Dr. Anderson, M.D., apparently at her attorney's request. (Ex. 10A, 11). However, there is no evidence that Dr. Warren concurred with, or even reviewed, Dr. Anderson's findings. Consequently, the Referee correctly did not consider Dr. Anderson's report in determining claimant's impairment.

In asserting that Dr. Anderson's findings 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." In Kathy Bott, supra, we found that, 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). In other words, the reference to "medical opinion" is limited (where no medical arbiter is involved) to those reports with which the attending physician concurred. Kathy Bott, supra. Here, as noted above, there is no evidence that Dr. Warren concurred with Dr. Anderson's report.

ORDER

The Referee's order dated July 14, 1992 is affirmed.

In the Matter of the Compensation of
BARBARA A. LUCKER, Claimant
Own Motion No. 91-0259M
OWN MOTION ORDER
Francesconi & Busch, Claimant Attorneys
Terrall & Associates, Defense Attorneys

The self-insured employer submitted claimant's claim for an alleged worsening of her February 9, 1984 compensable low back injury. Claimant's aggravation rights expired on May 29, 1990.

On May 30, 1991, claimant requested a hearing on the employer's "de facto" denial of the compensability of her May 9, 1991 L5-S1 surgery. (WCB Case No. 91-06716). On September 13, 1991, the Board issued an order postponing action on the own motion matter pending resolution of the litigation regarding compensability. On June 30, 1992, Referee Podnar issued an order in WCB Case No. 91-06716 in which he found the L5-S1 surgery compensably related to the February 9, 1984 low back injury. The employer appealed that order. On February 11, 1993, the Board affirmed Referee Podnar's order. On the basis of the February 11, 1993 Board order, we find that claimant has established a worsening of her compensable low back condition which required surgery. However, the employer also opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

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 making reasonable efforts to find work; or (3) not working but willing to work, but is not making reasonable efforts to find work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). A worker who has voluntarily withdrawn from the work force at the time of the worsening is not entitled to temporary disability benefits. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). Claimant has the burden of proof on the work force issue.

Claimant argues that the time to determine whether she was in the work force is at the time of her aggravation, which she defines as the date of her surgery on May 9, 1991. Claimant argues that, at that time, she was unable to work due to the compensable injury. Claimant cites Michael K. Jones, 44 Van Natta 1817 (1992), for her proposition. However, Jones does not support claimant's proposition. In fact, Jones is inopposite in that it involves the issue of diminished earning capacity as an element of an aggravation claim, not the issue of being in the work force as a requirement for entitlement to temporary disability.

We find that claimant's condition worsened at the time she first sought medical treatment in March 1991. On March 28, 1991, claimant sought medical treatment from Dr. Jenks, M. D., for her low back and right leg pain. (Ex. A-1). Claimant did not respond to conservative treatment and Dr. Jenks noted that she remained essentially incapacitated with low back and right leg pain. Id. On May 1, 1991, Dr. Jenks referred claimant to Dr. Masferrer, M. D., for a surgical opinion. On May 9, 1991, claimant underwent low back surgery. We find that Dr. Jenks' May 15, 1991 report establishes that claimant's condition worsened as of March 28, 1991, when she first sought medical treatment for her low back and right leg pain. (Ex. A). Therefore, the relevant date as to whether claimant was in the work force is March 28, 1991. Weyerhaeuser v. Kepford, supra.

There is no evidence in the record that claimant was gainfully employed, made a reasonable job search, or that such a job search was made futile by her compensable injury as of March 28, 1991. Although the record establishes that claimant was unable to work because of the compensable condition subsequent to the March 1991 worsening, it does not establish that claimant was in the work force at the time of that worsening. In fact, claimant has not worked since February 1990 when she left her job as a front desk clerk at Ramada Inn. (Exs. B-30 through -32, C-6, -8). Thus, claimant was out of the work force for more than a year before her condition worsened. Furthermore, there is no evidence that she had returned to the work force at the time of her worsening.

Claimant's former supervisor and the general manager at the Ramada Inn job were deposed for the hearing on WCB Case No. 91-06716, and reported that claimant told them that she left the Ramada Inn job to take a position as an apartment manager. (Exs. C-8, -16, D-11). However, claimant submitted no evidence regarding any employment as an apartment manager.

On this record, we find that claimant has not established that she was in the work force at the time of her disability. Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

May 4, 1993 Cite as 45 Van Natta 868 (1993)

In the Matter of the Compensation of
DONALD G. MUNSTER, Claimant
Own Motion No. 93-0072M
OWN MOTION ORDER ON RECONSIDERATION
Douglas L. Minson, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our February 12, 1993 Own Motion Order that reopened claimant's claim for temporary disability compensation beginning the date he was to be hospitalized for surgery. SAIF contends that it recommended reopening claimant's claim for temporary disability benefits in error because, although claimant's current condition is compensable, he does not require surgery or hospitalization.

In order to consider SAIF's motion, we withdrew our February 12, 1993 order and granted claimant an opportunity to respond to the motion. Claimant's response has been received. After further consideration, we issue the following 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 interpret "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. Fred E. Smith, 42 Van Natta 1538 (1990). The record contains no request for surgery or any indication that claimant has undergone surgery. Although claimant has had several tests, none of them involved inpatient or outpatient surgery or hospitalization. On October 12, 1992, claimant had an MRI of his cervical spine. On December 15, 1992, claimant had a cervical myelogram which was performed at the Emanuel Hospital & Health Center. However, this procedure did not involve surgery. Moreover, because the procedure did not require an overnight stay in the hospital, we do not regard the procedure as "hospitalization" sufficient to justify claim reopening. Fred E. Smith, supra. Finally, on January 20, 1993, Caremark Comp, SAIF's MCO, approved a request for the purchase of a spinal bone growth stimulator for claimant made by Dr. Misko, claimant's treating neurologist. However, there is no indication that application of this spinal growth stimulator requires surgery.

Accordingly, the record submitted to us fails to demonstrate that claimant has undergone or requires surgery or hospitalization in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim. Therefore, we deny the request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN P. LAMBERT, Claimant
WCB Case Nos. 90-21305 & 90-21162
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Liberty Northwest Insurance Corporation requests reconsideration of our March 12, 1993 Order on Review, as reconsidered April 7, 1993, which held that it, on behalf of West Coast Steel, is responsible for claimant's protruding discs and foraminal stenosis. Claimant has responded, contending that Liberty's request for reconsideration is untimely.

In order to further consider this matter, we withdraw our prior orders. The parties are granted a further opportunity to submit supplemental briefs regarding the issues presently pending before the Board. To be considered, each party's supplemental brief must be received within 14 days from the date of this order. Thereafter, the Board will proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN A. COFFMAN, Claimant
WCB Case No. 92-05043
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of that portion of Referee Nichols' order which declined to award an assessed attorney fee pursuant to ORS 656.386(1) for his counsel's services in a hearing where the sole issue was subjectivity. On review, the issue is attorney fees.

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

Attorney fees may only be awarded as specifically authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). An assessed attorney fee may be awarded pursuant to ORS 656.386(1) when a claimant finally prevails over a denial of the compensability of a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988); see also O'Neal v. Tewell, 119 Or App 329 (1993); Gloria J. Shelton, 44 Van Natta 2232 (1992). Here, the hearing did not address the merits of the compensability of the claim. The Referee was only authorized to consider the issue of whether claimant was a subject worker at the time of his injury. OAR 438-06-038. Accordingly, we find that the Referee did not err in declining to award an assessed attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services at the subjectivity hearing.

ORDER

The Referee's order dated August 31, 1992 is affirmed.

In the Matter of the Compensation of
WILLIAM D. FOSTER, Claimant
WCB Case No. 92-03347
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Gruber's order that: (1) increased claimant's scheduled permanent disability award for loss of the left middle finger from 65 percent (14.3 degrees), as awarded by Order on Reconsideration, to 70 percent (15.4 degrees); (2) increased claimant's scheduled award for loss of the left little finger from 58 percent (3.48 degrees), as awarded by Order on Reconsideration, to 68 percent (4.08 degrees); (3) affirmed the Order on Reconsideration award of 23 percent (11.04 degrees) scheduled disability for loss of the left thumb and 63 percent (6.3 degrees) for loss of the left ring finger; and (4) authorized the insurer to offset an overpayment of permanent partial disability. On review, the issues are extent of scheduled permanent disability 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

Extent of Scheduled Permanent Disability

Middle Finger

We adopt the Referee's reasoning and conclusions concerning the extent of claimant's scheduled disability for loss of his left middle finger.

Little Finger

We adopt the Referee's reasoning and conclusions concerning the extent of scheduled permanent disability for loss of his little finger.

Left Thumb

We apply the disability rating standards in effect on the date of the August 20, 1991 Determination Order. (WCD Admin. Order 2-1991). The Referee awarded claimant 5 percent each for loss of opposition due to partial amputations of the ring and little fingers pursuant to former OAR 436-35-040(3). The Referee also awarded claimant 15 percent for loss of opposition due to amputation of the left middle finger below the distal interphalangeal (DIP) joint.

Former OAR 436-35-040(3) provided that the value for loss of opposition for an amputation of the ring or little finger at the distal interphalangeal joint is 5 percent. The rule further provided that for amputations which are not exactly at the joints, the ratings are adjusted in steps of 5 percent, increasing as the amputation gets closer to the attachment to the hand and decreasing as it gets closer to the fingertips. See, e.g., Lori S. Pratt, 42 Van Natta 1814 (1990).

Although the amputation of all three fingers was initially through the distal interphalangeal (DIP) joint, in order to treat the injuries, the surgeon was required to shorten all three fingers by 2 or 3 millimeters below the joint. Thus, the fingers were not amputated exactly at the DIP joint. Under such circumstances, we conclude that claimant is entitled to an additional 5 percent for a total of 10 percent each for the left ring and little fingers. In addition, we conclude that the Referee correctly awarded claimant 15 percent for loss of opposition due to amputation of the left middle finger. Former OAR 436-35-040(3) provides for a rating of 10 percent for loss of opposition of the middle finger due to an amputation at the distal interphalangeal joint. Since the amputation was below the DIP joint, claimant was entitled to an additional 5 percent, for a total of 15 percent.

The values for loss of opposition due to amputations of the left middle, ring and little fingers are combined to total 32 percent (15.36 degrees). Former OAR 436-35-040(4).

Ring Finger

We adopt the Referee's reasoning and conclusions concerning the extent of scheduled permanent disability for loss of his ring finger.

Offset

We adopt the Referee's reasoning and conclusions concerning the offset issue.

ORDER

The Referee's order dated August 5, 1992 is modified in part and affirmed in part. In addition to the Referee and Order on Reconsideration awards of scheduled permanent disability for the loss of the left thumb, claimant is awarded 9 percent (4.32 degrees), which gives him a total award of 32 percent (15.36 degrees) scheduled permanent disability for loss of the left thumb. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, provided the total of fees awarded by the Referee and Board orders does not exceed $3,800. The remainder of the order is affirmed.

May 6, 1993 Cite as 45 Van Natta 871 (1993)

In the Matter of the Compensation of
MARTA I. GOMEZ, Claimant
WCB Case No. 92-00327
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Thye's order that upheld the self-insured employer's denial of her aggravation claim. In her brief, claimant contends that the Referee erred in declining to admit Exhibits 18A and 18B into the record. On review, the issues are evidence and aggravation.

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

Claimant contends that the Referee erred in failing to admit Exhibits 18A and 18B into the record. The documents at issue are untranslated foreign language medical reports. Because the physician who authored the report was not available for cross-examination by the insurer and no notice was provided that the reports would be offered, we agree with the Referee that Exhibits 18A and 18B were properly excluded. ORS 656.310(2).

ORDER

The Referee's order dated June 1, 1992 is affirmed.

In the Matter of the Compensation of
JACQUELINE R. INGRAM, Claimant
Own Motion No. 93-0101M
OWN MOTION ORDER ON RECONSIDERATION
Francesconi & Busch, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's April 7, 1993 Own Motion Order that denied the reopening of her claim for temporary total disability compensation on the ground that claimant failed to demonstrate that her treating physician is currently seeking authorization for surgery now or in the near future. With her request for reconsideration, claimant submits a copy of an April 16, 1993 evaluation from Dr. Berkeley, claimant's treating physician, in which he states that claimant remains in need of surgical treatment of her canal stenosis at L3-4 and L4-5.

In October of 1990, Dr. Berkeley requested authorization for surgery which was denied by the SAIF Corporation. Claimant requested a hearing, WCB Case No. 91-00265. On May 12, 1992, the Referee issued an Opinion and Order that found claimant's current low back condition compensable and set aside the December 3, 1990 denial. SAIF requested Board Review. On January 29, 1993, the Board affirmed the Referee's Opinion and Order.

On March 4, 1993, the Board received SAIF's recommendation that the Board reopen claimant's claim for temporary total disability compensation for a proposed surgery. In its recommendation, SAIF agreed that: (1) claimant's compensable low back injury worsened requiring surgery; (2) the surgery was reasonable and necessary; and (3) claimant was in the work force at the time of the current worsening. However, on April 7, 1993, the Board issued an order which denied reopening the claim for own motion relief on the basis that the most recent correspondence in the record from Dr. Berkeley indicated that he had not examined claimant since July 1991 and, for that reason, could not report on her current condition or current need for treatment.

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.

The April 16, 1993 evaluation from Dr. Berkeley establishes that claimant requires surgery in the near future for her compensable low back condition. Accordingly, we conclude that claimant has sustained a worsening of her compensable condition which requires surgery. On that basis, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date she is hospitalized for her low back surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESA J. LESTER, Deceased, Claimant
WCB Case No. TP-90061
THIRD PARTY DISTRIBUTION ORDER ON REMAND
Goldberg & Mechanic, Claimant Attorneys
Lundeen, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corporation v. Golden, 116 Or App 64 (1992). The court has reversed our prior order, Theresa J. Lester, (Dec'd), 43 Van Natta 338 (1991), which held that Liberty Northwest's third party lien for each specific workers' compensation beneficiary was recoverable only from that particular beneficiary's share of the third party settlement. Reasoning that the distribution of third party settlement proceeds under ORS 656.593 is to the beneficiaries as a class rather than as individuals, the court held that there is a single lien and a single third party settlement. Inasmuch as we used the wrong legal standard in determining a "just and proper" distribution of third party settlement proceeds, the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the Findings of Fact contained in our February 20, 1991 order.

CONCLUSIONS OF LAW

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

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). 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).

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b).

The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 and 656.794. See ORS 656.593(1)(c). Following the aforementioned distribution of a third party recovery, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

In our prior order, we concluded that, since the claim costs for each specific beneficiary could be identified, it was "just and proper" that the lien for each beneficiary be recovered solely from that beneficiary's share of the third party settlement. We reasoned that 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 the settlement.

The court has subsequently determined that since the third party settlement resolved an action brought for the benefit of persons who were workers' compensation beneficiaries, the distribution of settlement proceeds is to those beneficiaries as a class not as individuals. Liberty Northwest Insurance Corp. v. Golden, supra, at page 68. In other words, the court has ruled that there is a single lien and a single third party settlement. Id.

Considering the court's reasoning that this particular third party settlement is subject to a single lien, our prior concerns regarding the propriety of permitting Liberty Northwest to recover

reimbursement for one beneficiary's claim costs from another beneficiary's share of the settlement have proven to be ill-founded. In essence, the court has concluded that, since all beneficiaries of the settlement are also beneficiaries under the workers' compensation act, Liberty Northwest's lien attaches to the entire settlement, irrespective of each beneficiary's particular share of the settlement. Thus, after distribution of claimant's attorney fee, litigation costs, and statutory 1/3 share, we apply Liberty Northwest's lien to the remaining balance of the settlement (as if that balance was not apportioned to a particular beneficiary). Moreover, consistent with our longstanding policy of avoiding distributions on an ad hoc basis, we adhere to our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1). Consequently, we proceed with our analysis.

We previously found that Liberty Northwest was entitled to reimbursement from the third party settlement for the following claim costs for the children: $13,903 for Sarah; and $12,929 for Jeromy. The court has held that there is substantial evidence to support our determination. Liberty Northwest Ins. Corp. v. Golden, supra, at page 69. Consequently, our prior finding shall not be disturbed.

Turning to a determination of Liberty Northwest's projected claim costs for the surviving spouse, we note that the amount of its lien for those future expenses has not been contested. Considering such circumstances, we conclude that it is "just and proper" for Liberty Northwest to recover $113,186 from the remaining balance of the third party settlement as reimbursement for its claim costs attributable to the surviving spouse.

In conclusion, we find the following distribution of third party settlement proceeds to Liberty Northwest is "just and proper" under ORS 656.593(3). Liberty Northwest's actual claim costs for each beneficiary incurred as of December 1, 1990, plus $140,018 (surviving spouse's projected costs of $113,186 + Sarah's projected costs of $13,903 + Jeromy's projected costs of $12,929). It is unclear whether the remaining balance of the third party settlement (after distribution of claimant's attorney fee, litigation expenses, and 1/3 statutory share are distributed) meets or exceeds Liberty Northwest's recoverable lien. In any event, if Liberty Northwest's lien exceeds the remaining balance, claimant's attorney shall forward the entire balance to Liberty Northwest. On the other hand, if the remaining balance exceeds Liberty Northwest's lien, claimant's attorney shall satisfy Liberty Northwest's lien and forward the remainder to claimant.

IT IS SO ORDERED.

May 6, 1993 Cite as 45 Van Natta 874 (1993)

In the Matter of the Compensation of
RICHARD J. MESSMER, Claimant
WCB Case No. 91-12265
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hooton and Lipton.

Claimant requests review of Referee Hazelett's order which upheld the insurer's denial of claimant's aggravation claim for a neck condition. On review, the issue is aggravation.

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

Claimant contends that preexisting degenerative disease in the cervical spine is a compensable part of his claim, based on the insurer's conduct after it became aware of the degenerative condition. Claimant contends that by authorizing surgery to treat the degenerative condition and by failing to challenge a Determination Order which awarded permanent disability based on the effects of the surgery, the insurer accepted the degenerative condition and was, therefore, precluded from later denying compensability of the degenerative condition. We disagree.

The payment of compensation for a condition constitutes neither an acceptance of a claim nor an admission of liability. ORS 656.262(9). In Gloria T. Olson, 44 Van Natta 2519, 2520-21 (1992), we held that neither the employer's approval of payment for surgery nor its failure to challenge a Determination Order which awarded benefits for the residuals of the surgery constituted acceptance of the degenerative condition which the surgery was designed to treat. ORS 656.262(9); see also Maximino Cardenas, 45 Van Natta 457 (1993). Our decision in Gloria T. Olson controls the present case. Accordingly, we conclude that the insurer was not precluded from denying the compensability of claimant's preexisting degenerative condition.

ORDER

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

May 6, 1993 Cite as 45 Van Natta 875 (1993)

In the Matter of the Compensation of
DEWAYNE D. TURK, Claimant
WCB Case No. C3-00700
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Olson, Rowell & Walsh, Claimant Attorneys
Liberty Northwest Insurance Corp., Insurance Carrier

Reviewed by Board Members Neidig and Brazeau.

On March 17, 1993, 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.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. One requirement is that the disposition provide the total amount (excluding attorney fee) to be paid the claimant. OAR 436-60-145(3)(j). A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

The parties are to provide the amount of consideration for each disposition. See Jerry H. Foss, 43 Van Natta 48 (1991). Here, the proposed agreement recites that the amount of consideration is the insurer/employer's "waiver" against recovery, if any, from a possible third party action and the payment of $2,000. By addendum, the parties provide that "the possible third party action referenced in the above captioned Claim Disposition Agreement has not been settled or adjudicated between claimant and the potentially liable third party." For that reason, the parties state that a specific monetary value has not been attributed to the amount of the insurer/employer's potential third party lien against such recovery.

In circumstances where the third party action has not reached resolution and thus, there is no present settlement or judgement amount, we nonetheless require that the insurer/employer provide the amount of claim costs, i.e., the amount of its third party lien. In this case, however, because the agreement provides for a lump sum payment of $2,000, in addition to the waiver of the lien, we conclude that the agreement is not unreasonable as a matter of law, regardless of the monetary value of the potential lien. Accordingly, the claim disposition agreement is approved.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA J. WAY, Claimant
WCB Case No. 91-13913
ORDER ON REVIEW
Thomas A. Coleman, Claimant Attorney
Moscato, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Davis' order that upheld the self-insured employer's denial of her occupational disease claim for her psychological condition. In her brief, claimant also contends that the occupational disease statute, ORS 656.802(3), conflicts with the Americans with Disabilities Act (ADA). On review, the issues are the applicability of the ADA, and compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Americans with Disabilities Act

On review, claimant argues that the Americans with Disabilities Act, §42 USC 12131 et seq, conflicts with ORS 656.802, the Oregon occupational disease statute. Specifically, claimant argues that the state statute discriminates against her because it requires that she establish that her mental disorder is not the result of reasonable disciplinary, corrective or job performance evaluation action. ORS 656.802(3)(d). She contends that because no other claimants are required to prove such an element in establishing an occupational disease, the statute discriminates against workers with mental disorders.

Subtitle A of Title II of the ADA prohibits discrimination on the basis of disability by public entities. 42 U.S.C. 12131 et seq. Subtitle A protects qualified individuals with disabilities from discrimination on the basis of disability in the services, programs, or activities of all State and local governments.

Here, without finding either that claimant has established that the Title II effective date of January 26, 1992 applies to her claim, or that she is a qualified individual with a disability, we conclude that this is not the proper forum for an ADA complaint. Rather, Subpart G of Title II provides that investigation of such complaints of discrimination is delegated to the U. S. Department of Justice for all programs, services and regulatory activities relating to insurance. Subpart G further provides that the Department of Labor is the designated agency for all programs, services, and regulatory activities relating to labor and the work force. §35.190(b)(6),(7). Accordingly, we conclude that claimant's complaint with regard to discrimination by state government (and the workers' compensation statutes) falls within federal agency jurisdiction, rather than that of the Oregon Workers' Compensation Board.

Additionally, if claimant's argument is construed as a challenge pursuant to Title I of the ADA, which prohibits employment discrimination on the basis of disability, we similarly find that the Board is not the proper forum for such a challenge. Pursuant to Title I, the Equal Employment Opportunity Commission (EEOC) is the agency responsible for enforcement of Title I of the Act. Moreover, complaints must regard actions that occur after the July 26, 1992 effective date of the Title, and may be filed with either the EEOC or designated state human rights agency. 42 U.S.C. 12101 et seq.

Consequently, we conclude that claimant's complaint in this case is not within the jurisdiction of the Board.

Compensability

We adopt the Referee's Conclusions of Law and Opinion on the issue of compensability.

ORDER

The Referee's order dated March 13, 1992 is affirmed.

Board Member Hooton specially concurring.

I agree with the majority resolution of the compensability question arising in this claim. Claimant has failed to demonstrate that the mental disorder which was caused by her employment with Fred Meyer was not the result of reasonable disciplinary activity. I agree with the claimant's assertion that a work evaluation standard which is based on specific body movements is not reasonable unless it considers all such relevant movements. I disagree however, that claimant has demonstrated such a failure here.

I also agree with the majority that we are without authority to act on claimant's argument regarding the requirements of the ADA. However, I do so based on the following alternate reasoning.

The majority concludes that we are without authority to resolve the claimant's ADA complaint, and that claimant must take that complaint to another forum. I believe that the majority misunderstands the nature of the claimant's request.

Claimant argues that the ADA requires this agency to conform its conduct to the limitations of the act. The majority notes that the ADA requires nondiscriminatory treatment of all persons in the services, programs and activities of all State and local governments. Consequently, it seems fair to conclude that the claimant has a point. We no doubt are required to conform to the ADA requirements. However, the specific responsibilities of this agency prevent us from conforming, (assuming, of course, that we are not currently in conformity), in the manner the claimant suggests.

We are required to adjudicate claims under statute. The terms of the statute can be applied by this agency, and the constitutionality or legality of a specific statutory term can be addressed. We cannot, however, rewrite the statute.

Claimant is asking us to determine that ORS 656.802(3)(d) violates the terms of Subtitle A of Title II of the ADA, and on that basis to delete it from the statute. However, to do so would effectively change the nature and scope of the entitlement granted by the legislature. Should we find that the ADA prohibits any of the specific preconditions to compensability required by ORS 656.802(3), the most that this body could accomplish is to determine that 656.802(3), as written, has become illegal. Under that circumstance claimant still would not receive benefits for her psychological condition because entitlement to benefits for any psychological condition would have been deleted from the statute. To presume that the legislature would continue that entitlement without the offending precondition is reasonable, but not within the limits of our authority as adjudicators.

I view the claimant's argument as a reminder that the application of ORS 656.802(3)(d) may be violative of the requirements of the ADA, subjecting this agency, or the State, to prosecution. I acknowledge that the reminder is well taken. I also acknowledge that the issue is an important one deserving of litigation and complete resolution. I am unable to conclude, however, that the ADA empowers me with the authority constitutionally granted only to the legislative assembly, and find that I am without authority to provide the claimant with the relief requested.

The majority concludes that we are without jurisdiction to consider the question presented. I disagree. I believe that we do have jurisdiction to determine the effect of federal legislation on the standard of compensability or of specific benefits required by the Workers' Compensation Law, just as we have jurisdiction to consider questions properly resolved before other administrative forums when the ultimate determination of that question affects entitlement to compensation. See, Theron Stiehl, 43 Van Natta 686 (1991).

However, I agree with the majority resolution because we are without authority to provide the specific relief requested, and because claimant does not request that relief which is within our authority. Under such circumstances it would be inappropriate to consider the continued vitality of ORS 656.802(3).

In the Matter of the Compensation of
MARIA L. BACRE, Claimant
WCB Case No. 92-06195
ORDER ON REVIEW (REMANDING)
Estell & Bewley, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Quillinan's order that approved a stipulation. Contending that she was inadequately advised regarding the stipulation, claimant seeks its repudiation. On review, the issue is the validity of the stipulation. We remand.

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

Here, no record exists upon which to determine the circumstances surrounding the execution of the agreement. Thus, the record is insufficiently developed to resolve the issues raised by claimant's request for review. Consequently, we conclude that remand is appropriate. See Edwin L. Carson, 43 Van Natta 107, on recon, 43 Van Natta 835 (1991); Mary A. Summers, 42 Van Natta 2393 (1990).

Accordingly, this matter is remanded to Referee Quillinan with instructions to convene a hearing. At that hearing, evidence shall be taken concerning all of the issues raised by the parties herein. After closing the record and considering the evidence in light of the parties' respective arguments, the Referee shall issue a final, appealable order. See Edwin L. Carson, supra, at pages 107-108.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHAUN M. DONOVAN, Claimant
WCB Case No. 91-18350
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Menashe's order that: (1) declined to award an attorney fee under ORS 656.386(1) when the SAIF Corporation rescinded its denial of claimant's medical services claim for Lithium treatment prior to the hearing; and (2) declined to award an attorney fee under ORS 656.386(1) when SAIF accepted claimant's organic mood syndrome condition prior to hearing. On review, the issues are attorney fees. We reverse.

FINDINGS OF FACT

Claimant suffered a compensable injury on October 28, 1989 when he fell off a roof and hit his head and other parts of his body. His claim for multiple injuries, including injury to his head, was accepted by SAIF on November 27, 1989.

On February 19, 1991, claimant commenced treatment with Dr. Maletzky, psychiatrist. Dr. Maletski diagnosed "post CNS Trauma with Anger Outbursts" and prescribed lithium.

On April 10, 1991, SAIF received a report and chart notes from Dr. Maletzky that indicated that claimant was in need of medical treatment for a mood disorder.

SAIF paid for Dr. Maletzky's treatment and lithium medication until December 1991. On December 16, 1991, in response to a Lithium reimbursement request, SAIF issued a written denial stating:

> "SAIF Corporation is not responsible for the condition for which you were prescribed the Lithium. Therefore, we will not reimburse you for this expense." (Ex. 13).

Eleven days later, on December 27, 1991, claimant's counsel filed a request for hearing on claimant's behalf.

On January 13, 1992, reimbursement of claimant's lithium prescription was authorized by a claims adjuster with SAIF. Authorization followed from a telephone call from claimant to the claims adjuster.

On February 12, 1992, claimant's counsel wrote a letter to the claims adjuster inquiring as to whether SAIF had "formally accepted" claimant's "psychological problems (depression, etc.)." If not formally accepted, then claimant's counsel requested that the claims adjuster indicate whether the problems were considered compensable. (Ex. 22).

The claims adjuster responded by letter dated February 21, 1992. In that letter, the claims adjuster stated:

> "Per your letter of February 12, 1992, regarding whether or not [claimant's] psychological problem has been formally accepted, I have reviewed the file and even though the psychological condition has not been formally accepted as such, it is considered a compensable part of his accepted claim." (Ex. 24).

Claimant's counsel received the letter on February 24, 1992. Three days later, on February 27, 1992, claimant's counsel wrote a letter to the Hearings Division requesting that "[d]e facto denial of psychological condition, penalties and fees" be added to the pending issues set for hearing.

On March 18, 1992, Dr. Maletzky diagnosed organic mood syndrome. SAIF received this letter on March 23. At the June 25, 1992 hearing, on the record, SAIF accepted the organic mood syndrome.

FINDINGS OF ULTIMATE FACT

Claimant's counsel was instrumental in obtaining compensation for claimant in the form of Lithium treatment.

SAIF accepted claimant's psychological condition not later than February 21, 1992. Claimant's counsel was instrumental in obtaining SAIF's acceptance of that condition.

CONCLUSIONS OF LAW AND OPINION

Denial of Lithium Prescription

The Referee concluded that claimant was not entitled to attorney fees for counsel's assistance in obtaining payment for claimant's Lithium treatments. The Referee found that SAIF paid for claimant's Lithium treatments in response to a phone call by claimant to SAIF's claims adjuster, not in response to any of his counsel's acts. Therefore, the Referee reasoned, claimant's counsel was not instrumental in obtaining that compensation. ORS 656.386(1). We disagree and reverse.

Claimant's counsel filed a request for hearing in response to SAIF's denial of claimant's request for reimbursement of his paid Lithium prescription bill. We consider that request to have preserved claimant's right to challenge the propriety of SAIF's Lithium denial. Under those circumstances, regardless of the nature of the act which prompted SAIF's decision to recommence payment for claimant's Lithium treatment, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. See Kimberly Wayne, 44 Van Natta 328, 330

(1992)(although request for hearing does not prompt rescission of denial, it does preserve claimant's right to challenge denial thereby supporting an ORS 656.386(1) attorney fee award). Consequently, we hold that claimant is entitled to an attorney fee award under ORS 656.386(1). Jones v. OSCI, 108 Or App 230, 232 (1991).

"De Facto" Denial of Psychological Condition

The Referee also concluded that claimant was not entitled to an attorney fee award under ORS 656.386(1) based on claimant's request for a hearing on the psychological condition claim. The Referee reasoned that, because no denial was pending when the Request for Hearing was filed on February 27, 1992, that request had no legal effect and could not support an award of attorney fees under ORS 656.386(1). Because we conclude that SAIF "de facto" denied claimant's claim for his psychological condition prior to February 27, 1992, we disagree and reverse.

In Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992), the court agreed with the Board's conclusion that "a physician's report requesting medical treatment for a specified condition constitutes a claim." See also Jack Allen, 43 Van Natta 190, 191 (1991). Here, Dr. Maletzky's April 10, 1991 report and chart notes indicated that claimant needed medical treatment for his previously undiagnosed psychological condition. That was a claim. Because SAIF did not specifically accept or deny that claim within 90 days of the April 10, 1991 report, the claim is deemed "de facto" denied. Barr v. EBI Companies, 88 Or App 132, 134 (1987).

On February 12, 1992, claimant's counsel wrote to SAIF, inquiring into the status of claimant's psychological problems. SAIF responded by letter dated February 21, 1992 which stated that "even though the psychological condition has not been formally accepted as such, it is considered a compensable part of [claimant's] compensable claim." We conclude that SAIF's letter, although perhaps not a "formal" notice of claim acceptance, was nevertheless a legal claim acceptance. See SAIF v. Tull, 113 Or App 449 (1992)(whether an acceptance occurs is an issue of fact which does not require an official notice of acceptance to the claimant). Moreover, we conclude that SAIF's acceptance of claimant's "psychological condition" includes Dr. Maletzky's subsequent diagnosis of organic mood syndrome. Rouse v. FMC Corp. Marine-Rail, 118 Or App 25 (1993).

We conclude that SAIF's acceptance of the previously "de facto" denied psychological condition resulted from claimant's counsel's February 12, 1992 letter. Accordingly, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Consequently, we hold that claimant is entitled to an attorney fee award under ORS 656.386(1). Jones v. OSCI, supra.

For purposes of determining a reasonable assessed fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee for claimant's counsel's efforts in obtaining the acceptance of both claimant's lithium prescription and his organic mood syndrome condition without a hearing is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these issues (as represented by the record), the value of the interests involved, the complexity of the issues, and the risk that claimant's counsel might go uncompensated. We have also considered claimant's $250 attorney fee award under ORS 656.382(1) as previously granted by the Referee for SAIF's unreasonable claim processing.

ORDER

The Referee's order dated July 10, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1) is reversed. For claimant's counsel's pre-hearing services which were instrumental in obtaining compensation for claimant, claimant's attorney is awarded a reasonable assessed attorney fee of $500, payable by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JEFF G. GUIDO, Claimant
WCB Case Nos. 92-03921 & 92-04918
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The SAIF Corporation requests review of that portion of Referee Mongrain's order which set aside its denial of claimant's right shoulder injury claim. Claimant cross-requests review of that portion of the order which upheld SAIF's denial of his low back injury claim. On review, the issues are compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant was diagnosed with bursitis in the right shoulder in 1972. (Exs. A-2, A-4). In May 1991, he was treated for bursitis in the right shoulder. (Ex. 27B).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work incident on October 31 or November 1, 1991 was a material contributing cause of treatment for his right shoulder condition. Consequently, SAIF's denial was set aside. We disagree.

Subsequent to the Referee's order, the Court of Appeals held that when a work-related injury combines with a preexisting condition to cause disability or a need for treatment, the work-related injury is compensable only if it is the major contributing cause of the disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409, 412-13 (1992) (Emphasis in original). See ORS 656.005(7)(a)(B).

Here, claimant has a history of right shoulder problems previously diagnosed in 1972 as myofibrositis with associated subacromial bursitis. (Exs. A-2, A-4). Prior to the work incident, claimant had last received treatment for his right shoulder bursitis in May 1991. (Ex. 27B).

In January 1992, based on a history of a work incident in October or November 1991, Dr. Young, claimant's treating orthopedist, initially diagnosed a shoulder strain (Ex. 36-1). Dr. Young later obtained claimant's history of bursitis treatment. (Ex. 36-2). When the results of an MRI proved negative for rotator cuff tear, Dr. Young diagnosed "strain of the right shoulder with post traumatic bursitis." Id. (Emphasis added).

In light of claimant's history of right shoulder complaints and Dr. Young's diagnosis of a shoulder strain with post traumatic bursitis, we conclude that claimant's work incident combined with a preexisting shoulder condition. Accordingly, in order to prove compensability of his right shoulder condition, claimant must show that his work injury is and remains the major contributing cause of his right shoulder disability and need for treatment. We conclude that he has failed to meet his burden of proof.

In response to an inquiry from claimant's counsel concerning the relationship between claimant's shoulder condition and the work incident, Dr. Young stated that, because tendinitis/bursitis of the shoulder is an extremely common affliction of the musculoskeletal system, the precise etiology is always difficult to explain. Concluding that "there is no way to specifically delineate the major contributing cause," Dr. Young apologized for being unable to be more helpful. (Ex. 49).

Considering this opinion, we are unable to find that claimant's work injury is the major contributing cause of his right shoulder disability and need for medical treatment. Accordingly, we conclude that claimant has failed to prove that his shoulder condition is compensable. Thus, we reverse that portion of the Referee's order that found claimant's right shoulder condition compensable.

With regard to claimant's low back, the Referee concluded that claimant had failed to prove compensability of his current low back condition. We agree with the Referee, but reach our conclusion for the following reasons.

Here, there is no dispute that claimant has a preexisting low back condition. Therefore, if the medical evidence shows that the preexisting condition combined with the December 12, 1991 work incident, the work incident must remain the major contributing cause of claimant's disability and need for treatment for claimant to prove a compensable low back injury. ORS 656.005(7)(a)(B); Nazari, supra.

Dr. Woolpert, who examined claimant after the December 1991 incident, noted claimant's extensive low back history. (Ex. 56). A myelogram in November 1973, just prior to a lumbar laminectomy, indicated a slight irregularity at L4-5 and a slight bulge at L5-S1. (Ex. 8). A myelogram of claimant's back in 1981 indicated a small disc protrusion at L4-5 and poor filling of the left nerve root sleeve at L4-5. (Ex. 25F). Also in 1981, claimant reported low back pain with radiation into the left leg. He also had "numbness of a radicular character" on the leg. (Ex. A-5). Based on the low back history, Dr. Woolpert concluded that claimant's current symptoms were caused in major part by his preexisting disc degeneration and disc protrusion. (Ex. 56-7).

Furthermore, before his December 12, 1991 work incident, claimant reported that he had been unable to do any type of physical work or hold a job. Claimant related his daily limitations to ongoing low back pain and radiating leg and thigh pain. (Ex. A-6).

Claimant argues that, contrary to the Referee's finding, the opinions of Drs. Daven and Freeman are based on a correct history. We do not agree. The Referee correctly concluded that those physicians did not have an accurate history concerning claimant's back or leg symptoms requiring treatment until the December 1991 work incident. Each physician based his conclusion on the incorrect assumption that claimant required no treatment after recovering from his 1973 surgery until his December 1991 fall at work. (Exs. 48, 55).

Accordingly, in light of Dr. Woolpert's persuasive opinion, we find that claimant's preexisting back condition remains the major contributing cause of his current disability and need for treatment. Therefore, we conclude that claimant has failed to prove that he suffered a compensable low back injury on December 12, 1991. Nazari, supra.

ORDER

The Referee's order dated July 15, 1992 is reversed in part and affirmed in part. That portion of the order which set side the SAIF Corporation's denial of claimant's right shoulder condition is reversed. SAIF's denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

May 7, 1993 Cite as 45 Van Natta 882 (1993)

In the Matter of the Compensation of
DONALD E. LOWRY, Claimant
WCB Case No. 92-06158
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 7, 1993 Order on Review, as corrected April 8, 1993, which affirmed a Referee's order awarding claimant a total of 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of the leg (knee). In reaching our conclusion, we found that had established that he was unable to repetitively use his right knee due to a chronic and permanent medical conditon that claimant had become symptomatic and disabling as a result of his compensable injury. On reconsideration, SAIF argues that claimant is not entitled to scheduled chronic condition impairment because his ability to repetitively use his right knee is limited, not that he is unable to repetitively use his right knee.

In order to further consider this issue we withdraw our prior orders. The parties are granted an opportunity to submit supplemental briefs. In submitting their arguments, the parties are requested to discuss the effect, if any, the Board's decision in Walter T. Driscoll, 45 Van Natta 391 (1993) has on this issue. To be considered, the parties' briefs must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

May 7, 1993 Cite as 45 Van Natta 883 (1993)

In the Matter of the Compensation of
DANIEL J. McNEILL, Claimant
WCB Case No. 92-02022
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee T. Lavere Johnson's order that affirmed an Order on Reconsideration which awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a right shoulder injury. 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 the first full paragraph on page 2 of the order and with the following supplementation.

On July 13, 1991, Dr. Erkkila reported that claimant was medically stationary and could perform light work. Thereafter, claimant's claim was closed by an August 21, 1991 Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Order on Reconsideration which granted claimant 15 percent unscheduled permanent disability. We modify.

Claimant became medically stationary on November 30, 1990, and his claim was closed by Determination Order on August 21, 1991. Thus, 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; WCD Admin. Order 2-1991.

The Referee found that claimant was entitled to an 8 percent value for impairment. We agree with and adopt the Referee's finding. The parties do not dispute the values given for claimant's age and education (5). Therefore, we adopt this value when we calculate claimant's permanent disability and discuss only the value for adaptability.

The Referee concluded that claimant was not entitled to a value for adaptability because he found that claimant had returned to regular work. We disagree.

Subsequent to the Referee's order, we issued our decision in Heather I. Smith, 44 Van Natta 2207 (1992). In Smith we reaffirmed our holding in Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992) 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 found the Director's rule consistent with ORS 656.283(7) and the legislative history behind that provision. Smith, supra at 2208.

Here, the Referee found that claimant returned to regular work based on Dr. Erkkila's May 13, 1992 approval of a job analysis worksheet. However, as noted above, claimant's adaptability factor is based on his work status at or before the time of the Determination Order. Therefore, Dr. Erkkila's May 13, 1992 "release" is not relevant to determining claimant's adaptability factor. Id. In this regard, we note that Dr. Erkkila's January 30, 1992 letter to claimant's counsel is also not relevant for the same reasons.

The only evidence of claimant's adaptibility prior to the August 1991 Determination Order is a physical capacities form by Dr. Erkkila and a letter from Dr. Erkkila both dated July 13, 1991. (Exs. 1A & 4). On the physical capacities form, Dr. Erkkila indicated that claimant was medically stationary and reported that claimant was limited to light work. (Ex. 1A). In the letter, Dr. Erkkila noted that if claimant returned to his at-injury work (service station attendant) "[claimant] could pump gas and do the billing," but should not do any heavy lifting or repetitive pushing or pulling.

Inasmuch as the July 13, 1991 physical capacities form is Dr. Erkkila's most specific evaluation of claimant's residual physical capacity, we find it persuasive. Accordingly, as a result of the compensable injury, claimant is permanently limited to light work. Since claimant's at-injury work as a service station attendant was in the medium category and he now is permanently limited to light work, claimant's adaptibility factor is 3. Former OAR 436-35-310(3).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Claimant's value for age and education (5) is multiplied by claimant's adaptability value (3) for a product of 15. When that value is added to claimant's impairment value (8) the result is a total unscheduled award of 23 percent. See former OAR 436-35-280(7). Accordingly, we modify the Referee's order.

ORDER

The Referee's order dated June 29, 1992 is modified. In addition to the Order on Reconsideration's award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, for a total award to date of 23 percent (73.6 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
LELAND F. CORDOVA, Claimant
WCB Case No. C3-01145
ORDER DISAPPROVING CLAIMS DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

On April 28, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

By virtue of a May 13, 1988 Determination Order, claimant has received 20 percent unscheduled permanent disability for his back and chest contusion and post-traumatic headache condition. In consideration of the payment of $11,467.32, claimant agrees to partially release his rights to workers' compensation benefits under his August 1, 1985 injury. Specifically, claimant releases his "claim for payment of temporary total or temporary partial disability for the period from October 20, 1991 to September 29, 1992..."

Pursuant to ORS 656.236(1), the parties to a claim may make such disposition of any or all matters regarding a claim, except medical services, as the parties consider reasonable, subject to such terms and conditions as the Director may prescribe. In accordance with OAR 436-60-145(3)(h), the parties are required to specifically identify all benefits, rights and insurer obligations under the Workers' Compensation Law which are released by the agreement. "Release" means to discharge a claim one has against another. Black's Law Dictionary, Abridged Fifth Edition, 1983.

Here, the proposed disposition provides that claimant "releases" his right to temporary disability benefits from October 20, 1991 to September 29, 1992. Despite the use of the term "releases," claimant is receiving payment of temporary disability benefits for a specified period of time.

If claimant is releasing his right to temporary disability benefits from October 20, 1991 to September 29, 1992, he cannot simultaneously acknowledge receipt of, and the insurer receive credit for providing such benefits. In this respect, the attempted dual purpose for the proceeds from this proposed disposition is not permissible. See Lawrence Woods, 43 Van Natta 643 (1991). Therefore, a CDA is not the proper method to resolve this matter.

Furthermore, although the parties have submitted a proposed Disputed Claim Settlement (DCS) in WCB Case No. 92-14839 which proposes to settle the identical period of temporary disability benefits for the same amount of consideration provided for in the CDA, the DCS has not been executed. Presumably, the DCS would not be an appropriate disposition of this matter, as a DCS resolves compensability of a denied claim. Rather, the appropriate method of resolution would appear to be by means of a stipulation submitted for Referee approval. See OAR 438-09-005(1), and (2).

Consequently, for the reasons previously discussed, we find such an agreement to be contrary to OAR 436-60-145(3)(h) and, as such, unreasonable as a matter of law under ORS 656.236(1)(a). Accordingly, the proposed disposition is disapproved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JESUS R. CORONA, Claimant
WCB Case No. 92-07011
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of those portions of Referee Menashe's orders which: (1) found that claimant was not entitled to be paid scheduled permanent disability at $305 per degree; and (2) declined to award an assessed attorney fee under ORS 656.382(1). On review, the issues are rate of scheduled permanent disability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

We affirm and adopt that portion of the Referee's order regarding this issue. SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992).

Attorney Fees

The Referee awarded a penalty under ORS 656.268(4)(g) because the Department, on reconsideration, ordered more than a 25 percent increase of the compensation awarded by the Notice of Closure and claimant was found to be at least 20 percent permanently disabled. Claimant asserts that he is also entitled to an assessed attorney fee under ORS 656.382(1) in conjunction with the assessment of a penalty under ORS 656.268(4)(g).

The insurer first contends that we should not address this issue because claimant did not raise it until he moved for reconsideration of the Referee's order and, therefore, he is now precluded from asserting it on review. We need not address that contention because even if claimant can raise the issue, we conclude that no attorney fee under ORS 656.382(1) is warranted.

We conclude that the imposition of a penalty under ORS 656.268(4)(g) by itself does not constitute grounds for awarding an assessed attorney fee under ORS 656.382(1). While ORS 656.382(1) expressly requires an unreasonable resistance to the payment of compensation by the carrier in order to award an assessed attorney fee, unreasonable conduct by the carrier is not necessary for imposition of a penalty under ORS 656.268(4)(g), Kevin Northcut, 45 Van Natta 173 (1993). In this case, we find no evidence that the insurer engaged in unreasonable conduct by awarding claimant 11 percent permanent disability. Thus, we find no basis for awarding an attorney fee under ORS 656.382(1).

ORDER

The Referee's order dated August 25, 1992, and the Order Denying Reconsideration dated September 9, 1992, are affirmed.

In the Matter of the Compensation of
THOMAS E. EDISON, Claimant
WCB Case No. 90-12890
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

This matter is before us on remand from the Court of Appeals. SAIF v. Edison, 117 Or App 455 (1992). The court has agreed with that portion of our prior order, Thomas E. Edison, 44 Van Natta 211 (1992), which held that claimant's hearing request from the SAIF Corporation's denial of his stroke claim was timely. However, the court noted that our order neglected to address SAIF's contention that claimant's stroke was not compensable under ORS 656.005(7)(a)(B). See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's "Findings" relating to compensability except for the last paragraph. Furthermore, the Referee's reference to "December 18" in the last paragraph on page 4 is corrected to "January 18."

CONCLUSIONS OF LAW AND OPINION

Claimant is a circuit court judge who sustained a cerebral vascular thrombosis, or stroke, following a stressful telephone conference with an attorney. Claimant filed a claim based on the stroke. Claimant suffers from preexisting hypertension and diabetes.

The Referee first found that, under ORS 656.262(8), claimant had 60 days from the receipt, rather than mailing, of the denial, to file a request for hearing and that, under this interpretation of the statute, claimant's request was timely. The Referee then addressed compensability, treating the claim as one for an accidental injury. The Referee found that claimant was required to prove only that work conditions were a material contributing cause of his stroke and that he carried this burden. As such, the Referee rejected SAIF's contention that claimant had to prove that work events were the major contributing cause of his stroke under ORS 656.005(7)(a)(A).

We agreed with the Referee's interpretation of ORS 656.262(8) and, with regard to the issue of compensability, merely adopted the Referee's conclusion and reasoning. Thomas E. Edison, supra.

The Court of Appeals similarly interpreted ORS 656.262(8) as providing that actual or constructive receipt of the denial constituted notification. However, the court further found that "the Board did not consider this claim under the appropriate statute." Although the court agreed that ORS 656.005(7)(a)(A) was not applicable, the court concluded that, "[g]iven the record and, because [SAIF] has argued all along that the claim should be considered under ORS 656.005(7)(a)(B), the case must be remanded for reconsideration. See Tektronix, Inc. v. Nazari, [117] Or App [409] (1992)." SAIF v. Edison, supra, 117 Or App at 459.

We first note that the court has ruled that any claim for on-the-job stress is treated as a claim for an occupational disease under ORS 656.802. SAIF v. Hukari, 113 Or App 475, 480 (1992). Because the present claimant asserted that the stress of work-related events was a factor in causing his stroke, it would appear that Hukari is applicable to this case. However, because the court has instructed us to consider this case under ORS 656.005(7)(a)(B), we proceed with our analysis under that statute.

When a compensable injury combines with a preexisting disease or condition, the resultant condition is compensable only if the work-related injury is the major contributing cause of claimant's disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra. Here, based on the opinion of Dr. Leonard, claimant's treating neurologist, we are persuaded that claimant's preexisting hypertension and diabetes combined with the stressful work events to cause claimant's stroke. (Exs. 11AAAA, 12). Therefore, whether analyzed under ORS 656.802 or 656.005(7)(a)(B), claimant must prove that employment conditions were the major contributing cause of his stroke in order to prevail.

In response to claimant's attorney's letter, Dr. Leonard initially reported that, although claimant suffered from preexisting hypertension and diabetes, both of which are significant risk factors for stroke, "the emotionally-charged hearing * * * was an important material contributing factor in the development of [claimant's] stroke." (Ex. 11AAAA-2). Dr. Leonard also stated that there was "reasonable probability that [claimant] had pre-existing small vessel vascular disease in the brain, but a cascade of [work] events * * * simply tipped the scales too far and [claimant] suffered a stroke." (Id).

SAIF's attorney then requested Dr. Leonard to review Dr. Denekas' 1988 neurological consultation report showing that claimant had a history of diabetes and significant hypertension. In response, Dr. Leonard reported that "the major contributing cause was [claimant's] pre-existing physical state related to diabetes mellitus and hypertension * * *. The emotionally-charged hearing on 1/19/90 was an important factor, but not the major factor, causing [claimant's] stroke." (Ex. 12-2).

Dr. Stryker, internal medicine specialist who initially treated claimant, stated that, after studying claimant's medical history, he agreed with Dr. Leonard's conclusion that "stress coupled with dietary control and alcohol use caused the onset of a "cerebral vascular accident prematurely." (Ex. 12A-2). Because Dr. Stryker stated that he was responding to claimant's attorney's letter dated July 18, 1990, which was prior to the date on Dr. Leonard's second report, it appears that Dr. Stryker wrote his opinion only with reference to Dr. Leonard's first report.

Dr. Valleroy, physical medical and rehabilitation specialist, deferred to Dr. Leonard regarding etiology and contributing factors of claimant's stroke. (Ex. 12B). The record does not show the extent, if any, of Dr. Valleroy's contact with claimant's case, since her letter states only that she is responding to claimant's attorney's letter "with enclosures from Dr. Leonard." (Id).

Dr. Belknap, diabetes specialist, responding to a request by claimant's attorney, first stated that he concurred with "Dr. Leonard's opinion that [claimant's] work activity was the cause of this on-the-job injury which manifested as a stroke." (Ex. 14). A month later, in response to a request by SAIF's attorney, Dr. Belknap stated that he totally deferred to Dr. Leonard's judgment and opinion. (Ex. 15). It appears that Dr. Belknap's opinion was based on Dr. Leonard's reports as well as his discussions with Dr. Leonard regarding claimant's case. (Exs. 14, 15).

Unless there are reasons to the contrary, we give more weight to the opinion of the treating physician regarding causation. Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no reason not to defer to the opinion of Dr. Leonard as the treating physician. Although Dr. Leonard initially stated that claimant's work activities were an "important material contributing factor," Dr. Leonard later refined his opinion and explicitly reported that employment conditions were not the major contributing cause of the stroke. The remaining opinions essentially only defer to Dr. Leonard's opinion. Therefore, based on Dr. Leonard's opinion, we conclude that claimant failed to prove that work events were the major contributing cause of his stroke and, consequently, his claim is not compensable.

Accordingly, on reconsideration, we reverse that portion of the Referee's order dated January 17, 1991 which set aside SAIF's denial. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,700 attorney fee award is reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY G. LUEHRS, Claimant
WCB Case No. 92-03795
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of those portions of Referee Neal's order that: (1) found that claimant had timely given notice of his industrial accident; and (2) set aside its denial of claimant's back injury claim. Claimant cross-requests review of that portion of the order that awarded an assessed attorney fee of $3,500. On review, the issues are timely filing of the claim, compensability, and attorney fees.

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

An injured worker must give written notice of an injury no later than 30 days after the accident. ORS 656.265(1), (2). The employer contends that claimant did not comply with this statute because he first reported that he was injured on December 10, 1991 but did not notify his supervisor of an injury until January 10, 1992.

Although claimant initially reported to his physicians and on the 801 form that the accident was on December 10, 1991, we agree with the Referee that claimant proved that his injury occurred on December 18, 1991. Claimant testified at hearing that he had been "guessing" when he gave December 10 as the accident date and that he later had been able to pinpoint the date as December 18 when he realized that the accident had occurred during the week that Eric Borst had begun working for the employer. Claimant's testimony regarding his initial uncertainty as to the date of injury was corroborated by his supervisor, Richard Charlesworth. (Ex. 18-6, 18-7). Furthermore, claimant's foreman, John Rider, supported claimant's testimony regarding the correct date of injury as December 18. (Tr. 20). In short, we find claimant's testimony explaining the discrepancy between accident dates to be convincing and conclude that he proved that an accident occurred on December 18.

Moreover, even if we found that December 10, 1991 should be used as the date of accident, the employer had knowledge of the injury prior to the 30-day expiration. John Rider testified that, after claimant requested a break, he spoke to claimant, who told him that he had "kicked out" of his gaff hook and fallen a short distance down the tree and that he felt pain in his hip. (Tr. 12-13). Mr. Rider also observed claimant in obvious pain after that date and that he had difficulty performing his job. (Id. at 14).

When an individual in a supervisory position, such as a foreman, has knowledge of a worker's injury, that knowledge may be imputed to the employer. Colvin v. Industrial Indemnity, 301 Or 743, 747 (1986). Based on claimant's statements to Mr. Rider, we find that the employer knew that claimant had sustained an on-the-job injury. Therefore, even if Mr. Charlesworth was not aware of the injury until January 10, we conclude that the employer (through the foreman) had knowledge of the injury shortly after the occurence of the accident. See Argonaut Ins. Co. v. Mock, 95 Or App 1, 5-6, rev den 308 Or 79 (1989). Consequently, any failure by claimant to timely give written notice would not bar his claim. See ORS 656.265(4)(a).

The employer also asserts that claimant failed to provide medical evidence showing that his employment was a material cause of his back injury. See ORS 656.005(7)(a). We disagree. Although none of the medical reports explicitly attribute the injury to the industrial accident, when viewed in their entire context, we find that they establish causation. For instance, Dr. Ordonez, neurological surgeon and claimant's treating physician, and Dr. Treible, who saw claimant on referral from Dr. Ordonez, cited only the industrial accident in discussing the history of claimant's herniated disc and onset of symptoms. (Exs. 8, 11, 11aa-). Furthermore, Dr. Ordonez treated the case as a workers' compensation claim. (Ex. 9).

Finally, we find no merit to the employer's argument that the testimony of claimant, his wife, Mr. Rider, and Eric Borst, all of whom supported compensability, was unreliable.

Claimant asserts that the Referee should have awarded him an assessed fee of $5,870, the amount sought at hearing, instead of $3,500, for services at hearing. As both parties recognize, the Referee and Board determine a reasonable attorney based on the factors set forth in OAR 438-15-010(4), only one of which is the time devoted to the case. After considering the remaining factors, we affirm the Referee's award of $3,500. In particular, we have considered the nature of the issues and the value of interest involved, as well as the risk that claimant's attorney might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review because the employer requested review and the Board did not disallow or reduce the compensation to claimant. 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 concerning the compensability issue is $1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of interest involved. We note that claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue.

ORDER

The Referee's order dated August 7, 1992 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

In the Matter of the Compensation of
SANDRA N. PECKHAM, Claimant
WCB Case No. 92-03455
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of those portions of Referee Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claim for a left thumb condition; (2) denied the employer's motion to reopen the record; and (3) awarded an attorney fee for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are compensability, propriety of the Referee's denial of the employer's motion, 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 affirm and adopt the portion of the Referee's order regarding this issue.

Validity of the Referee's Order Denying the Motion to Reopen

We affirm and adopt the Referee's order with regard to this issue.

Attorney Fees

The Referee awarded a "penalty-related attorney fee" of $300 for unreasonable resistance to the payment of compensation, although there were no amounts then due. The Referee cited our decision in Charles E. Condon, 44 Van Natta 726 (1992). Subsequent to the Referee's order, the Court of Appeals reversed our order in Condon, reasoning that an "insurer cannot unreasonably resist the payment of compensation that has been paid." SAIF v. Condon, 119 Or App 194 (1993). Therefore, because compensation had been paid in this case, we reverse that portion of the Referee's order awarding an attorney fee for unreasonable resistance to the payment of compensation.

However, because the employer requested review and we did not disallow or reduce claimant's compensation, claimant's counsel is entitled to an assessed attorney fee for services on review. See ORS 656.382(2). After considering the factors contained in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services on review is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the attorney fee issue.

ORDER

The Referee's order dated September 3, 1992 is affirmed in part and reversed in part. That portion awarding an attorney fee of $300 for unreasonable resistance to payment of compensation is reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

May 12, 1993 Cite as 45 Van Natta 891 (1993)

In the Matter of the Compensation of
ERMA J. BROWN, Claimant
WCB Case No. 92-08115
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Lipton and Hooton.

The SAIF Corporation requests review of Referee Mills' order that: (1) directed it to pay additional temporary disability benefits; and (2) assessed a penalty for its unreasonable refusal to pay those benefits. On review, the issues are temporary disability and penalties.

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

Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), SAIF argues that the Referee erred in awarding claimant additional temporary disability benefits after September 5, 1991, the date claimant was declared medically stationary, because she is not substantively entitled to temporary disability benefits beyond that date.

SAIF's argument begs the question. Substantive entitlement to temporary disability benefits is determined upon closure of the claim. See Galvin C. Yoakum, 44 Van Natta 2403, 2405, recon 44 Van Natta 2492 (1992); Rosa J. Ramirez, 44 Van Natta 2280, 2282 (1992). Here, claimant's claim was never closed; therefore, her substantive entitlement to temporary disability benefits has not yet been determined.

In Seiber, on the other hand, the claim had been closed and the claimant's substantive entitlement to temporary disability benefits had been determined. Under those circumstances, the court held that temporary disability benefits could not be awarded beyond the claimant's substantive entitlement, i.e., medically stationary date.

Because this claim has not yet been closed, claimant's entitlement to temporary disability benefits is procedural, rather than substantive, in nature. Pursuant to the prior referee's order finding claimant's claim compensable, SAIF was obligated to process the claim, including paying temporary disability benefits until those benefits may be terminated according to law. As the Referee correctly found, SAIF was not authorized to terminate temporary disability benefits.

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 temporary disability issue is $700, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for her counsel's services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated July 28, 1992 is affirmed. Claimant's attorney is awarded $700 for services on Board review, to be paid by the SAIF Corporation.

Board Member Hooton specially concurring.

I agree with the result in this case. I do not agree with the additional language of the order which discusses the distinction between procedural and substantive entitlement. The Legislature in 1990 specifically deleted from ORS 656.268 all of the language in ORS 656.268 relied on in Fazzolari v. United Beer Distributors, 91 Or App 592 (1988), to create that distinction. The changes to ORS 656.268 in 1990 occurred with the specific intent to overrule Fazzolari. Our continued effort to support that distinction by repeating its continued existence despite legislative action to the contrary is simply wrong.

It is also dicta which is inappropriate in this order. The court in Lebanon Plywood v. Seiber, 113 Or App 651 (1992) held only that "[i]f processing delay does not result in an overpayment, the Board has no authority to impose one." 113 Or App at 654. That is not the case here. Here, SAIF seeks to avoid the proper processing of the claim prior to closure. Seiber provides no support for that attempt. That is all that need be said.

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant, pro se, requests reconsideration of our April 15, 1993 Own Motion Order Reviewing Carrier Closure in which we found that his claim was not prematurely closed and affirmed the SAIF Corporation's Notice of Closure. Claimant contends that he was not medically stationary at claim closure because his neurogenic bladder condition, which is secondary to his compensable back injury, was not medically stationary at that time. In support of his contention, claimant submits a February 16, 1993 report from Dr. Mulchin, treating urologist, which recommends surgery for claimant's urological problems.

"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 claim closure may be considered to the extent the evidence addresses the condition at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625 (1987), rev den 303 Or 590 (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).

In order to prevail, claimant must prove that his neurogenic bladder condition was not medically stationary as of October 13, 1992, the date his claim was closed. In other words, claimant must prove, based on competent medical evidence that, as of October 13, 1992, further material improvement of his neurogenic bladder condition would reasonably be expected from medical treatment or the passage of time.

In order to fully consider claimant's motion, we withdraw our April 15, 1993 order. SAIF is granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN J. MILLER, Claimant
WCB Case No. 91-16848
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband, Lipton, and Gunn.

The insurer requests review of that portion of Referee Schultz' order that awarded claimant 6 percent (9 degrees) scheduled permanent disability for loss of use or function of each leg (hip). Neither the Determination Order nor the Order on Reconsideration awarded scheduled permanent disability, nor did claimant request such an award until the hearing. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the second finding of ultimate 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).

The Referee found that claimant could raise the issue of extent of scheduled permanent disability at hearing even though, in his request for reconsideration, he had indicated that scheduled permanent disability was not an issue on reconsideration. We disagree.

Claimant sustained a compensable injury to his low back. His claim was closed by Determination Order on May 22, 1991. Claimant disputed the impairment findings used in rating his disability at claim closure. (Ex. 47). As a result, a medical arbiter was appointed and the arbiter's report was considered on reconsideration. In his request for reconsideration, claimant also disputed the rating of unscheduled permanent disability by the Evaluation Section. However, claimant checked the box marked "no" on the request for reconsideration form regarding whether he was raising the potential issue of the rating of scheduled permanent disability. (Ex. 47). Thus, claimant explicitly indicated that he was not raising the issue of scheduled permanent disability.

Dr. Gritzka, orthopedist, was appointed as the medical arbiter. His examination included a measurement of loss of range of motion in claimant's hips. This was the first measurement of claimant's hip range of motion in the record. Dr. Gritzka did not address the cause of this loss of range of motion. Impairment to the hips is rated as either unscheduled or scheduled permanent disability, depending on whether the pelvis and/or acetabular is involved. It is rated as unscheduled permanent disability if the loss is a residual of pelvic and/or acetabular involvement. Former OAR 436-35-340(1). However, it is rated as scheduled permanent disability if there is no pelvic bone involvement. Former OAR 436-35-220(5). We agree with the Referee's finding that the record does not contain any evidence of pelvic or acetabular involvement. The parties do not dispute that finding. Therefore, if claimant has a ratable disability as a result of the loss of range of motion in his hips, it is a scheduled permanent disability.

At hearing and on review, the insurer argued that claimant could not first raise the issue of extent of scheduled permanent disability at hearing when he had not raised that issue in his request for reconsideration. We agree.

We recently held that a party may not raise new issues at hearing relating to a determination order or notice of closure which were not raised at the reconsideration proceeding. Raymond L. Mackey, 45 Van Natta 776 (1993). We found that to hold otherwise would circumvent the legislative intent to provide an administrative remedy at the Department level for issues involving extent of disability. We found this legislative intent evidenced by the mandatory language of ORS 656.268(4)(e) and 656.268(5), which provide that a party who objects to a determination order or notice of closure

must first request reconsideration by the Department. We also relied on legislative history which indicated that a goal of this mandatory process was to reduce costs to the system by reducing the number of appeals to the Hearings Division. In addition, we found that the administrative rules and our prior cases supported our conclusion. See former OAR 436-30-050(2); Charlene J. Erspamer, 44 Van Natta 1214 (1992)(an issue of rate of payment of scheduled permanent impairment will not be considered at hearing or on review unless reconsideration was first requested); Chester L. Schulze, 44 Van Natta 1493 (1992)(an issue of premature closure will not be considered at hearing or on review unless reconsideration was first requested).

The same reasoning applies here. Claimant objected to the Determination Order and requested a reconsideration. However, he did not raise the issue of extent of scheduled disability at the reconsideration proceeding. Having failed to raise that issue at the reconsideration proceeding, he may not raise it at hearing. Raymond L. Mackey, supra.

Our decision prohibiting claimant from raising the issue of extent of scheduled permanent disability for the first time at hearing does not decide the issue of the compensability of claimant's hip condition. In fact, rating claimant's hip condition is premature because compensability for that condition has neither been litigated nor resolved. Thus, our decision should not be interpreted as a ruling, in any manner, regarding the compensability of that condition.

ORDER

The Referee's order dated March 6, 1992 is reversed in part and affirmed in part. That portion of the order that awarded 6 percent (9 degrees) scheduled permanent disability for loss of use or function of the right leg (hip) and 6 percent (9 degrees) scheduled permanent disability for loss of use or function of the left leg (hip) is reversed. The attorney fee relating to that award is reversed. The remainder of the order is affirmed.

Board member Gunn dissenting.

As in Raymond L. Mackey, 45 Van Natta 776 (1993), upon which this case is based, I must respectfully dissent. The majority opinion shifts an unprecedented amount of authority to the reconsideration "process" (i.e., checking a set of boxes). The majority's opinion liquidates the statutory language of ORS 656.283(7). The majority also begs the question of whether a claimant's hearing rights are effectively eliminated when he/she is mandatorily shotgunned through the reconsideration process.

For these reasons, as well as those expressed in my dissent in Raymond L. Mackey, supra, I dissent.

May 12, 1993 Cite as 45 Van Natta 894 (1993)

In the Matter of the Compensation of
LYNDA J. THOMAS, Claimant
WCB Case No. C3-01068
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

On April 19, 1992, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

A claim disposition agreement must contain the terms, conditions and information prescribed in OAR 436-60-145(3) and (4). The Director's rules define a "claim disposition agreement" as a written agreement in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. (Emphasis supplied).

Here, the proposed disposition agreement provides that:

> "This claim has previously been denied by denial letter of September 22, 1992. However, prior to hearing on this denial, this claim was settled with this Claims Disposition Agreement so that claimant will be provided benefits due and payable as a result of this Claims disposition Agreement." (Emphasis supplied).

Moreover, the agreement recites that:

> "A separate Form 1502 will set forth the acceptance of this claim, which acceptance is conditioned upon the approval of this Claim Disposition Agreement." (Emphasis supplied).

As noted, the function of the CDA is to dispose of an "accepted claim," with the exception of medical services, as the claim existed at the time the Board received the CDA. See ORS 656.236(1). It is not the function of a CDA to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations and disputed claim settlements. See Frederick M. Peterson, 43 Van Natta 1067 (1991).

Moreover, the Director's rules state that a claim disposition agreement concerns an accepted claim. OAR 436-60-005(9). Claims that are in denied status are, by definition, not "accepted." Inasmuch as the present agreement purports to dispose of a denied claim, the claim disposition agreement impermissibly exceeds the bounds of OAR 438-09-020(1)(b).

We note that the parties have attempted to convert the denied claim into an accepted claim, apparently to bring it within the purview of the CDA process, as well as to more efficiently administer claimant's claim. We cannot approve such an arrangement. See Randi E. Morris, 43 Van Natta 2265 (1991). Further, we note that the parties have made the "acceptance" of the denied claim contingent on Board approval of the claim disposition agreement. We also do not approve agreements that are subject to the occurrence of a future uncertain event. See James J. Treml, 42 Van Natta 2594 (1990); Raymond E. Clonkey, 43 Van Natta 1778 (1991). Thus, because acceptance of the claim is contingent upon approval of the claim disposition agreement, we do not find there has been an acceptance of the denied claim.

We note that the improper portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration. We, therefore, conclude that we cannot approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990).

We also note that attorney fees in claim disposition agreements are limited to 25 percent of the first $12,500, plus 10 percent of any amount in excess of $12,500. OAR 438-15-052.

Here, the total proceeds of the agreement equal $15,000. Thus, in accordance with the aforementioned rule and absent extraordinary circumstances, claimant's attorney fee cannot exceed $3,375. The agreement, however, effectively provides for a total fee of $3,750. See page 1 and 3. Furthermore, the agreement does not recite extraordinary circumstances justifying an excessive fee.

For the above-stated reasons, we disapprove the present agreement and return it to the parties. See ORS 656.236(1)(a). Following our standard procedure, we will consider a revised agreement.

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.

In the Matter of the Compensation of
DEBRA R. THOMSON, Claimant
WCB Case No. 92-01249
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Mongrain's order that upheld the SAIF Corporation's denial of her claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 32 year old office counter worker. Her desk is situated in the middle of the employer's showroom on a raised platform. (Tr. 6). There is one step from the platform to the floor. On December 9, 1991, claimant slipped as she stepped down from the platform and her left foot "slammed" into the stair. Claimant felt pain from her back down her left leg, but was able to finish her shift. The morning after the injury claimant had mumbness in one of her toes and numbness on the inside of her left ankle. (Tr. 20).

The pain became more intense on December 18, 1991, and claimant had difficulty walking. On December 20, 1991, she sought treatment from Dr. Donohoe, naturopath, complaining of hip numbness and left leg pain beginning on December 18, 1991. (Ex. B-1). Thereafter she was also treated by Drs. Helman, Schefstrom and Shonerd and was seen for an independent medical examination by Drs. Coletti and Brooks.

On December 18, 1991, claimant told the employer's sales manager that she was having back pain. On December 20, 1991, claimant informed the employer that she believed her back injury had occurred at work. (Tr. 29).

Claimant's husband testified that he recalled claimant coming home one day and telling him she had pain in the back, leg and toe caused by slipping on a stair.

SAIF denied the claim on January 24, 1992. (Ex. 12).

CONCLUSIONS OF LAW AND OPINION

Although the Referee found that all witnesses were credible based upon their demeanor and that the incident claimant described was plausible, he concluded that claimant's symptom history was inconsistent and that the only medical opinion that established a probable relationship between the injury and a work incident was unexplained. On this basis, the Referee concluded that claimant had failed to prove that her low back condition was compensable.

In order to establish the compensability of her low back condition, claimant has the burden to prove, by medical evidence supported by objective findings, that her work activities were a material contributing cause of her disability or need for treatment. Mark N. Wiedle, 43 Van Natta 855 (1991).

Although we agree that the description which claimant gave to most of the physicians of the symptoms she experienced after the injury is inconsistent with her testimony at hearing, we nevertheless conclude that claimant has established compensability of her low back condition.

When claimant saw Dr. Donohoe on December 20, 1991, she reported hip numbness and left leg pain. Claimant could not at that time recall any specific injury. Dr. Donohoe's chart notes indicate that claimant subsequently telephoned and stated that she believed the injury happened at work when she "slipped off a chair."

When claimant saw Dr. Helman on December 23, 1991, she reported a history of missing a step at work and jamming her left leg. Claimant reported immediate pain which went away. She reported radiation of pain down her left leg for one day on December 18, 1991, which resolved. Dr. Helman diagnosed acute lumbar strain secondary to an industrial fall on December 9, 1991.

Dr. Shonerd reported a history that claimant slipped and fell on stairs at work. He reported that claimant's back hurt briefly at the time and felt somewhat better and then within a few days was worse with pain, stiffness and immobility. Dr. Shonerd diagnosed a left hip and lumbar strain.

Finally, claimant told independent medical examiners, Coletti and Brooks that she slipped on the stair and her left foot impacted on the stair with force. Claimant did not recall having any pain, but reported that she had back pain which developed slowly over a few days and required her to seek care about a week after the injury. Drs. Coletti and Brooks diagnosed a lumbar strain.

At hearing, claimant testified that she was truthful with all of the physicians. Claimant specifically recalled the history she gave to Drs. Donohoe, Helman and Shonerd. However, claimant testified that she had pain starting the morning after the incident which then worsened on the 18th of December. This history differs from that given to several of the doctors in that most of the physicians understood that there was no pain after the injury or that the pain resolved and then returned on December 18, 1991. Claimant's testimony is, however, consistent with the history Dr. Shonerd obtained which was that the pain was somewhat better after the incident and then worsened later.

In spite of the inconsistencies in claimant's reports of her symptoms after the December 9, 1991 incident, we are persuaded by the record as a whole that the December 9, 1991 incident occurred and was the cause of the back condition diagnosed by the physicians who examined claimant. In this regard, there is no evidence that claimant was injured off work or that she had a preexisting condition which could be responsible for her symptoms. In her testimony and in her reports to all of the physicians except for Coletti and Brooks, claimant stated she had pain at least initially right after the slipping incident. In addition, her reports of the mechanism of the injury and when the injury occurred are generally consistent. Finally, all examiners felt that the strain injury they diagnosed was consistent with the incident as claimant described it. In other words, no physician opined that the incident claimant described could not have resulted in the strain injury.

We note that Dr. Donohoe's chart note indicates that claimant recalled slipping off a chair rather than slipping on a stair. In light of the fact that all of the other physicians indicated that claimant reported slipping on a stair, we are persuaded that Dr. Donohoe's chart note is in error and that the correct history is that claimant slipped on a stair.

Accordingly, based on the record, we conclude that claimant has established that she sustained a compensable injury.

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 $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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 May 12, 1992, as reconsidered on July 1, 1992, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded $3,500, payable by SAIF.

In the Matter of the Compensation of
RANDEL G. JENSEN, Claimant
WCB Case No. 92-02227
ORDER ON RECONSIDERATION
Hollander & Lebenbaum, Claimant Attorneys
Lane, et al., Defense Attorneys

Claimant requested reconsideration of our January 26, 1993 Order on Review that found he was not entitled to interim compensation. Contending that he was forced from the work force as a result of his work-related condition, claimant seeks reinstatement of the interim compensation award granted by the Referee's order.

In order to fully consider the matter, we abated our prior order and granted the self-insured employer an opportunity to respond. After receiving the employer's response, we proceed with our reconsideration.

FINDINGS OF FACT

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

The Referee found that claimant was suspended from his job on September 16, 1991 for a period of 30 days. We find instead that, in accordance with the employer's drug policy, claimant was terminated from his job on September 16, 1991. However, he had the option of seeking reinstatement after 30 days if he could supply a "clean" drug test.

Following the expiration of the 30-day period, claimant was contacted by the employer to determine his interest in returning to work. (Tr. 102). Aware of his continuing bilateral hand/wrist symptoms, claimant did not ask his employer for reinstatement.

CONCLUSIONS OF LAW AND OPINION

In our initial order, we reversed the Referee's award of interim compensation. Upon further consideration, we agree with the Referee.

Claimant worked approximately 17 months for the employer, a wood products company. (From April 1990 to September 1991). He initially worked as an edger tailer. Some 4 months into his employment, claimant was assigned a "line-up" position on the trim saw feeder. This job required the repetitive use of his hands/wrists in that he flipped "2 x 4" lumber in a manner which permitted the sawyer to see the "bad side" of the lumber. In an average day, claimant handled between 8,000 and 9,000 pieces of lumber. After performing this "line-up" job for about 2 1/2 to 3 months, claimant began experiencing pain and swelling in both of his hands. Prior to this job, he had not experienced hand or wrist problems.

Aware of claimant's symptoms, his supervisor eventually reassigned him to lighter work duties (a job "measuring wood" and, subsequently, a "chipper tender position"). Although the latter position required less repetitive use of his hands, claimant's problems persisted. Despite these persistent problems, he neither sought medical attention nor filed a claim.

In September 1991, claimant suffered an injury which did not pertain to his hands/wrists. As a result of that injury, a urinalysis was performed. When the tests results were positive for marijuana, claimant was terminated pursuant to the employer's drug policy. In accordance with the employer's drug policy, claimant could seek reinstatement after 30 days if he could supply a "clean" drug test.

Following the expiration of the 30-day period, claimant was contacted by the employer to determine his interest in returning to work. Aware of his continuing bilateral hand/wrist symptoms, claimant did not ask his employer for reinstatement. Instead, he filed for unemployment benefits and sought other employment.

Claimant's unemployment compensation claim was denied. He worked as a roofer for two days and as a tree cutter for one day. Claimant also worked for a temporary employment agency that directed him to various available jobs. His first job involved the installation of custom concrete paving stones. However, because of his increasing hand and wrist symptoms, claimant was unable to perform these jobs for more than two days in a row.

Finally, on November 26, 1991, claimant sought treatment for his bilateral symptoms. He was examined by Dr. Rabie, who stated that claimant attributed his complaints to the repetitive handling, pulling, and twisting of lumber products. Noting claimant's work history for the employer (as an edger tailer, "line-up" for the trim saw, and chipper tender), Dr. Rabie diagnosed "bilateral wrist tendinitis (flexor, rule out carpal tunnel syndrome) with bilateral lateral epicondylitis). Prescribing medication, analgesics, wrist splints, and elbow straps, Dr. Rabie released claimant to "modified duty." Specifically, Dr. Rabie recommended that claimant perform no lifting, pushing or pulling over 15 pounds, and no repetitive gripping or bending with either wrist.

The employer received claimant's bilateral wrist claim in late November 1991. Its denial issued on February 11, 1992. Pending the issuance of its denial, the employer did not pay interim compensation. In light of claimant's "suspension" and his failure to return to work, the employer contended that claimant was not entitled to such benefits.

The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. ORS 656.262(4)(a). Pending acceptance or denial of the claim, such compensation is referred to as "interim compensation." Jones v. Emanuel Hospital, 280 Or 147, 151 (1977). The purposes of interim compensation are to prevent processing delays and to insure a worker's well being during the period in which acceptance or denial of a claim is being considered. Id.

Although a claimant is entitled to interim compensation whether or not his or her claim is ultimately found compensable, there is no duty to pay such compensation if the worker has not "left work" pursuant to ORS 656.210(3). Bono v. SAIF, 298 Or 405, 410 (1984). In Bono, the claimant sought interim compensation for a 22-month period between his employer's notice of his work-related accident and the subsequent denial of his claim. Noting that the record did not establish that the claimant "had been absent from work nor that his earning power was diminished," the Supreme Court determined that there was no entitlement to interim compensation. Id. In reaching its conclusion, the Court further reasoned as follows:

> "It is not necessary for a worker to be totally disabled in order to receive interim compensation. Any claim for a disabling compensable injury will trigger the ORS 656.262(4) payments. However, to the extent that the amount of such payments cannot be calculated, the worker should receive as interim compensation the temporary total disability benefits specified in ORS 656.210." Bono v. SAIF, supra, at page 410.

This "left work" requirement has been applied by the Court of Appeals on several subsequent occasions. There are two decisions which are particularly instructive.

In Weyerhaeuser Company v. Bergstrom, 77 Or App 425 (1986), the claimant filed an occupational disease claim after retiring from his employer. He sought interim compensation for the period between the date of his claim and the employer's denial, contending that his retirement was due to his allegedly work-related physical condition from an industrial hazard. (Claimant's claim was subsequently found noncompensable.) The court reached the following conclusion:

> "Whatever the merits of claimant's grievance about his retirement, the fact remains that he was retired at the time he filed his claim. Like the claimant in Bono, supra, he did not establish that he had been absent from work or that his earning power was diminished." Weyerhaeuser Company v. Bergstrom, supra, at pages 427 - 28.

In Nix v. SAIF, 80 Or App 656 (1986), the claimant was injured as a result of a work-related truck accident. As a result of his injuries, the claimant was unable to work for two weeks. Nevertheless, the carrier did not pay interim compensation pending its denial of the claim because the claimant had been terminated as of the date of the accident. Claimant sought interim benefits up to the

date of claim acceptance. Applying Bono and Bergstrom, the Nix court affirmed the Board's conclusion that the claimant was entitled to interim compensation for only the two week period of his disability. In light of claimant's firing, the court reasoned that he was away from work after recovering from his injuries for reasons unrelated to his injury. Nix v. SAIF, supra, at page 659. Consequently, after the claimant's two weeks of work-related disability, the court held that he was not entitled to additional interim compensation. Nix v. SAIF, supra, at pages 659 - 60.

The aforementioned court holdings instruct the Board to consider the following factors when determining entitlement to interim compensation. One, a claimant must "leave work;" i.e., either have been absent from work or have sustained diminished earning power. Two, if retired (or not in the work force) at the time of claim filing, a claimant has not established absence from work or diminished earning power. Three, if fired from work, but otherwise in the work force, a claimant is entitled to interim compensation only for that period attributable to work-related disability.

Here, claimant was terminated from his employment as a result of his positive drug test. He did not return to work for the employer. Rather, he petitioned for unemployment benefits and sought other employment. His work-search efforts proved successful, resulting in periods of employment as a roofer, tree cutter, and concrete paver. Nevertheless, each of these employments was short-lived due to his increasing hand and wrist symptoms.

Claimant finally sought medical treatment for his continuing complaints on November 26, 1991, when he was examined by Dr. Rabie. Attributing claimant's bilateral wrist condition to his repetitive work activities for the employer, Dr. Rabie released claimant to modified work. Specifically, claimant was restricted from repetitive gripping and bending activities, as well as lifting, pushing, or pulling over 15 pounds.

Thus, at the time he filed his claim, claimant was not working for the employer. Nonetheless, he was unable to perform work activities which required repetitive hand/wrist motions or handling items in excess of 15 pounds. Considering claimant's previous work history of manual labor for the employer and his subsequent employers, such limitations effectively precluded him from performing any of his past jobs. Consequently, in light of Dr. Rabie's "modified work" restrictions, we conclude that claimant suffered a diminution of his earning power. Accordingly, we agree with the Referee that claimant is entitled to interim compensation. See James E. Marek, 42 Van Natta 2578 (1990)(a claimant has "left work" if unable to work due to the injury regardless of whether the claimant initially left a particular job for other reasons).

We recognize that claimant was terminated from his employment with the employer prior to the filing of his claim. In addition, had claimant not been terminated, the employer might have been able to accommodate his "modified work" release without a corresponding reduction in wages. Yet, as noted above, the critical date for evaluating entitlement to interim compensation is the date claimant filed his claim. Weyerhaeuser Company v. Bergstrom, supra. Thus, since claimant was no longer employed by the employer at the time his claim was filed, any discussion of potential modified jobs with the employer would not only be mere speculation but also would not be germane to our analysis in resolving this interim compensation issue.

Furthermore, the case law establishes that the diminishment of the worker's earning power focusses on the worker's employment potential or capacity in general, as opposed to the worker's specific capacity for a particular employer. In reaching this conclusion, we draw from the analysis employed by the court when determining substantive entitlement to temporary disability for an initial claim or aggravation claim.

In such cases, the court has identified the critical time for determining whether a claimant has "withdrawn" from the work force to be at the time of the claimant's disability. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989); Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990). In making such a determination, the court has concluded that a claimant is deemed to be in the work force if: (1) the claimant is engaged in regular gainful employment; or (2) although not employed at the time of the claim, the claimant is willing to work and is making reasonable efforts to obtain employment; or (3) although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, the claimant is willing to work, but such efforts would be futile. Id.

Here, claimant was not engaged in regular gainful employment for any employer at the time of filing of his claim. Nevertheless, as demonstrated by his work-search efforts and brief employment stints for other employers, he was willing to work and had made reasonable efforts to obtain employment after his termination from the employer. Under such circumstances, we conclude that claimant was in the work force at the time he filed his claim with the employer. Thus, the imposition of Dr. Rabie's "modified work" restrictions resulted in a diminution of claimant's earning power.

Further support for our conclusion can be found in the reasoning expressed by the Supreme Court in Bono. As previously quoted, the Court recognized that a worker's entitlement to interim compensation is not contingent on total disability. Moreover, when determining the exact amount of such compensation, the Court referred to the calculations specified in ORS 656.210. Section (1)(b)(B) of the current version of that statute provides that if a worker is not working at the time that medical verification is received that the worker is unable to work because of the disability caused by the occupational disease, the worker's benefits shall be based on the wage of the worker at the worker's last regular employment. Thus, the statute envisions the possibility of the payment of temporary disability benefits from an employer for a claim filed after the termination of that particular employment relationship.

In reaching this conclusion, we distinguish Faustino Martinez, 44 Van Natta 2578 (1992), Dawes v. Summers, 118 Or App 15 (1993), and Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987). In Martinez, supra, following the claimant's termination from his employment, he filed a claim contending that he had suffered a work-related injury approximately one month before his firing. There was no discussion in the order concerning whether the claimant remained in the work force at the time his claim was filed. Rather, the claimant sought interim compensation on the basis that he was terminated because of his inability to perform his regular work duties as a result of his injury. In denying claimant's entitlement to interim compensation, we found that the claimant had been terminated for reasons unrelated to the alleged industrial injury. Thus, we were not persuaded that the claimant had sustained a work-related disability; i.e., he had not suffered a diminishment of his earning power as a result of his work activities.

Dawes did not involve the entitlement to interim compensation. Instead, Dawes concerned the employer's unilateral termination of temporary disability while processing an accepted claim. Specifically, four days after her return to work following a compensable injury, the claimant was terminated for reasons unrelated to her injury. She did not seek other work. (The court expressly noted in a footnote that "[t]he Board made no specific finding as to whether claimant voluntarily left the work force before she was fired. It found that 'claimant was released to modified work which she left for reasons unrelated to her compensable condition.'"). Thereafter, the employer unilaterally terminated her temporary disability benefits. The court upheld the termination of benefits, reasoning that "no wages, in whole or in part, were lost because of claimant's compensable injury. Therefore, no temporary compensation was due." Dawes v. Summers, supra, at page 20.

Similarly, Noffsinger v. Yoncalla Timber Products, supra, did not concern interim compensation. Rather, the issue was the claimant's entitlement to temporary disability following a litigation order which found the claim compensable. Nevertheless, the court's reasoning provides further support for our decision.

In Noffsinger, the claimant was fired from his employment as a millworker. The following day, the claimant saw a physician for symptoms related to stress. Shortly thereafter, the claimant was released for "regular work." His physician explained that he was in favor of the claimant's working, but not for his former employer. The claimant subsequently filed an occupational disease claim which was litigated and ultimately found compensable. The carrier refused to pay any temporary disability benefits, arguing that the claimant was not entitled to temporary disability because he was released for "regular work." The court agreed that no temporary disability benefits were payable.

The court framed the issue as whether "claimant is or has ever been disabled from work as a result of his compensable stress claim." Id. at 121. The court concluded:

> "Claimant's doctor released him for "regular work," including the millwork that he had done before, but recommended that he not return to [the employer] because of

his reaction to stress peculiar to that work place. The evidence establishes that claimant left work at Yoncalla because he was fired, not because he was disabled. He is not precluded from working for any other employer. We conclude that he has not lost wages because of an inability to work as a result of his compensable condition and that, therefore, he is not entitled to temporary disability benefits." Id. (Emphasis supplied).

Therefore, the focus is not solely on the claimant's "at-injury" employment. The Noffsinger court also considered the claimant's ability to perform work generally. Finding that the claimant was capable of working for "any other employer," the court concluded that the claimant had not lost any wages because of an inability to work. Similarly, in Dawes the court noted that the claimant did not seek other work following her termination. Here, in contrast, claimant remained in the work force after his firing and, in fact, performed work for other employers prior to the filing of his claim and the implementation of Dr. Rabies' "modified work" restrictions. Moreover, as we have concluded above, Dr. Rabie's modified work restrictions precluded claimant from performing any of his past jobs. Thus, even if Dawes and Noffsinger are applicable, claimant has established lost wages, in whole or in part, because of his compensable injury.

In conclusion, we find that claimant "left work" as that phrase is used in ORS 656.210(3) as a result of his work activities with the employer. Consequently, we hold that he is entitled to the interim compensation granted by the Referee.

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 and on reconsideration concerning the interim compensation issue is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and reconsideration memorandums), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 1, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the self-insured employer.

Board Member Hooton, specially concurring.

I agree with the majority position that claimant is entitled to interim compensation, that claimant remained in the work force following his termination from employer, and that the disabling effects of his compensable claim prevented his return to regular work for another employer. As a consequence I believe that claimant has demonstrated that he left work for reasons related to the compensable condition, and that his earning power was diminished as a result of the disabling effects of the compensable condition. See, Bono v. SAIF, 298 Or 405 (1984). I write only to address additional concerns at least one of which has special significance given the prevalence of drug testing programs in the modern workplace.

In this case, claimant appears to accept that his termination, which resulted from a positive drug screen following the report of an on the job injury, meant that he left work for the employer for reasons unrelated to the injury. I am not convinced that the law requires that result. Indeed, to the extent that the legislature has considered the question, it would appear that a contrary conclusion is appropriate.

First, and foremost, it is important to note that the evidence presented indicates that claimant, by company policy is required to submit to a drug screening examination whenever he files a claim for a work related injury. From the testimony of the claimant, in this regard, one could reasonably infer that there are no preconditions, such as evidence which would indicate probable cause to support the belief that claimant used drugs, which were necessary prior to requiring claimant to submit to drug screening. All that was required to trigger the obligation to submit to screening, was the filing of a workers' compensation claim. Claimant's testimony was confirmed by the employer representative.

Claimant is not entitled to interim compensation if he "left work" for reasons unrelated to his injury. Here the employer, by its own conduct, establishes the connection between the filing of a claim for compensation and claimant's subsequent termination. Where the employer establishes that connection, it is inappropriate to conclude that it does not exist. Nor am I willing to excuse the connection because it relates to the use of illegal drugs.

There is no evidence that claimant used drugs during work hours, or that his rare use of controlled substances ever placed him in a position in which he was operating machinery, or otherwise performing tasks for the employer in an inebriated state. There is also no evidence that the employer otherwise seeks to control the off duty use of drugs or alcohol by its employees. The only time that an employee is apparently required to submit to testing is following the filing of a workers' compensation claim.[1]

There is, at best, a nebulous argument to support drug testing following a work related injury. While it is possible that the use of drugs or alcohol could contribute to such an injury, workers are injured every day in Oregon who neither use controlled substances nor are otherwise "impaired" at the time of the injury. An injury alone, therefore, provides little, if any, basis for the suspicion that claimant is a user of controlled substances. Here, however, the employer deprives itself of even that nebulous basis for requiring a mandatory drug screen. It is not the injury, but the filing of a claim, that triggers the obligation to submit to such testing.

This is not to say that the employer has no interest in whether his employees use controlled substances on, or off, the job. Certainly, the employer does have such an interest and may reasonably advance it. It is also not to say that the use of controlled substances is acceptable behavior. Whether on, or off, the job, use of specific controlled substances is prohibited by law. All that I intend to say, and the limit of this opinion is that it is not appropriate for the employer to link mandatory testing for controlled substances to the filing of a workers' compensation claim, or, if they do, to terminate a worker for failing to pass the test, and then seek to further deprive the claimant of benefits authorized by the Workers' Compensation Law on the theory that claimant's termination is unrelated to an injury, or to the filing of a claim for that injury.

The legislature considered a similar, though not identical, proposition in the 1990 Special Session. The legislature did not conclude that a claimant could be deprived of benefits merely because of his use of alcohol or controlled substances. The legislature did provide a defense based upon such use, but required the employer to establish by clear and convincing evidence that the major cause of the injury was the claimant's use of alcohol or other controlled substances. See, ORS 656.005(7)(b)(C). Here, the employer seeks to use the claimant's acknowledged drug use to that same end, despite the fact that it has not established the requisite causal connection. I am unable to conclude that the legislature would accept the notion that the substance of the defense to liability should change because the denial of benefits that follows would be partial only, rather than a total denial of the claim.

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[1] It is arguable that we need not concern ourselves with providing claimant a remedy, since the legislature has already done so in ORS 659.410(1). That statute provides in pertinent part as follows:

> "(1) It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS chapter 656. . ." (Emphasis added).

Nevertheless, I would conclude, that where the employer, by its own action or policy, establishes the connection between an on the job injury and the claimant's subsequent termination, his entitlement to disability benefits should not depend upon whether he chooses to proceed under the terms of ORS 659.410(1) or, indeed, whether he is successful in the attempt.

Board Chair Neidig, dissenting.

My review of the evidence and application of the relevant statutes and case precedent has brought me to the conclusion that claimant is not entitled to interim compensation. Consequently, I must respectfully dissent.

To begin, temporary disability benefits are designed to replace wages lost due to a compensable injury. Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991). When a worker has been fired for reasons not related to the claim, no wages (either in whole or in part) have been lost because of a worker's compensable injury. Dawes v. Summers, 118 Or App 15, 20 (1993).

Here, it is undisputed that claimant did not leave his work for the employer as a result of his bilateral carpal tunnel syndrome claim. Rather, his departure from his employer was triggered by his "positive" drug test. Since claimant did not return to work for this employer prior to the filing of his claim, there are no wages from this employer to be replaced. Consequently, claimant is not entitled to temporary disability from this employer.

Secondly, to receive entitlement to interim compensation pending acceptance or denial of a claim, the worker must have "left work" pursuant to ORS 656.210(3). Bono v. SAIF, 298 Or 405, 410 (1984). In other words, claimant must estabish that his work-related condition has caused him to be absent from work or has resulted in diminished earning power.

I submit that claimant has failed to prove either portion of the Bono test. First, as previously discussed, claimant did not leave work as a result of his bilateral carpal tunnel syndrome claim. Second, his physician released him to modified work, which would appear to be within the lighter job duties claimant was performing for the employer prior to his departure. Since the burden of proof rests with claimant, such evidence does not establish that claimant's earning power has been diminished by the modified work release.

In conclusion, I consider an award of interim compensation under these circumstances (particularly when a worker has left his employment due to the violation of an employer's drug policy) to be inappropriate. For the foregoing reasons, I respectfully submit that the majority errs in awarding such benefits.

In the Matter of the Compensation of
RONNIE E. TAYLOR, Claimant
WCB Case Nos. 91-08984, 91-03910, 91-03909, 91-08983 & 91-08982
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Julie Bolt (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Schultz's order that: (1) upheld the SAIF Corporation's denial of his claim for a back injury; (2) declined to assess a penalty or related attorney fee for SAIF's allegedly unreasonable claims processing; and (3) declined to assess a penalty or related attorney fee for SAIF's allegedly unreasonable failure to provide discovery. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

We adopt the Referee's findings of ultimate fact with the exception of those findings numbered 4 and 5.

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on our decisions in Judy Witham, 40 Van Natta 1982 (1988) and David D. Allen, 43 Van Natta 2458 (1991), the Referee found that by acceding to the issuance of a ".307" order, SAIF accepted compensability of claimant's injury claim. Therefore, the Referee reasoned that SAIF could only deny the claim pursuant to ORS 656.262(6). On the merits, the Referee concluded that SAIF had sustained its burden of proof under ORS 656.262(6) and, therefore, upheld its denial. We agree that SAIF's denial should be upheld, but offer the following reasoning.

Subsequent to the Referee's decision, the Court of Appeals issued its decision in Castle & Cooke v. Alcantar, 112 Or App 392 (1992). In Alcantar, the court reversed the Board's holding that a carrier had waived the issue of compensability by acquiescing to the issuance of a ".307" order. The court stated:

> "A concession of compensability only admits that a claimant's condition resulted from a work exposure. It does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment." Id. at 395.

Although a ".307" was not ultimately issued in Alcantar, we find the court's reasoning equally applicable to cases in which a ".307" order has issued. The issuance of a ".307" order, like a concession of compensability, does not operate as an acceptance of the claim by the carriers involved. Rather, the carriers are conceding only that the claim is work-related as a general proposition, but not necessarily work-related to each specific carrier. In this regard, the distinction between acceptance of the claim and a concession of compensability by a ".307" order is crucial. Acceptance of a claim ends litigation of the matter. Issuance of a ".307" order, on the other hand, removes only one aspect of the case, which otherwise continues to proceed to arbitration. In addition, the distinction is particularly relevant to this case as ORS 656.262(6), which increases and transfers the burden of proof, is specifically premised on the finding that the carrier has accepted the claim.

The statutory scheme and the pertinent administrative rules are consistent with our reasoning. ORS 656.307(1) provides for the issuance of a ".307" order "if the employers and insurers admit that the claim is otherwise compensable." OAR 436-60-180(6) states that an agreement to the issuance of a ".307" order is "not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer."

When viewed in context, the statute and the rules establish that a primary goal of the ".307" procedure is to permit a worker to receive compensation notwithstanding a continued dispute over responsibility for the claim, by assigning initial responsibility for claim processing to a particular carrier. See ORS 656.307(1); OAR 436-60-180(11), (13). Appropriate reimbursements and adjustments are subsequently made to place the incurred claim costs with the ultimately responsible carrier following final resolution of the dispute. See OAR 438-60-190.

Section (6) of the aforementioned rule further confirms our conclusion that acquiescence to the issuance of a ".307" order does not constitute acceptance of a claim. Specifically, the rule provides that when compensability becomes an issue after the issuance of the ".307" order, the Compliance Section shall order termination of further benefits. The rule further instructs the designated paying agent to seek joinder of the issue of compensability with the responsibility proceeding and, if the responsibility issue is not concluded, the designated paying agent is precluded from recovering reimbursement.

The present case involves a compensability dispute following the issuance of a ".307" order. Consistent with OAR 436-60-190(6), the compensability issue has been joined with the responsibility issue.[1] Since such claim processing conduct is not only not statutorily or administratively prohibited, but in fact is contemplated by administrative rules, we do not consider such actions to be unlawful.

In conclusion, based on the aforementioned reasoning, we hold that the issuance of a ".307" order does not preclude a carrier from subsequently denying compensability. To the extent that our holdings in Judy Witham, supra and David D. Allen, supra are to the contrary, we disavow those decisions.

Inasmuch as we have concluded that SAIF was not precluded from denying compensability, SAIF does not have the burden of proof in this matter. Rather, it is incumbent on claimant to establish that he sustained a compensable injury while working for SAIF's insured. On the merits, we adopt the Referee's reasoning and conclusion as set forth in the second paragraph on page 6 of the Referee's order, that the claimant's back injury is not causally related to his work activities.

Penalties and Attorney Fees

We adopt the Referee's conclusion and reasoning concerning the penalty and attorney fee issues. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated February 6, 1992 is affirmed.

Board Member Brazeau, specially concurring.

The majority finds that although SAIF acquiesced in the issuance of a director's order pursuant to ORS 656.307, and did not attempt to alter its position until the time of the hearing, SAIF could still deny that claimant's claim was compensable and place the burden on him to prove his claim. Although I agree with the majority that SAIF should prevail on its denial, I believe the Referee was correct to hold that by acquiescing to a .307 order, SAIF conceded that claimant's claim was compensable and, therefore, could retroactively deny compensability only if it also assumed the burden of proof. I, therefore, write in special concurrence with the majority opinion.

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[1] Member Hooton argues that SAIF is precluded from contesting compensability because it never issued a written compensability denial. We conclude that it was appropriate for the Referee to consider the issue. First, SAIF did "orally" deny compensability at the initial June 27, 1991 hearing. (Tr. 4). Secondly, even if SAIF did not take the position that it was issuing an "oral" denial, it was apparent to all parties that the compensability of the claim was being contested. At the continued January 10, 1992 hearing, claimant did assert that SAIF was prohibited from contesting compensability as a result of its "acceptance" of the claim by virtue of the ".307" order. He also objected to SAIF's failure to issue a formal written denial. Nevertheless, claimant did not seek further continuance of the hearing on the grounds of surprise or prejudice. In light of such circumstances, the Referee was authorized to consider the compensability issue. OAR 438-06-031.

The original version of ORS 656.307 was enacted by way of the Legislature's 1965 omnibus workers' compensation bill. House Bill 1001 enacted, among other things, Section 39: "Payment of compensation when there is uncertainty as to identity of employer." That section provided that in multiple employer situations, the Board was to issue an order designating which of the employers was to pay the worker's claim, "if the claim is otherwise compensable." Or. Laws, Chapter 285, Sect. 39 (1965).

ORS 656.307 remained unchanged until 1971, when several new sections were added via Senate Bill 101. Among them was subsection (3), which provided, "The claimant shall be joined in any proceedings under this section as a necessary party, but may elect to be treated as a nominal party." Or. Laws, Chapter 70, Section 1 (1971) (emphasis added). That subsection remains the law today. See ORS 656.307(5).

Other significant changes were made to ORS 656.307 by the 1987 Legislature. Subsection (1) was amended to provide that the director would issue an order designating who should pay the worker's claim "if the employers and insurers admit that the claim is otherwise compensable." Or. Laws, Chapter 713, Sect. 5 (1971) (emphasis added). In addition, subsection (2) was created, providing that once the director issued a .307 order, the Board was to appoint a Referee to act as an arbitrator of the responsibility dispute. Board review of the arbitrator's order was then limited to questions of law and was not reviewable by any other court or administrative body. The 1987 changes to the statute also remain part of the current law. See ORS 656.307(2).

From the foregoing statutory history, I conclude that the purpose of ORS 656.307 is, and always has been, to provide for an orderly resolution of responsibility disputes, but only in those cases in which each employer and insurer have affirmatively "admitted" that a worker's claim is compensable. See ORS 656.307(1)(d). By specifically providing in ORS 656.307(5) that a worker may elect to be a nominal party to a dispute arising under the statute, I believe the Legislature intended for the worker not to be placed in a position of having to prove the compensability of his claim. Rather, I believe the Legislature's intent was to have employers and insurers that concede to the issuance of a .307 order be deemed to have effectively excused the worker from further participation in the responsibility process, except under the circumstances to be discussed infra.

The prejudice that may result from allowing an employer or insurer to shift the burden of proof to the claimant after acquiescing to a .307 is amply illustrated by the case before us. Here, SAIF issued a disclaimer of responsibility on May 26, 1991. Upon the Department's subsequent request for clarification, a SAIF claims examiner specifically admitted that claimant's claim was "work-related," that the sole remaining issue was responsibility as between SAIF and EBI, and that the intent of SAIF's denial was to deny responsibility only. EBI thereafter confirmed that only the issue of responsibility remained at issue, and it requested a .307 order on May 28, 1991. Based on the insurers' concessions, the Department issued a .307 order on June 27, 1991.

Thus, as of the date of the hearing, claimant had notice only that each insurer had "admitted" compensability and was going forward solely to assert that the other carrier was responsible. Claimant was not on notice that he had to appear to prove his claim in the first instance. I agree with the Referee that, under these circumstances, if SAIF wished to change its position at hearing, it was SAIF, rather than claimant, that should have been assigned the burden of proof.

Prior to the 1990 amendments to the workers' compensation law, we held that retroactive denials of a worker's right to compensation were not allowed, except as permitted by the exceptions set forth in Bauman v. SAIF, 295 Or 788 (1983), i.e., upon a showing by the insurer that the worker's claim was accepted as a result of fraud, misrepresentation or other illegal activity. See Gerald N. Ahlstrom, 38 Van Natta 958 (1986), citing Retchless v. Laurelhurst Thriftway, 72 Or App 728, rev dev 299 Or 251 (1985); Jeld-Wen, Inc., v. McGehee, 72 Or App 12, rev den 299 Or 203 (1985).

As a result of the 1990 Special Session, amended ORS 656.262(6) provides that if an employer or insurer accepts a claim in good faith, it may later revoke that acceptance within two years if it obtains evidence that the claim is not compensable. The statute specifically assigns the burden of proof to the employer, however, to prove noncompensability by clear and convincing evidence. Claimant, therefore, need not do anything until the employer or insurer sets out a prima facie case that the claim is not compensable.

I acknowledge that both Bauman, supra, and ORS 656.262(6) contemplate that an "acceptance" by the employer or insurer is a condition precedent to the invocation of the principles of retroactive denial. Further, my research has revealed no appellate court decision that has addressed the specific issue of whether acquiescence to a .307 order constitutes an "acceptance" of a claim.

The Board, however, answered that question in the affirmative in Judy Witham, 40 Van Natta 1982, 1986 (1988). Although I believe Witham may have overstated the effect of the insurers' concession to a .307 order, i.e., "a specific acceptance of the compensability of [a worker's] condition by both insurers," id. (emphasis added), I believe it correctly held that, in the context of the entire responsibility scheme, acquiescence to a .307 order should at least put an employer/insurer wishing to retroactively deny compensability in the position of having the burden to change the status quo.

As did the Referee, I would conclude that because SAIF sought to deny compensability after previously conceding that claimant's claim was compensable, it was SAIF, rather than claimant, that should have been assigned the burden to prove that claimant's claim was not compensable. I agree with the Referee that SAIF was successful in that regard, but disagree with the majority that it did not have the burden of proof in the first instance. I, therefore, specially concur with the opinion of the majority.

Board member Kinsley, specially concurring.

I agree with the majority's conclusion that this fraudulent claim is not compensable based on the authority cited therein.

The applicable law regarding the processing and litigation of claims when responsibility between two or more employers or insurers is in issue has long been one of the most complex and confusing areas of the Workers' Compensation Law.

One of the main causes of confusion is the assumption that an employer or insurer is able to "admit" that another insurer or employer is liable for the claim. This, of course, is impossible. A party may only admit or concede its own liability. A party may allege that another party is liable, or all the parties may agree to stipulate that a particular party is liable. However, one party cannot unilaterally "admit" on another party's behalf that the other party is liable. Given that being a party to an order issued pursuant to ORS 656.307 "is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer [whomever that may be]", it follows that SAIF never conceded compensability as to it and never accepted the claim. (Emphasis added.) See OAR 436-60-180(7).

It's no wonder that claims examiners are confused when they are asked to do the impossible. However, claims examiners are quite able to evaluate the work exposure that a particular claimant had with the particular employer that they insure. They do this every day in claims where responsibility is not at issue. If this was the question that responsibility laws asked of employers and insurers, we would be a long way down the road in simplifying this area of the law.

This is how it would work:

1. The insurer against whom a claim has been filed determines if there is another Oregon employer or insurer that could be potentially liable for the claimed condition under our responsibility assignment laws.

2. The insurer then determines if there was a sufficient causal relationship to its covered employment to establish its liability for the condition. Under this step, the insurer is ignoring the responsibility assignment laws which apply the principle that, in Oregon, we do not apportion liability for a claim. In other words, but for the responsibility assignment laws, would this insurer be liable for at least a portion of the payment?

In the case of an injury, the insurer determines whether the employment exposure at its insured's employment was a sufficient cause of the claimed injury condition under ORS

656.005(7). In the case of a disease, the insurer determines whether the employment exposure at its insured's employment was a sufficient cause of the claimed disease condition under ORS 656.802.[1]

At this step, the insurer would also determine if there would be any other compensability defense to the claim particularly pertaining to it, such as the claim being barred due to untimely filing or that claimant was not a subject employee.

3. If, but for the responsibility assignment laws, the insurer determines that it would be liable for payment of the claim, then it should apply for an order designating a paying agent pursuant to ORS 656.307. In doing so, the insurer could truly admit that the claim is otherwise compensable, but, because of the responsibility assignment laws, there remains a question of which insurer will be ultimately liable for payment.

In these situations, if the claimant has properly filed claims against all potential employers and insurers so that the responsibility assignment laws would place liability on an employer or insurer who was a party to the arbitration proceeding, then the claimant would be assured of receiving compensation pursuant to ORS 656.307 and OAR 436-60-180.

However, the method suggested above was not the one required at the time this claim was processed. The applicable rule only required SAIF to "admit" that claimant's condition was related to some other work exposure. SAIF did that when it alleged that a prior employer and insurer may be responsible for the claim. SAIF had not waived its "right to argue that the disability is not related to a work exposure in its employment." Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992).

Further, I disagree with the opinion in the dissent that the claimant did not have proper notice of SAIF's oral denial of compensability. OAR 438-06-031 states that amendments to the parties' initial specification of issues shall be freely allowed up to the date of the hearing. SAIF stated its denial on the record when the hearing was first convened on June 27, 1991. SAIF asserts in its brief that it denied compensability in its March 26, 1991 denial. However, it takes the secondary position that it denied compensability on June 27, 1991, the same date that the order was issued pursuant to ORS 656.307. The hearing was not reconvened until January 10, 1992. Therefore, the claimant was given notice of the denial in person, at hearing and with his attorney present, and he was given six additional months to prepare his case on that issue for presentation at the reconvened hearing. It is true that SAIF did not reveal the basis of its denial until the testimony of its witness, Gary Nelson, took place on January 10, 1992. However, OAR 438-06-031 further provides:

"The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice."

Here, claimant did not request a continuance. The purpose of a written notice of denial is to apprise a claimant in a timely manner of what was denied, the reason for the denial, the right to request a hearing and the right to be represented by legal counsel. All of these purposes were fulfilled by the oral denial except that the reason for the denial was offered late. However, the rule cited above gave claimant the opportunity to request further time to prepare his case should he require it. Claimant declined to make this request at hearing. It is too late for claimant to rely upon that reason now in order to oppose our review of SAIF's oral denial on review.

Finally, contrary to the dissent's suggested remedy, it appears that the claimant has not asked us to find EBI responsible for his claim. Given that Referee Schultz and a majority of this Board has found that the injury that was alleged to be both the basis of the aggravation claim against EBI and the new injury claim against SAIF did not occur, it is reasonable to approve both insurers' denials.

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[1] I recognize that simultaneous employment-caused and successive employment-caused conditions combined with the "major contributing cause" test and the "could have caused over some indefinite period of time" test may make this determination difficult. Here, I would suggest that the claims examiner would have to determine both that work exposure overall was the cause of the condition and that their particular work exposure actually contributed, at least in part, to the condition. There may be a need for further refinement of these tests so that claims examiners can determine the proper steps to process a claim based on actual causation, rather than being based on speculative causation.

Board Member Gunn, dissenting.

I agree with Board Member Brazeau's most thorough and logically persuasive analysis in his special concurrence. However, I dissent from the majority's conclusions for the following reasons.

I believe that the parties' acquiescence to a .307 order creates a "good faith acceptance" as stated in ORS 656.262(6). I reach this conclusion because the majority's interpretation that a .307 order does not constitute an acceptance renders the provisions of ORS 656.307 a nullity.

I understand the majority's struggle to divine a legal acceptance from the responsibility law. Therefore, I offer the following viable legal construction (with member Brazeau comments) which hopefully will make such an interpretation more palatable to the Court, if not the majority.

I am driven to this idea by the conclusion that the Board in its prior interpretation of "good faith acceptance" has broaden that concept to cover a host of sins by insurers that do not seem to constitute an acceptance. See Sharon J. True, 44 Van Natta 121, on recon 44 Van Natta 261 (1992) and Susie A. Fimbres, 44 Van Natta 1730 (1992). Moreover, construing a .307 order as a "good faith acceptance" seems more rational than to allow insurers to invalidate the provisions of ORS 656.307 by the simple act of a belated compensability denial. If, as the majority concludes, the insurer has no onus to bear by such actions, the logical inquiry is to ask is: why even allow for the .307 process? If the bottomline is that a .307 order has no substantive effect via subsequent denials, then what reason is there for the statute's existence? Therefore, the only satisfactory result which I could accept is for SAIF be allowed to revoke their claim acceptance by issuing a back-up denial and consequently, assume the burden of proving by clear and convincing evidence that the claim is not compensable.

Accordingly, to first reach the issue of whether ORS 656.262(6) and a "good faith acceptance" analysis is applicable here, the threshold issue is whether a .307 order acts as an acceptance. I note that the issue before us was previously decided in Eler M. Cousin, 44 Van Natta 2285 (1992). In Cousin, we found that the insurer could issue a back-up denial subsequent to a .307 order and compensability must be established pursuant to ORS 656.262(6). Cousin, notwithstanding, I also find appellate court decisions which indicate that a .307 order's admission of compensability constitutes an "acceptance" of a claim.

To begin, I believe the majority's reliance in Castle & Cooke v. Alcantar, 112 Or App 392 (1992) in support of its conclusion is erroneous. The majority reasons that Castle & Cooke holds that a concession of compensability does not operate as an acceptance of a claim; rather, a carrier is only conceding that the claim is generally work-related. I do not agree that a reading of Castle & Cooke renders such a holding.

Rather, Castle & Cooke provided that a concession of compensability is conceding that a claim is compensable to someone but not a concession that the disputant employer is the responsible party for the compensable claim. The Castle & Cooke opinion merely demonstrates that a dispute regarding the issue of causation may arise in the context of responsibility even where there is no causation dispute concerning compensability.

To break it down further, Castle & Cooke acknowledges that causation is a two-prong issue. There is the issue of causation as it relates to compensability. There is the issue of causation as it relates to responsibility. The court in Castle & Cooke was distinguishing the two types of causation issues. However, no where in Castle & Cooke does the court suggest that it was distinguishing a "concession" from an "acceptance" of compensability.

Next, in Davis v. R & R Trucking, 112 Or App 485 (1992), SAIF was designated as the insurer/processor for Buker Trucking, a noncomplying employer. SAIF also insured Roberts Fire Sprinklers. SAIF issued two denials, one on behalf of each of its insured. The first denial was for both compensability and responsibility (Buker) and the other denial (Roberts) was a denial of responsibility only. Thereafter, SAIF requested a .307 order. The .307 order issued (with the compensability denial still outstanding). The result was that the Board and court declared the .307 order invalid because acceptance/concession of compensability is a requirement for a valid .307 order.

I acknowledge that the facts of Davis are distinguishable from the present case. However, the court's treatment of the facts are useful and provide guidance to the present matter.

In particular, Davis holds that where the question of compensability is specifically reserved, there is no acceptance of compensability. Thus, a .307 order cannot issue. Davis supports that there must be an acceptance of compensability before there is a valid .307 order. In other words, accepting compensability is a procedural requirement. Without that, a .307 order is invalid and the issues of compensability and responsibility are thrust into dispute again.

Accordingly, if the majority is correct in finding that there was no "acceptance", then under Davis, the .307 order must be invalid. There is no other choice because a valid .307 order requires that the issue of compensability no longer be in dispute.

I need not list all the possible horrific ramifications of such an outcome as it is freely evident that problems involving lapsed memories, missing witnesses, lost medical reports, and a legion of other vicissitudes would arise from the delayed and extended litigation of claims. Even the most iniquitous of minds could not envision such a log jam to be the legally proper resolution of workers' compensation claims.

Accordingly, since the procedural requirement (compensability conceded) has been met in the instant case, then I find no rationale for invalidating the .307 order. However, under the analysis of Eler M. Cousin, supra, I find it necessary to apply ORS 656.262(6) in regard to SAIF's back-up denial.

In further support of my conclusion, I briefly mention the following additional court and Board opinions.

In International Paper Company v. Riggs, 114 Or App 205 (1992), neither party had conceded compensability; thus, it was still in issue and could be litigated at hearing. Hence, the court found that ORS 656.307 was not applicable.

Again, the court set forth that a .307 order is applicable when the the issue of compensability is no longer an issue still available for challenge. Therefore, a "concession of compensability" must equate to an acceptance of compensability inasmuch as that is the only way it can be removed from being an available issue at hearing absent a back-up denial.

Or simply put, in Riggs, both parties denied responsibility and did not concede compensability. Accordingly, the court held that compensability could be an issue at hearing. I find that the converse would apply. That is, here, both parties denied responsibility and did concede compensability. Therefore, we ought to hold that compensability cannot be in issue without a back-up denial.

Finally, in Ben Santos, 44 Van Natta 2228 (1992), SAIF denied compensability. The Board held, therefore, that SAIF was prevented from the use of a .307 order.

In sum, a denial prevents the issuance of a valid .307 order. Therefore, in the present case, if SAIF did not accept compensability, then it is prevented from the appointment of a paying agent pursuant to ORS 656.307. However, if the .307 order constitutes an acceptance, then SAIF may issue a back-up denial and then meet the constraints of ORS 656.262(6).

It cannot be both ways. Nor can it be somewhere in the middle. SAIF cannot have a .307 order and litigate compensability without issuing a back-up denial. The only other possible solution, within the policy considerations of the workers' compensation laws and as supported by legislative history, is to find that the .307 order constituted a good faith acceptance of compensability.

Since SAIF, after being informed by claimant of the circumstances under which claimant alleged the injury was sustained, sought issuance of a .307 order, I would find that SAIF accepted the claim in good faith. Accordingly, SAIF's at hearing oral denial is a back-up denial and it is SAIF's burden to prove by clear and convincing evidence under ORS 656.262(6) that the claim is not compensable.

Quite frankly, I believe the majority's determination on this matter opens up an undesirable can of worms that I'm afraid I would not offer to a hungry sparrow let alone legally force feed to claimants and insurers. In conclusion, I would find that .307 order constitutes at least a good faith acceptance. To do otherwise jettisons established law, rewards gamesmanship over legal obligations and breeds and multiplies litigation.

Board member Hooton, dissenting.

I disagree with the majority's apparent conclusion that a .307 order has no bearing on the question whether the insurer has accepted a claim. I agree that conceding to the issuance of such an order is not an acceptance. However, agreeing to the issuance of such an order does deprive the insurer of the right to raise compensability related issues at the hearing on responsibility, unless the insurer first takes steps to eliminate the Order Designating Paying Agent. In addition the majority fails to reach significant issues that must be resolved prior to reaching the conclusion that SAIF's "denial" of compensability is proper and should be affirmed.

The vast majority of cases discussing the inherent qualities of responsibility litigation occur in the context of a request for attorney fees. In those cases the oft repeated maxim is that in a responsibility setting the claimant's entitlement to receive compensation is not at risk. See, for example, Davis v. Aetna Casualty Co., 102 Or App 132 (1990); Mercer Industries v. Rose, 100 Or App 252, modified on recon 103 Or App 96 (1990); Howard v. Willamette Poultry, 101 Or App 584 (1990); Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985); John L. Law, 44 Van Natta 1091 on recon 44 Van Natta 1619 (1992). Those case make responsibility litigation appear to be a magically simple resolution of the issue "whose paying, because somebody must". The present case is one of the examples of responsibility litigation that shatters the illusion of simplicity and security, and exposes our basic ignorance of what we are trying to accomplish when resolving a responsibility dispute.

There are at least two different underlying theories of responsibility that have been applied to the Workers' Compensation law over time. The first, and most frequent, is that responsibility litigation is the determination of which of two or more insurers with actual liability ought to bear responsibility for the cost of an acknowledged compensable claim. This theory has the same basis as the standard coordination of benefits provisions in first party insurance agreements.[1] The coordination of benefits provisions of such a contract comes in to play where a single insured is covered by more than one contract. The coordination of benefits provision will determine which of two insurers, both of whom have an obligation to provide reimbursement under their separate contracts, will ultimately be responsible for paying the claim.

It is also possible for a third party situation to arise in which there a multiple potentially liable insurers. These situations arise either because there are two or more insurers agreeing to defray the liabilities of the same insured, or because there are multiple insureds who causally contributed to the loss experienced by the victim. In the first case, responsibility is established similar to first party situations, by a coordination of benefits provision designating who will be the primary, and, who the secondary payor. In the second case, the question of responsibility is resolved by settlement between the insurers, or, in litigation based upon the degree of contribution, and thus, on actual liability. Nevertheless, third party and first party insurance are similar in that the responsibility situation only arises after liability on the contract has been established.

A third form of responsibility dispute that can arise in insurance law is the relationship that arises where a first party insurer is responsible under its contract to reimburse the expenses of its own insured, who is also a victim eligible to receive reimbursement from a third party covered by liability insurance. This situation is resolved by the application of subrogation law, in which the first party insurer is entitled to reimbursement for its expenses because, by virtue of having provided benefits under its contract, it is elevated to the shoes of the victim in the third party case.

Ultimately each of these models of responsibility litigation is based on the notion that more than one insurer is ultimately, and legally, responsible for providing the economic benefit of their contract to an identifiable individual or group. Liability is not at issue. This is the theory of responsibility litigation applied by the court and this Board when the issue is the payment of attorney fees. See for example, John L. Law, 44 Van Natta 1091 (1992).

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[1] First party insurance contracts are contracts between an insured individual or group and an insurer which provide benefits directly to the insured in the event he requires certain services or makes certain expenditures covered under the contract. The archetypal first party insurance coverage is health insurance, in which an insurer pays or reimburses the insured for services required as a consequence of illness or injury. First party insurance contracts are distinct from third party insurance contracts in which the insurer agrees to defray a liability for the expenses of a third party created by the act of the insured.

The second theory of responsibility litigation is, so far as I have been able to determine, peculiar to the Workers' Compensation Law. Under that theory, claimant must make a claim against every potentially responsible employer. Some of those employers will not have a sufficient causal impact on claimant's condition, perhaps even none at all, to warrant liability under the Law. However, if the insurers generally agree that claimant's condition arose from employment, the resulting litigation is called responsibility, even though claimant is required to prove the causal element as to each and every potentially liable insurer. As noted in the dissent in John L. Law, supra, this theory of responsibility litigation means that claimant could conceivably fail in his burden of proof as to each and every employer, and therefore fail to receive any compensation at all. This is not responsibility litigation, it is compensability litigation in a very thin disguise.

This second theory of responsibility is applied in this forum, and in the courts, though it is usually applied when attorney fees are not at issue, but claimant's rights are. See for example, Castle & Cooke v. Alcantar, 112 Or App 392 (1992); Rodney L. Kosta, 43 Van Natta 180 (1991).

Neither inurers, self-insured employers nor claimant's are able to readily determine how to approach responsibility litigation. Because we apply two different theories that are wholly inconsistent, it is doubtful whether insurers are even aware what is being asked of them when the Department inquires whether responsibility is the only issue. Certainly in the absence of a .307 order the cases waffle between the two theories presented above sufficiently to deprive the parties of a sound method for determining liability, or even of preparing their case for hearing. The only bright spot to date has been .307 litigation in which, because the claimant was generally considered a nominal party, the only real question was who would pay the claim. Nevertheless, the confusion in responsibility law is such that I seriously doubt that there is any uniformity of belief among the parties what an insurer is agreeing to when it concedes to the issuance of a .307 order.

Only the first of the two theories presented above adequately addresses what is at issue in the "responsibility" question. In other insurance situations the question is resolved based on principles of coordination of benefits which apportions the obligation to provide payment between two or more insurers both of whom have a contractual obligation to provide similar or identical benefits. However, under the Oregon Workers' Compensation Law, we do not recognize the principle of apportionment as a method of determining the obligation of insurers to provide the benefits required by statute. Inkley v. Forest Fiber Products Co., 288 Or 337, 342 (1980). Consequently, we are required to select one of several insurers to provide benefits for a condition to which more than one employment exposure has contributed.

With this in mind it is apparent that the question of responsibility cannot arise unless there are two or more insurers each of whom would be liable for the claimant's condition, were it not for the contribution of the other's employment exposure. The insurers involved in a true "responsibility only" dispute would both be in a position where there was a sufficient causal relationship to their covered employment to establish their liability for the condition as a matter of legal obligation. Since claimant is not entitled to a double recovery, and since Oregon does not recognize apportionment, responsibility litigation determines which of these two employers will actually pay the benefits required by law.

Chapter ORS 656 does not define the term "responsibility". Prior to July 1, 1990, when the amendments to chapter 656 made by Oregon Laws, 1990, Special Session, Chapter 2 became effective, the only statute which addressed the question of responsibility was ORS 656.307. At Subsection (1) that statute provided that the question of responsibility arose in the following four situations:

"(1) Where there is an issue regarding:

"(a) Which of several subject employers is the true employer of a claimant worker;

"(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

"(d) Joint employment by two or more employers,. . ." (Emphasis Added).

Subsection (a) represents the original form of ORS 656.307 adopted in 1965. Subsections (b) through (d) were added to ORS 656.307 in 1971 and have remained virtually unchanged since their adoption. These sections tend to indicate that the primary focus of the legislature in resolving responsibility disputes is to resolve disputes in which the elements of a compensable claim have been established as to more than one employment, or contributing party, a view of responsibility litigation that is consistent with the first theory of responsibility presented above.

In 1990 the legislature added ORS 656.308 which further solidifies the implication that the legislature considers responsibility issues to be reached when two or more insurers are, or would be, required to provide benefits under the statute based on incidents occurring in their individual employment coverage. ORS 656.308 provides in pertinent part that:

> "(1) When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition..."

By distinctly describing the responsibility issue as a separate issue from compensability, and arising only after compensability has been established, the legislature clearly indicates its view that responsibility litigation involves situations in which the liability of every potential employer is already established.

It is at this point, however, that sanity ends in responsibility law and the Department, the Board, and the courts create a quagmire which snares both claimants and employers in confusion and doubt. The Department, which is suppose to adopt rules for the efficient administration of the Workers' Compensation Law which are consistent with and effectuate the terms of the statute, leads the way.

In response to the specific statutory language at ORS 656.307 the Department adopted administrative rules governing the issuance of an Order Designating Paying Agent Pursuant to ORS 656.307 at OAR 436-60-180. That administrative rule defines "compensability" and "responsibility" as follows:

> "(1) For the purpose of this rule:
>
> "(a) 'Compensable injury' means an accidental injury or damage to a prothetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death." (Emphasis added.)
>
> "(b) 'Exposure' means a specific incident or period during which a compensable injury injury may have occurred."
>
> "(c) 'Responsibility' means liability under the law for the acceptance and processing of a compensable claim."

The definition of "Compensable injury" utilized by the department in the issuance of a .307 order modifies the statutory requirements that are a prerequisite of the order and require the insurer to determine whether claimant has a compensable injury related to "any" Oregon employment. That is not the requirement laid out in ORS 656.307, which requires the insurer only to determine whether a potentially causal event has occurred during the period of its own coverage exposure, a requirement consistent with the first theory of responsibility litigation laid out above. The Department's administrative rule, however, adopts the second.

This shift away from the statutory view of responsibility litigation toward the adoption of a theory of responsibility contaminated by the principles of compensability, is furthered by the Board in Rodney L. Kosta, 43 Van Natta 180 (1991). In that case a compensability denial by a single insurer was used to raise the issue of causation as to any Oregon employment, and thus defeated the entire claim for compensation, even though the balance of the insurers in the claim denied only responsibility, conceding that the claim was otherwise compensable. Under the first theory of responsibility litigation,

each party's stipulation of compensability would apply to establish that a sufficient causal connection existed to that insurer's covered employment exposure to permit the assignment of responsibility in the absence of other contributing employment. A denial of compensability by a single insurer would effect only its own coverage and thus be a denial that there was a potentially causal event during its employment exposure.

By treating a compensability denial as though it were a denial that claimant suffered a compensable injury in any covered employment the Board adopted the reasoning of the administrative rules, ignoring the express requirements of the statute.

Finally, the Court of Appeals joined the band wagon in Castle & Cooke v. Alcantar, 112 Or App 392 (1992), when it identified a causation issue that is peculiar to responsibility litigation, as distinct from compensability. I note that it did not indicate how causation differed in responsibility litigation, nor did it cite any authority for the distinction.

Under this non-statutory theory of responsibility, claimant may arrive at a hearing at which responsibility is the only issue, certain in his knowledge that, under Petshow, regardless of the outcome of the hearing, he will receive the benefits to which he believes himself entitled. At the hearing, however, each and every insurer may indicate that there is insufficient evidence of a causal relationship to its employment exposure to justify assigning responsibility to it. If claimant is unable to establish the necessary causal link he will not receive compensation, even though compensability was supposedly never at issue, and even though every employer for whom he has ever worked in his life was made a party. Clearly, this is not what the legislature intended when it adopted ORS 656.307, or even envisioned as a possible outcome in a responsibility only case.

It is also worth noting that, with the possible exception of the Department's rule (which I have not traced back beyond 1989), the development of the second theory of responsibility litigation is relatively recent. The principle cases, Kosta and Alcantar, were only recently decided, and by all appearances this second theory is applied only when doing so seems to promote the desired end of depriving claimant of compensation to which, absent the concessions of the insurers, he would probably never have been entitled.

To support the position that responsibility litigation is really compensability litigation in a very thin disguise, the majority could assert any one of three arguments. First, it can argue that ORS 656.307 does not say what it says. The contents of ORS 656.307 have been adequately addressed above to demonstrate the absurdity of that argument. Second, the majority can assert that there is a difference between litigation under ORS 656.283 at which responsibility is the only issue and litigation pursuant to ORS 656.307. However, that issue was raised, discussed, and rejected by the legislature when the attorney fee provision of ORS 656.307(5) was adopted. Third, it can demonstrate that there is a difference between the causal question arising under compensability litigation and the causal question that arises under responsibility. While I can think of no differences that would support such an argument, I would be interested in the attempt.

What the majority actually does, however, is the same thing the Court of Appeals did in Alcantar; i.e. provide no argument in support of its position and no citation to authority except Alcantar, which itself has no basis.

I agree with the majority that some responsibility cases must now be disavowed. The dispute, however, is which cases those ought to be. If the first theory of responsibility is correct we must disavow Kosta and ignore Alcantar. If the second theory is correct, we must disavow the attorney fee portions of Law and all similar cases, and ignore Petshow and its progeny. Under no circumstances, however, does Alcantar require that we disavow the Board's prior precedent in Judy Witham, 40 Van Natta 1982 (1988), or David D. Allen, 43 Van Natta 2458 (1991).

The appropriate question, at this point, of course, is what has all of this to do with the present case?

SAIF agreed to the issuance of a .307 order after specifically advising the Department that responsibility was the only issue and that all issues of compensability had been resolved. Under the terms of the statute, though not the rule, SAIF could not argue that there was no causal link to its employment. By the express language of ORS 656.307 SAIF conceded that there had been an accidental injury in the course and scope of employment with its insured. See ORS 656.307(1)(c).

Even if we adopt the second theory of responsibility litigation, however, which, following Alcantar we may be required to do, the terms of the statute notwithstanding, SAIF can only raise causation issues following the issuance of a .307 order as those issues relate to its own employment exposure, and do not affect the causation issues related to EBI's coverage. The final outcome of this case is only reached through the reaffirmation of the Kosta analysis, and a proper denial of compensability.

Given the express language of the statute and the concession by SAIF, Referee Schultz properly concluded that SAIF was entitled to litigate compensability only by way of a back-up denial, in which SAIF bore the burden of proof. The majority concludes that he is wrong based on an extension of the reasoning in Alcantar that is clearly violative of the statutory directives in responsibility litigation and which are not warranted by the court's holding in that case.

In Alcantar the court indicated that a responsibility only denial does not prevent the insurer from alleging that there was no causal event while it was on the risk that would warrant an assignment of responsibility against that insurer. It does not permit the insurer to deny compensability as to any covered employment. Neither does it consent to such a denial, absent a properly issued back up denial with the attendant shift in the burden of proof.

The more interesting element of this case, however, is not the reasoning of the majority in reaching its inappropriate conclusion, but rather the lack of any symmetry between the allegations and arguments of the parties and the majority's ultimate decision. The claimant contends that the referee was precluded from reaching the issue of compensability by virtue of the .307 order. Throughout the hearing, claimant maintained that he was not required to respond to the insurer's oral denial of compensability and that the Referee lacked the authority to address it. Because the denial is oral only it does not meet the requirements of ORS 656.262(6) for a denial, and claimant is correct.

ORS 656.262(6) provides in pertinent part as follows:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. . . ."

This statutory mandate has been interpreted by the Board to include the requirement that the notice of claim denial "specify the factual and legal basis for denial." OAR 438-05-055. The notice of denial, therefore, not only provides notice to the claimant that legal action is required to establish a compensable claim, but provides the claimant with the basis for the insurer's objection so that claimant may prepare his claim to meet those objections.

The written denial has been given specific significance in subsequent litigation by the court who stated recently that the insurer's intentions at the time of issuance of the denial are irrelevant, and the plain language of the denial controls the issues and the proof claimant is required to present. Tattoo v. Barrett Business Service, 118 Or App 348, 351-2 (1993).

That is not, of course, to say that compensability can never be litigated without the issuance of a written denial. We recognize that compensability may be placed at issue in a hearing by the claimant as a de facto denial of compensation where the insurer has failed to issue either a notice of acceptance or denial. We have also permitted litigation of compensability based upon an oral denial where claimant agrees to litigate the issue despite the irregularity. Here, however, the claimant did not allege a de facto denial, and did not agree to litigate compensability. Indeed, throughout both portions of this continued hearing claimant consistently objected to proceeding on the compensability of the claim, arguing that only responsibility could be litigated based on the status of the case at the time of hearing. Because claimant did not agree to go forward on the issue of compensability, and because SAIF, despite multiple opportunities to do so, never issued a written denial conforming to the requirements of ORS 656.262(6) and OAR 438-05-055, the Referee lacked both the authority and the jurisdiction to reach that issue.

It is also noteworthy that the Referee concluded that SAIF had issued a back up denial and had demonstrated by clear and convincing evidence that the claim was not compensable. SAIF has never taken the position that it issued such a denial. The Referee's conclusion, therefore, exists despite the express representation of the concerned party to the contrary.

The majority asserts that SAIF orally denied compensability at hearing. The discussion above is adequate to address the question whether an oral denial of compensability at the time of hearing on another issue is sufficient to confer jurisdiction over that issue on the Referee. However, the conclusion of the majority also ignores the representations of the party that supposedly issued that denial.

SAIF does not argue that it denied compensability orally at the hearing. It alleges that it issued a written denial of compensability that has never been withdrawn and that its agreement to a .307 order was a mistake. Since that is the position taken by SAIF, we should examine that position and decide the claim based upon it, rather than create a resolution that ignores the representations of SAIF regarding what it believes it has done.

The denial issued by SAIF on March 26, 1991 does not provide a factual or legal basis to support a compensability denial. It does state a basis to support a disclaimer of responsibility as required by ORS 656.308 and OAR 438-05-053. (Ex. 35.) The only support for the proposition that SAIF denied the claim is the fact that the notice includes the language required by OAR 438-05-053 (4) when a notice of intent to disclaim responsibility is joined with a denial of the claim. I am unable to conclude that the mere recitation of that notice is sufficient to provide the claimant with notice of the factual and legal basis of a compensability denial as required by Board rule. Consequently, I am unable to conclude that the disclaimer is also a denial of the claim.

A written denial of a claim for compensation ought to be sufficiently clear to provide the claimant with notice of the denial and the basis thereof. The form used by SAIF in this case provides claimant with notice only of the basis for disputing responsibility. Claimant could, and did, interpret the denial as a denial of responsibility only. Unfortuantely, so also did the claims examiner who responded to the information request of the Department upon receipt of claimant's request for designation of a paying agent. Even if we accept the claims examiner's testimony that she had made a mistake, that mistake was, at least in part, made possible by the confusing form the disclaimer of responsibility had taken. Claimant should not be required to defend a claim on compensability grounds based upon a "denial" that is so confusing that even the claims examiner who issued it failed to interpret it, at a crucial point in the claim, as a denial of compensability.

Finally, I am not convinced that this claims examiner simply made a mistake. Indeed, I find her testimony outrageous and directly contradicted by the documentary evidence.

The claims examiner indicated that she had eight years of experience in processing workers' compensation claims. She was advised by the Department of the importance of her response, and specifically directed to the appropriate administrative rules. Her answers are clear and concise. The later allegation that she had simply made a mistake is not sufficient to overcome so clear a record.

If a claimant, who had requested a hearing on a denied claim, later advised his treating doctor in writing that his injury was not work related but happened at home, and then came to hearing with no other explanation than that the representation to the doctor had been a mistake, we would not hesitate to find the claim not compensable based exclusively on the lack of credibility of the claimant, and his own admission that the claim was not compensable. Nevertheless, when confronted with a similar situation involving a claims examiner of SAIF, we decline to comment, and apparently are willing not only to accept, but assist that claims examiner in rectifying her "mistake". The truly comedic element of this exercise is that we should not need to.

ORS 656.262(6) provides SAIF with an avenue of relief through the proper issuance of a back up denial. Our own prior precedent, which the majority now seeks to disavow, also required that act. SAIF didn't comply. There is no reason for this Board to go out of its way to relieve SAIF of the consequences of that failure, even acknowledging that the claim is most probably fraudulent. SAIF is a big boy. It knows how to accomplish what it needs to accomplish to protect its own interest. It does not need the Board to relieve it of the consequence of its own negligence, and to bring further confusion to the responsibility law in the attempt.

Because I am unable to find that SAIF ever issued a denial of compensability, I am forced to conclude that SAIF was precluded from litigating compensability issues. Consequently, I would reverse and order acceptance of the claim by SAIF with the payment of an appropriate attorney fee based on its

attempt to reach compensability issues. At the very least, I would find under the second responsibility theory, that claimant had failed to show a causal connection as to SAIF, but that EBI had never challenged a causal connection to its employment and that claimant was, therefore, entitled to benefits provided by EBI. Again, I would permit an appropriate attorney fee under ORS 656.307(5).

The Majority seeks to relieve the insurer's of the obligation to provide benefits on a fraudulent claim, despite the fact the the insurer's themselves to perform the most basic claims processing tasks necessary to achieve that end. To do so, the majority ignores the arguments of the parties, and forges a legal theory to support its desired end out of whole cloth. To reach that end it must disavow long standing authority, and misinterpret recent precedent of the Court of Appeals. It is not the task of this body to act as the savior for any party in a dispute. Therefore, I must dissent.

In the Matter of the Compensation of
AMY T. OAKLEY, Claimant
WCB Case No. 92-00390
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Barber's order that found that claimant's request for hearing was not timely filed. On review, the issue is timeliness.

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

Under ORS 656.268(6)(b), a party who objects to an Order on Reconsideration may request a hearing within "180 days after copies of Notice of Closure or the Determination Order are mailed," excluding the time period from the date of the request for reconsideration until the date the reconsideration is made. Here, the parties stipulated that claimant's request for hearing was filed within 183 days after the Determination Order was mailed, excluding the time period between the date of the request for reconsideration and the date of issuance of the Order on Reconsideration.

As she did at hearing, however, claimant asserts that her request for hearing was timely under ORCP 10C. Under that rule, "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, 3 days shall be added to the prescribed period." Claimant, therefore, argues that she actually had 183 days in which to file her request for hearing.

The Oregon Rules of Civil Procedure govern procedure and practice in "special proceedings," "except where a different procedure is specified by statute or rule." ORCP 1A. Even assuming that ORCP 10C would otherwise be applicable to requests for hearing, because the procedure for requesting a hearing when a party objects to an Order on Reconsideration is specified by statute under ORS 656.268(6)(b), we find that ORCP 10C is inapplicable. Therefore, because claimant filed her request for hearing 183 days after the Determination Order was mailed, her request for hearing was untimely.

ORDER

The Referee's order dated September 14, 1992 is affirmed.

In the Matter of the Compensation of
WILLIAM H. WAUGH, Claimant
WCB Case No. 92-06956
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of those portions of Referee Herman's order which set aside its denial of claimant's skin condition. On review, the issue is the propriety of the employer's denial. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's counsel's letter of June 13, 1991 did not constitute a claim for a skin condition related to claimant's February 1989 compensable right knee injury, and even if a claim had been made, it had been subsequently withdrawn by claimant's counsel. The Referee, therefore, set aside the denial as procedurally improper. We disagree.

In Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990), we held that if the claimant contends that, in fact, she is not making a claim for a denied condition, the denial will be set aside as premature, unless the claimant waives the procedural defect and proceeds to litigate the merits of the denial. Id. at 1123.

Relying on Jackson-Duncan, claimant contends that he, in fact, had not made a claim for a skin condition, but rather only made a claim for a "rule-out" examination to determine whether or not his skin condition was compensably related to his accepted injury. He submits that the likelihood of a claim for the skin condition depended on the results of the "rule-out" exam. He, therefore, contends that the employer's denial of the skin condition is premature. We disagree.

A claim is "a written request for compensation from a subject worker or someone on the worker's behalf." ORS 656.005(6). The request does not have to take any particular form. A physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition constitutes a claim. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992).

In Smith, the employer accepted a claim for a right wrist and forearm condition. The claimant's treating physician subsequently reported that the claimant was also experiencing pain in her neck, shoulder, and arm and prescribed treatment for those conditions. The court held that the doctor's subsequent reports constituted an additional claim for the other conditions, which the employer failed to timely accept or deny.

Here, on May 27, 1991, Dr. Bert, claimant's treating physician for his accepted knee condition,[1] wrote that he believed that claimant's skin condition could possibly be related to claimant's work injury/exposure and requested a "rule out" exam to determine that possibility. On June 13, 1991, claimant provided Dr. Bert's report to the employer and requested authorization for the "rule out" examination. We construe Dr. Bert's report, and claimant's June 13, 1991 letter, as a claim for a skin condition. Both letters requested compensation in the form of medical services for a skin condition claimant believed could be work-related. These letters would lead a reasonable employer to conclude that workers' compensation liability was a possibility, thereby obligating the employer to accept or deny the claim. The employer, therefore, properly issued a denial of a condition which it reasonably believed could be a claim. Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989).

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[1] Claimant treated with Dr. Maeyens and then Dr. Oelke for his skin condition. The doctors recommended testing for diagnostic purposes, but did not relate the skin condition to claimant's work exposure nor indicated that treatment or diagnostic testing were rendered to determine a causal relationship with claimant's work injury.

Claimant can establish that the denial is premature if he can show that no claim for the skin condition was made. Here, the record does not support such a finding. Notwithstanding claimant's attempt to withdraw a claim for the skin condition, Dr. Bert's May 27, 1991 letter constituted a claim, which the employer had a legal duty to accept or deny. Michael C. Holt, 44 Van Natta 962 (1992)(referee correctly declined to set aside the employer's denial based on the claimant's attorney's assertion that no claim had been made, where the treating doctor had made a claim which the employer had a duty to accept or deny). We, therefore, conclude that the employer's August 12, 1991 denial was a procedurally proper precautionary denial. See Cindy L. Smith, 44 Van Natta 1660, 1661 (1992); Jack Allen, 43 Van Natta 190 (1991); Sidney M. Brooks, 38 Van Natta 925, 926 (1986).

Although diagnostic procedures to determine a causal relationship, if any, between a noncompensable condition and compensable injury may be compensable, Brooks v. D&R Timber, 55 Or App 688 (1982), claimant has accepted the Referee's finding that the "rule out" examination is not compensable. Because the "rule out" exam was not compensable and because we have found that a claim for the skin condition has been filed, we proceed to the merits of the skin condition claim. Michael C. Holt, supra.

We find the record sufficiently developed to proceed to the merits. To establish compensability, claimant must establish that his February 1989 compensable injury is the major contributing cause of his alleged consequential skin condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Dr. Oelke opined that claimant suffered from Sweet's syndrome, which is a hypersensitivity type of skin condition of unknown etiology. He could not state what, if any, contributor was the major contributing cause of claimant's skin disease. There is no contrary evidence. Consequently, claimant's skin condition is not compensable.

ORDER

The Referee's May 29, 1992 order, as reconsidered on July 16, 1992, is reversed in part and affirmed in part. The self-insured employer's August 12, 1991 denial of the skin condition is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EUGENIO GONZALEZ, Claimant
WCB Case No. 92-04830
ORDER ON REVIEW
Sheila Annette Dale, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Peterson's order that found that the Hearings Division was without jurisdiction because claimant failed to file a hearing request on the SAIF Corporation's denial of claimant's back injury claim within 180 days. On review, the issues are jurisdiction and timeliness.

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

A request for hearing must be filed no later than the 60th day after claimant is notified of a denial. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

Claimant argues that: (1) the law requires that he receive actual notice of the terms of the denial; and (2) he did not receive actual notice of the time limitations on his appeal rights until April 3, 1992, when he sought the advice of a Spanish speaking attorney. Thus, claimant argues, his appeal rights did not begin to run until April 3, 1992, and his request for hearing was timely filed on that date. We disagree.

We recently rejected a similar argument in Bertha Vega, 45 Van Natta 378 (1993). There, the claimant did not speak English, but she testified that she received a denial letter, which was interpreted by her daughter as saying that her claim was closed. The claimant did not consult with an attorney until more than 60 days after receipt of the denial letter, at which time a hearing was requested. The claimant argued that, although she actually received the denial letter, she was not notified of the denial at the time of receipt because she could not read English and did not understand the meaning of the document. The claimant argued that she filed a request for hearing within 60 days of notification of the denial, which she alleged occurred when she talked to a school teacher shortly before consulting an attorney.

Relying on SAIF v. Edison, 117 Or App 455 (1992), we rejected that argument on the basis that notification occurs, and the 60-day and 180-day appeal periods begin to run, when claimant has either actual or constructive receipt of the denial. Bertha Vega, supra at 379. We found that the claimant's request for hearing was not timely filed because she actually received the denial letter more than 60 days before filing her request for hearing. Furthermore, we found that the claimant failed to establish good cause for filing her request for hearing after the 60-day period but before the 180-day period had run because she had failed to prove reasonable diligence. Id.; ORS 656.319(1)(b). Finally, we noted that we had previously found that failure to take steps necessary to understand mail is substantially the same as refusal to accept mail, and neither constitutes good cause for failing to timely file a request for hearing. Bertha Vega, supra at 378; Juanita Trevino, 34 Van Natta 632, 633 (1982).

The same reasoning applies here, and we conclude that claimant did not timely file a request for hearing. Claimant testified that, in July 1991, he received the denial letter and was aware that his claim had been denied. (Tr. 35, 36). Furthermore, claimant signed the certified mail receipt on July 26, 1991 (Tr. 30, Ex. 7-2), which establishes that he had actual receipt of the denial letter on that date. Claimant testified that, within five days of receiving the denial, he had his nephew translate it for him, although he did not listen closely to what his nephew was saying. (Tr. 36, 43). Claimant testified that he was unaware of the time limitations on filing an appeal of the denial. He did not file his request for hearing until April 3, 1992, more than 180 days after he received the denial letter. Under these facts, claimant did not timely request a hearing. ORS 656.319(1)(a) and (b); SAIF v. Edison, supra; Bertha Vega, supra.

Furthermore, because the hearing request was made more than 180 days after notification of the denial, the "good cause" exception is not available to claimant. ORS 656.319(1)(b).

On review, claimant raises several constitutional issues. However, claimant did not raise these issues at the outset of the hearing. (Tr. 1, 2). Instead, claimant stated that the issues were the "appropriateness of the denial" and timeliness. (Tr. 2). SAIF raised the issue of jurisdiction. (Tr. 2). Because claimant first raises these constitutional issues on review, we decline to address them. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Donna M. Moore, 44 Van Natta 1635 (1992).

In addition, we have held that we will not consider a new issue first raised during closing arguments. Leslie Thomas, 44 Van Natta 200 (1992); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2135 (1989). Claimant's attorney recently submitted the transcript of her oral closing argument. We may consider this submission. See Charles T. Brence, 39 Van Natta 422 (1987). In her closing argument, claimant's attorney offered to submit a "memorandum supporting [her] argument and make references to the Oregon Constitution and maybe federal law." (Closing Argument for Claimant, page 10). Assuming that claimant's offer to submit a "memorandum" raised a new issue of constitutionality during closing arguments, we decline to address that issue on review. Leslie Thomas, supra.

In any event, claimant has not shown that he was injured by any alleged unconstitutionality of a notice of denial which did not contain a Spanish translation of its contents. Claimant testified that he cannot read or understand English and can read only eight to ten words in Spanish. (Tr. 25, 40). Claimant testified that his nephew translated the denial for him five or six days after claimant received it and that he knew in July 1991 that his claim had been denied. (Tr. 36, 42). Claimant also testified that his nephew translated the whole document and did so easily. (Tr. 42, 43). No evidence was presented showing or suggesting that claimant's nephew misunderstood the denial or translated it inaccurately. Rather, claimant testified that he was preoccupied and did not listen to what his nephew was saying during the translation. (Tr. 43). Thus, responsibility for claimant's inattentiveness cannot be laid at SAIF's feet. The dismissal order shall stand.

ORDER

The Referee's order dated July 24, 1991 is affirmed.

In the Matter of the Compensation of
GREG S. MEIER, Claimant
WCB Case No. 92-08832
ORDER ON REVIEW
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Peterson's order that set aside its denial of claimant's left leg injury claim. On review, the issue is compensability.

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

Claimant filed a claim, contending that he had suffered an open compound fracture of the left leg while performing his work activities as a volunteer firefighter. Claimant described the injury as occurring when a tire rim struck his leg while he was changing a tire. Claimant's employer agreed that the injury had occurred as claimant had described. However, it further noted that claimant had been changing the tire in a manner contrary to the employer's policy.

Thereafter, SAIF denied the claim. SAIF asserted that claimant's injury "did not arise from your employment."

Claimant requested a hearing concerning SAIF's denial. At the hearing, SAIF contended that the injury had occurred while claimant was changing a tire for a co-worker's son. Consequently, SAIF argued that the injury did not arise out of and in the course of his employment.

The Referee considered the evidence in light of the seven factors set forth in Mellis v. McEwen, 74 Or App 571 (1985). Finding that claimant was on duty under his employer's control and performing an activity with his employer's approval at the time of his injury, the Referee concluded that the injury arose out of and in the course of his employment.

On review, SAIF contends that the claim is not supported by medical evidence. Based on this alleged insufficiency, SAIF asserts that claimant's hearing request should have been dismissed. We disagree.

To begin, since SAIF did not move for dismissal at the hearing, we are not inclined to consider such a belated motion. In any event, because there is no contention that claimant untimely appealed from SAIF's denial, there would be no basis for dismissal of claimant's hearing request. See ORS 656.319(1).

Finally, until the submission of its appellant's brief, SAIF's sole defense to the claim has been its contention that the injury did not arise out of and in the scope of his employment. Since it has not previously questioned the sufficiency of the medical evidence in support of claimant's fractured left leg, we consider it to be fundamentally unfair to permit SAIF to raise this issue at this late date. See Karen K. Malsom, 42 Van Natta 503 (1990) (Board declined to consider a carrier's challenge to an aggravation claim based on no worsening when the carrier had only contested the claim on causation grounds at the hearing).

ORDER

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

May 18, 1993 Cite as 45 Van Natta 923 (1993)

In the Matter of the Compensation of
KIM S. JEFFRIES, Claimant
WCB Case Nos. 90-15064, 90-05652 & 90-12569
ORDER ON REMAND
Max Rae, Claimant Attorney
Snarskis, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Tooze, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Conagra, Inc. v. Jeffries, 118 Or App 373 (1993). The court has reversed our prior order, Kim S. Jeffries, 44 Van Natta 824 (1992), which assessed a penalty for an unreasonable denial based on all compensation "then due" (including medical services) at the time of hearing. The court agreed with our previous conclusion that any benefits due as a result of the setting aside of an unreasonable denial are considered "then due" for purposes of a penalty assessment. Because claimant had undergone surgery for his compensable claim at the time the self-insured employer withdrew its denial pursuant to a stipulation, the court reasoned that the surgery was an amount "then due." Nevertheless, since our prior order assessed a penalty based on amounts "then due" as of the date of hearing, the court has remanded for assessment of a penalty based on all benefits due on the date of the withdrawal of the employer's denial (which occurred pursuant to the post-hearing stipulation).

In accordance with the court's instructions, our previous penalty assessment is modified as follows. For its unreasonable denial, the employer is assessed a penalty equal to 25 percent of all compensation (including medical services) which were "then due" as of the date of the stipulation in which the employer withdrew its denial and accepted the claim (April 4, 1991).

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY L. BRODELL, Claimant
WCB Case Nos. 91-07925 & 92-01670
ORDER ON REVIEW
Hoelscher & Associates, Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that: (1) dismissed his hearing request concerning the self-insured employer's denial of his aggravation claim on the basis that it was not timely filed; and (2) upheld the employer's denial of his occupational disease claim for a stress-related mental disorder. On review, the issues are timeliness and compensability.

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

Timeliness of Request for Hearing on Aggravation Claim

Claimant has an accepted stress claim dating from March 1987. On February 14, 1991, he filed a second claim for stress. The 801 form indicated that the stress had been building up over the last year and gave the date of the injury or occupational disease as February 14, 1991. On the section of the form that asks whether the body part had been injured before, claimant indicated he had had a previous claim.

On May 6, 1991, the employer denied the stress claim filed on February 14, 1991. Claimant filed a request for hearing on June 19, 1991. The issues raised by the request for hearing included compensability of an occupational disease and aggravation claim.

On July 19, 1991, the employer denied a claim for an aggravation. The aggravation denial stated, in part:

> "On February 14, 1991, you filed a new claim for stress, which you allege is a result of your employment with the [employer]. That claim was denied and subsequently, your attorney has filed the February 14, 1991 claim as a [sic] aggravation of the above captioned injury * * *"

Claimant never appealed the July 19, 1991 aggravation denial.

The Referee found that claimant's hearing request on the aggravation issue was premature. The Referee further found that claimant did not timely request a hearing from the employer's July 19, 1991 denial.

On review, claimant contends that the 801 form filed on February 14, 1991 constituted a claim for an aggravation of his prior accepted stress claim. Claimant further argues that since his hearing request on the employer's May 6, 1991 denial of his occupational disease claim raised the issue of aggravation, the hearing request was not premature.

We do not agree that the 801 form constituted a claim for an aggravation. An aggravation claim may be filed under ORS 656.273(2) or through a physician's report under ORS 656.273(3). Jimmie L. Martin, 44 Van Natta 520 (1992). Under either method, the claim must give sufficient notice that a claim is being made for a worsened condition resulting from the original injury.

Here, although the form indicates that the same "body part" had been injured before and a previous claim had been filed, the 801 form does not give notice that claimant is seeking additional compensation for a worsened condition resulting from the original accepted claim. Rather, the 801 form indicated claimant was filing a new occupational disease claim for stress. Therefore, we conclude that the 801 form did not constitute a claim for aggravation.

The employer was not aware of an aggravation claim until claimant's June 1991 hearing request which raised an aggravation issue. Assuming without deciding that the hearing request constitutes an aggravation claim, the employer would have 90 days to accept or deny. The employer denied the "claim" on July 19, 1991 within 90 days and claimant never appealed that denial. Accordingly, we agree with the Referee that the hearing request on the aggravation issue was premature. See Syphers v. K-M Logging, Inc., 51 Or App 769 (1991).

Occupational Disease Claim

The Referee found that claimant had failed to establish a compensable stress claim pursuant to ORS 656.802(1)(b). We agree.

In order to establish compensability of a stress-related mental condition, the worker must prove that the 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. Finally, 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).

The record is devoid of evidence concerning what specific work-related stressors claimant alleges caused his mental disorder. Claimant did not testify at hearing. However, in a statement taken by the employer, claimant was unable to identify the cause of the stress. When asked if there was anything at work specifically that caused him stress during the previous year, claimant jokingly replied that work in general caused him stress.

The only specific incident that claimant mentioned in relation to his stress involved an altercation in February 1991 between claimant and a co-worker over possession of some fire wood. The altercation ended with claimant pouring a cup of orange juice over the co-worker's head, swearing at her, and moving in a way that gave her the impression that claimant was intentionally blocking her in a threatening manner. After an investigation, the employer suspended claimant citing the February 1991 altercation as well as numerous past documented work performance problems and notified him that discharge was a possibility. (Ex. 39). The February 1991 incident ultimately led to claimant's discharge from employment. (Ex. 42).

Dr. Worthington, a clinical psychologist who treated claimant, noted that claimant had been experiencing increased depression over the past several months, most notably associated with boredom and interpersonal frustration on the job. He further noted that claimant had "a history of interpersonal conflict with a female co-worker, and eventually they had an altercation in the employee lunchroom, which resulted in [claimant] facing possible termination from his job." On a form 827, Dr. Worthington indicated that claimant reported interpersonal problems and lack of enthusiasm at work and also distress by ongoing termination procedures following the altercation with claimant's co-worker. Dr. Worthington referred claimant to Dr. Romero, a psychiatrist, for evaluation. Dr. Romero reported that claimant appeared to be stressed on his job. Dr. Romero further indicated that claimant reported a problem of being misunderstood by people and had difficulty relating to some supervisors.

It is not clear from the record what, if any, specific job-related stressors are allegedly responsible for claimant's mental condition. On this record, we are unable to find that the employment conditions exist in a real and objective sense and are conditions other than conditions generally inherent in every working situation. The medical record refers only to general stressors such as interpersonal conflict, frustration and boredom at work and stress over termination from the job. We note that such common and nonspecific stressors are likely to be generally inherent in every working situation. See Kathleen M. Payne, 42 van Natta 1900 on recon 42 Van Natta 2059 (1990), rev'd on other grounds, City of Portland v. Payne, 108 Or App 771 (1991) (conditions which are "generally inherent in every working situation" are those conditions which are usually present in all jobs and not merely the specific occupation involved).

In addition, to the extent that claimant's stress resulted from the employer's disciplinary measures concerning the February 1991 incident, we find, based on this record, that those disciplinary measures were reasonable. Thus, the employer's reasonable disciplinary actions (which in this case involved claimant's suspension and ultimate discharge from employment) are excluded by ORS 656.802(2)(b), and may not be the basis of a stress claim. Brenda K. Allen, 44 Van Natta 2476 (1992) (on reconsideration).

Finally, we agree with the Referee that Dr. Parvaresh's opinion is the most persuasive because it is based on complete information and is better reasoned than the opinions of Drs. Worthington and Romero. Somers v. SAIF, 77 Or App 259 (1986). Dr. Parvaresh opined that claimant had mixed personality problems which were longstanding and that claimant's employment conditions were not the major contributing cause of these problems. Thus, we are not convinced that claimant has established by clear and convincing evidence that any mental disorder he may have arose out of and in the course of his employment. Accordingly, we conclude that claimant has failed to establish a compensable stress claim.

ORDER

The Referee's order dated May 27, 1992 is affirmed.

In the Matter of the Compensation of
MARK S. GORDON, Claimant
WCB Case No. 92-06153
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 Livesley's order that directed the insurer to calculate claimant's rate of temporary disability benefits pursuant to ORS 656.210(2)(a). Noting that former OAR 436-60-025(4) requires the Compliance Section to resolve rate disputes under certain circumstances, the insurer also contends that the Referee lacked jurisdiction to determine the rate of temporary disability benefits. On review, the issues are jurisdiction and rate of temporary disability benefits. We reverse.

FINDINGS OF FACT

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

Claimant was moved to a job covered by a Forest Service contract in November, 1991.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

In resolving this case, we apply the rules in effect on January 2, 1992, the date of injury. ORS 656.202(2).

Former OAR 436-60-025(4) provides, in part, that if the appropriate wage for determining the rate of temporary disability benefits cannot be determined under the provisions of former OAR 436-60-025 or ORS 656.210, and the insurer cannot negotiate a reasonable wage, then the Compliance Section shall resolve the issue. The insurer contends that that rule divests the Hearings Division of jurisdiction over this dispute. We disagree.

Initially, we note that the insurer has presented no authority, and we could find none, that holds that an administrative rule can divest the Hearings Division of its statutory subject matter jurisdiction over this "matter concerning a claim." See ORS 656.708; see also ORS 656.704(3); ORS 656.283(1). Nevertheless, assuming that that could happen, we need not decide if that has happened here. Under the express terms of former OAR 436-60-025(4), the Compliance Section has the authority to determine wage disputes only if no other provision of former OAR 436-60-025(4) or ORS 656.210 applies. Because we conclude that claimant's wage can be determined under former OAR 436-60-025(4)(a), the Compliance Section has no authority to resolve this wage dispute.

Rate of Temporary Disability

The Referee correctly found that, at the time of his injury, claimant was regularly employed 5 days a week. Therefore, the Referee concluded that claimant's wage should be determined under ORS 656.210(2)(a), which provides that "the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving" by 5 if the worker was regularly employed 5 days a week. The insurer contends that, because claimant was paid by the hour, ORS 656.210(2)(a) is inapplicable. We agree.

Claimant testified that he was paid by the hour, and that he was paid a different hourly wage depending on whether he was working on the Forest Service contract or on the employer's regular work. (Tr. 9-10). In Lowry v. Du Log, Inc., 99 Or App 459 (1989), the court held that, under ORS 656.210(2)(c), the Director is authorized to prescribe the method of establishing the weekly wage of a worker who is "regularly employed," if that worker "is paid on other than a daily or weekly basis." 99 Or App at 462.

Because claimant was paid on an hourly basis for a varying wage, he was paid on other than a daily or weekly basis. See Gerald A. Couzens, 43 Van Natta 1321 (1991). Therefore, claimant's wages should be calculated according to the method prescribed by the Director.

Former OAR 436-60-025(4)(a) provides, in part:

> "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."

That method of averaging weekly wages earned during the 26 weeks preceding the injury has been approved by the court as an appropriate exercise of the Director's authority under ORS 656.210. See Lowry v. Du Log, Inc., supra. Consequently, we conclude that the insurer correctly based claimant's TTD rate on the weekly wage calculated pursuant to former OAR 436-60-025(4)(a).

Offset

The insurer requests authorization to offset against any future permanent disability award claimant may be entitled to, the $693.13 of excess temporary disability benefits it paid pursuant to its initial erroneous calculation of claimant's wage rate. Because we conclude that the insurer paid claimant temporary disability benefits at an erroneously high rate, that authorization is given.

ORDER

The Referee's order dated July 31, 1992 is reversed. Claimant's rate of temporary disability shall be calculated in accordance with former OAR 436-60-025(4)(a). The Referee's attorney fee award is reversed. The insurer is entitled to an offset of $693.13 against any future permanent disability award granted under this claim.

In the Matter of the Compensation of
CHRISTA LEE, Claimant
WCB Case No. 92-06055
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Myers' order that awarded 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had awarded 9 percent (28.8 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant argues that, because she occasionally lifted 50 pound sacks of muffin mix at work, her at-injury job was "medium" or "heavy" rather than "light," based on the Dictionary of Occupational Titles' (DOT) job description entitled Dough Mixer. (DOT 520.685-234). Thus, she contends, the Referee should have calculated her permanent disability award using an adaptability factor of 4 or 5 (rather than 2 as found by the Referee). We are not persuaded by claimant's argument.

Under the applicable standards (see WCD Admin Order 2-1991), the prior strength (physical demands) category for a worker's at-injury job is derived from the strength category assigned in DOT for the worker's at-injury job. Former OAR 436-35-270(3)(h). In determining the proper DOT job description, we consider the record as a whole, as it relates to job duties as well as strength demands to find the position which appropriately describes claimant's job at injury. See William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993).

In this case, we note that claimant's muffin making occupied significantly less time than her counter work. In addition, claimant lifted bags of muffin mix only infrequently or, at most, occasionally. Consequently, after considering claimant's job duties as her strength demands, we find that the DOT job title most accurately reflecting claimant's at-injury job is sales clerk (retail) (DOT 290.477-018). The DOT identifies that job as being in the light category. Because claimant is now limited to performing light/sedentary work, the adaptability value is 2, as found by the Referee. Former OAR 436-35-310(3).

ORDER

The Referee's order dated August 7, 1992 is affirmed.

In the Matter of the Compensation of
VALORIE L. LESLIE, Claimant
WCB Case No. 92-02861
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Miller, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Podnar's order that: (1) declined to direct the self-insured employer to pay temporary partial disability for the period from February 4, 1991 to October 3, 1991, as awarded by an Order on Reconsideration; (2) declined to award claimant an attorney fee pursuant to ORS 656.382(2) for prevailing on the temporary disability issue; (3) declined to assess penalties and attorney fees for the employer's allegedly unreasonable failure to pay temporary partial disability; (4) increased claimant's unscheduled permanent disability award from 11 percent (35.2 degrees), as awarded by Order on Reconsideration, to 13 percent (41.6 degrees) for a right shoulder injury; (5) found that claimant was barred from raising a scheduled permanent disability issue at the hearings level; and (6) declined to remand the issue of extent of unscheduled permanent disability to the Director for adoption of temporary rules amending the standards. On review, the issues are temporary partial disability, penalties and attorney fees and extent of scheduled and unscheduled disability.

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

Claimant contends that the employer failed to pay temporary partial disability compensation from February 4, 1991 through October 3, 1991, as awarded by an Order on Reconsideration. Although the Referee did not modify the Order on Reconsideration award of temporary partial disability from February 4, 1991 through October 3, 1991, he concluded that there was no temporary disability due after February 4, 1991. We agree.

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 436-60-036(1). We conclude that claimant was entitled to an award for temporary partial disability until her benefits were terminated according to law. OAR 436-60-030(4). However, if a worker is receiving at least his or her regular wage for modified work, he or she 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).

Here, there is evidence that claimant's wages at her modified work were greater than her wages at her job at injury. Although there is evidence that claimant initially returned to part-time work on February 4, 1991, there is no evidence that her initial return to part-time work caused her wages at her modified work to be lower than her wages at injury. In fact, the only evidence presented on this issue was that her post-injury wages were higher than her wages at injury. Accordingly, although we find that claimant was entitled to temporary partial disability benefits until her benefits were properly terminated, we also conclude that she is entitled to an award of temporary partial disability equal to zero. Safeway v. Owsley, supra; Robert C. Clayton, 44 Van Natta 2216 (1992).

Claimant contends that since the Referee did not reverse the reconsideration order award of temporary partial disability from February 4, 1991 through October 3, 1991, she is entitled to an attorney fee pursuant to ORS 656.382(2) for prevailing over the employer's cross-appeal on the temporary disability issue. We disagree. The employer did not assert at hearing that the Order on Reconsideration award of temporary disability should be disallowed or reduced. Rather, the employer asserted in opening arguments that there was no temporary disability due and payable under the order. (Tr. 9-10). Thus, the employer's contention did not constitute a cross-appeal designed to disallow or reduce claimant's temporary disability award. Rather, it was a direct response to claimant's argument at hearing that the employer had failed to pay temporary disability due under the Order on Reconsideration. The Referee agreed with the employer's contention that no temporary partial disability was due and we have affirmed the Referee's order. Accordingly, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2).

Claimant next requests that we remand this case to the Director to adopt temporary rules addressing claimant's disability due to shoulder surgeries. Subsequent to the date of the Referee's order, we held that the Director has the exclusive authority under ORS 656.726(3)(f)(C) to make findings as to whether or not a worker's disability is addressed by the standards and, if not, to stay further proceedings and adopt temporary rules to accommodate the worker's impairment. Gary D. Gallino, 44 Van Natta 2506 (1992). In Gallino, we further held that the applicable statutes contain no indication that the Board and Hearings Division have authority to promulgate disability standards or to remand to the Director to enact rules for evaluating disability. Id at 2508. Accordingly, we are without authority to remand this matter to the Director or to promulgate a rule addressing claimant's disability.[1]

Finally, claimant argues that her failure to raise the issue of scheduled disability in her request for reconsideration does not bar her from contending entitlement to a scheduled award at hearing. We disagree.

We have recently held that a party is barred from raising an issue which stems from a notice of closure or determination order and if that issue was not first raised on reconsideration. Raymond L. Mackey, 45 Van Natta 776 (1993). Here, claimant's request for reconsideration explicitly indicated that extent of scheduled disability was not an issue on reconsideration. In accordance with our holding in Mackey, we conclude that the scheduled disability issue is not properly before us.[2]

ORDER

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

[1] Although a signatory to this order, Member Gunn directs the parties to his dissent in Gallino, supra.

[2] Although a signatory to this order, Member Gunn directs the parties to his dissent in Mackey, supra.

May 19, 1993 Cite as 45 Van Natta 930 (1993)

In the Matter of the Compensation of
ROBERT W. LITTLE, Claimant
Own Motion No. 92-0395M
OWN MOTION ORDER
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 November 4, 1979. SAIF has accepted the compensability of claimant's current condition. However, SAIF opposed the reopening of the claim on the ground that the proposed surgery is neither reasonable nor necessary.

In order to establish entitlement to medical services for the compensable back injury, claimant must prove both a causal relationship between the medical services and the compensable injury and the reasonableness and necessity for the medical services. See ORS 656.245. Iordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985); Douglas A. Eichensehr, 44 Van Natta 1755 (1992).

SAIF did not contest the causal relationship between the proposed surgery and the compensable injury. However, SAIF contended that the surgery was not reasonable and necessary treatment for claimant's compensable condition and requested a Director's review to determine the appropriateness of the proposed treatment. ORS 656.327. The Board postponed action on the own motion matter pending resolution of that litigation. On March 9, 1993, the Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute which concluded that the low back was not appropriate.

There is no record of any appeal of the Director's order. Unless and until claimant appeals this order to the Hearings Division and it is set aside, claimant has failed to prove one of the elements necessary to establish that the surgery is compensable.

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. However, the surgery or hospitalization must be compensable. Here, claimant failed to establish that the proposed surgery is compensable. Consequently, we are not authorized to reopen claimant's claim.

IT IS SO ORDERED.

May 19, 1993 Cite as 45 Van Natta 931 (1993)

In the Matter of the Compensation of
PABLO S. MALDONADO, Claimant
WCB Case Nos. 91-16092 & 91-07248
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Mongrain's order that upheld the SAIF Corporation's denial of claimant's mid-back injury claim. On review, the issues are subjectivity and compensability.

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

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or 186 (1992). Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. In applying the test, no one factor controls. Rather, all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the state laws and regulations that the employer is otherwise subject to and the residence of the employees. Id. (citing Power Master, Inc. v. Blanchard, 103 Or App 467, 471 (1990); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, 635, rev den 303 Or 590 (1987).

Here, the evidence is uncontroverted regarding the key inquiry, i.e., the extent to which claimant's work outside Oregon was temporary. Claimant explained that he had worked on three separate "contracts" for this employer, in Oregon first, in California second, and in Montana finally. (Tr. 10-12, 19). He injured his back while in Montana. The only evidence which relates, to some degree, to claimant's expectation of future work for the employer after the two-month Montana "contract," came in response to a question about what happened to claimant's fellow workers. Claimant said "[T]hat was all the work there was with that company." (Tr. 15-16). Claimant's knowledge of the nature and extent of the employer's operations in Oregon was clearly limited and no individual representing the employer was called to testify. As it stands, the record cannot support a finding that claimant had a reasonable expectation of continued employment in Oregon after the Montana contract. Claimant has failed to establish that he was an Oregon subject worker for purposes of this claim. See ORS 656.126(1).

ORDER

The Referee's order dated August 27, 1992 is affirmed.

In the Matter of the Compensation of
JOSEPH W. MIKEN, Claimant
WCB Case No. 92-06319
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Black's order that: (1) declined its request to reopen the record for the submission of additional exhibits; and (2) set aside its denial of claimant's injury claim for a cervical 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

Approximately one week after the hearing, the insurer moved, pursuant to OAR 438-07-025, to reopen the record for the admission of two additional exhibits. The Referee denied that motion, because the evidence was not new, in that it could have been discovered with due diligence. The insurer now contends that OAR 438-07-025 does not apply.

OAR 438-07-025(2) provides:

> "(2) A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state;
>
> "(a) The nature of the new evidence; and
>
> (b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing."

The insurer argues that the rule applies only when a party requests that the record be reopened after an order has issued, i.e., when an order has issued that might be reconsidered. However, we need not reach the insurer's argument, for the insurer's problem is not merely the result of OAR 438-07-025(2), if at all. Specifically, it is a basic and longstanding rule of the Board that, after a hearing record is closed, additional evidence will not be admitted if that evidence could have been discovered, with due diligence, before the hearing. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Here, the Referee concluded that the proffered evidence could have been discovered prior to the hearing. We agree. Consequently, we conclude that the Referee did not abuse his discretion by declining to reopen the record. See Angie J. Gallo, 44 Van Natta 1107, 1108 (1992).

Compensability

We affirm and adopt the Referee's conclusions and reasoning concerning the compensability issue, with the following supplementation.

The disputed issue here is whether claimant was within the course and scope of his employment with the insured employer at the time of his injury. The Referee concluded that he was. The insurer contends that that conclusion is erroneous, because claimant is not credible. We disagree.

The Referee found, based on demeanor, that claimant was a credible witness. The insurer contends that we should reject that determination, because the record reveals inconsistencies and untruths in claimant's various reports concerning his injury. Although we generally defer to a Referee's demeanor-based credibility findings, we do not do so where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. Angelo L. Radich, 45 Van Natta 45, 46 (1993). This is not such a case.

Claimant's testimony at hearing was consistent throughout. Essentially, he testified that, at the time of the accident, he was returning to his office after canvassing in the area. The insurer contends that that testimony is inconsistent with his prior reports concerning the accident. In those reports, claimant consistently stated that he was "not on company time" at the time of the accident. (Ex 5).

The question of whether a person is within the course and scope of employment is a complex one involving an analysis of the facts and circumstances of each case. See McKeown v. SAIF, 116 Or App 295 (1992); Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985); but see PP&L v. Jacobson, 117 Or App 280 (1992). The end result of that analysis is a legal conclusion, i.e., an ultimate fact.

Claimant is a salesperson who has no set working hours or location, does not have a company car, is not paid mileage and is paid on a strictly commission basis, although he is reimbursed for some expenses when he is asked to work outside of his territory. Under such circumstances, the determination of whether he was "on company time" is tantamount to the determination of whether he was within the course and scope of employment. Therefore, by stating that he was "not on company time," claimant was offering a legal conclusion, not a factual assertion. Because claimant is not expected to have legal knowledge of such matters, we do not find his statement to be dispositive.

The insurer does not challenge the Referee's conclusion that the facts claimant presented at hearing establish that he was in the course and scope of his employment. It only challenges the veracity of those facts. Because we find no basis to discredit claimant's testimony, we agree with the Referee that claimant proved that his claim was compensable, and we adopt his conclusions on that issue.

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 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 October 1, 1992 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
LARRY R. RUECKER, Claimant
Own Motion No. 92-0492M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable right shoulder injury. Claimant's aggravation rights expired on April 23, 1992. On October 21, 1992, the Board postponed action on the own motion request because SAIF had requested a Director's review of the reasonableness and necessity of the proposed surgery pursuant to ORS 656.327 and OAR 436-10-046. By a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute dated February 23, 1993, the Director found the proposed right shoulder surgery appropriate and ordered SAIF to reimburse for the surgery, if rendered to claimant.

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. Based on the Director's order, we conclude that claimant has sustained such a worsening.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant has not worked since June 11, 1991. On that date, Dr. Stewart, treating orthopedist, examined claimant and initially recommended surgery for his right shoulder. At that time, Dr. Stewart stated that claimant would be on light duty with no repetitive motion and no lifting over 20 pounds until the surgery was scheduled. By a letter dated July 17, 1992, Dr. Stewart stated that claimant had a worsening of his underlying condition and again recommended shoulder surgery. On July 29, 1992, Dr. Stewart examined claimant and stated that he could not perform any gainful employment that required any repetitive motion of his shoulder or any moderate lifting. However, he also stated that claimant was fit for light duty. By a letter dated October 27, 1992, Dr. Stewart stated that claimant "can do simple activities of daily living only, but somply [sic] cannot do any gainful employment where he has to use his shoulder to any degree at all."

Even if we assume that Dr. Stewart's October 27, 1992 statements represent a release from all work due to the compensable injury, claimant has not established that he was in the work force at the time his condition became disabling. Claimant has not worked since June 11, 1991 and, until October 27, 1992, he was released to light duty work with restrictions. Thus, the record does not establish that a reasonable work search within claimant's physical capacity would have been futile due to the compensable injury, at least prior to October 27, 1992.

By a letter dated April 21, 1993, claimant's attorney submits a printout from the Employment Division showing that claimant received unemployment benefits from December 30, 1991 through July 22, 1992. We agree that this documentation establishes that claimant was in the work force during that period. However, as noted above, Dr. Stewart released claimant to light work with restrictions until October 27, 1992. Claimant submits no evidence of any employment or work search from July 22, 1992 to October 27, 1992. Claimant's attorney asserts that the Employment Division recently notified claimant that his unemployment benefits were inappropriately terminated and would be reinstated. If claimant was entitled to receive unemployment benefits during the relevant period, we agree that he remained in the work force at the time of his disability. However, claimant submits no evidence supporting his attorney's assertion that he remained eligible for unemployment benefits.

Furthermore, claimant's attorney asserts that claimant, claimant's wife, and claimant's mother share a household and would all testify that claimant regularly sought work. Claimant's attorney also states that claimant has always been willing to work. However, claimant submits no evidence of this work search. It is claimant's burden to prove that he remained in the work force and, other than these statements by his attorney, claimant offers no evidence to meet his burden of proof. In short, claimant must offer more than the bare assertions of legal counsel.

Finally, claimant's attorney submits a April 12, 1993 letter from Dr. Stewart stating that, when he last saw claimant on July 29, 1992, he felt that claimant "was fit for light work only, no lifting of over 20 lbs. up to waist, and perhaps 10 lbs. up to mid chest and no lifting above his head or repetitive notions of his right shoulder." This statement is a medical opinion, which Dr. Stewart is qualified to give. However, Dr. Stewart also stated that "[w]ith these limitations, it was my opinion that [claimant] was fit for no gainful employment commensurate with his age [40 at the time of Dr. Stewart's July 29, 1992 examination], skills, education, and physical condition." This statement goes beyond Dr. Stewart's medical expertise and is, in effect, a vocational opinion. There is no evidence in the record that Dr. Stewart is qualified to render a vocational opinion. Thus, we do not find Dr. Stewart's vocational opinion persuasive. Therefore, the record continues to indicate that, at least until October 27, 1992, claimant remained able to perform light work with restrictions.

On this record, claimant has failed to establish that he remained in the work force at the time of his disability. Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

May 19, 1993 Cite as 45 Van Natta 935 (1993)

In the Matter of the Compensation of
DAVID A. TENTINGER, Claimant
WCB Case No. 90-08977
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Emerson's order which: (1) found that claimant was entitled to temporary disability benefits between December 6, 1988 and March 26, 1989; and (2) declined the insurer's request to recover an alleged overpayment of temporary disability benefits paid during the aforementioned period. On review, the issues are temporary disability and offset. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant became medically stationary on December 5, 1988. He participated in vocational training between March 27, 1989 and December 28, 1989. The insurer paid temporary disability from December 6, 1988 until February 1, 1990, when a Determination Order closed the claim.

The Referee found that claimant was entitled to temporary disability benefits between the medically stationary date and the date he began vocational training. Therefore, the Referee declined to authorize an offset of temporary disability benefits between December 6, 1988 and March 26, 1989. The Referee reasoned that none of the events authorizing cessation of compensation for temporary disability, pursuant to former ORS 656.268(2)(c) and ORS 656.268(3), had occurred.

The insurer argues that the statutes cited by the Referee refer only to claimant's procedural entitlement to temporary disability benefits, not to substantive entitlement to those benefits. It contends that claimant was not substantively entitled to temporary disability benefits between the dates that he became medically stationary and before he began vocational training. We agree.

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; Rosa J. Ramirez, 44 Van Natta 2280 (1992); Esther C. Albertson, 44 Van Natta 2058 (1992). Moreover, a carrier is entitled to offset any temporary disability benefits paid in excess of a claimant's substantive entitlement against permanent disability awards. Soledad Flores, 43 Van Natta 2504, 2507 (1992).

Here, the record establishes (and claimant does not contend otherwise) that his compensable condition was medically stationary between December 6, 1988 and March 26, 1989. Therefore, we conclude that claimant was not substantively entitled to temporary disability benefits during that time.

Claimant is, however, entitled to temporary disability benefits while actively engaged in vocational training pursuant to ORS 656.340 and 656.726. See ORS 656.268(1). Accordingly, claimant's substantive entitlement to temporary disability benefits ended after he became medically stationary on December 5, 1988, and began again on March 27, 1989, when he began his vocational training program.

Consequently, we modify that portion of the Referee's order which declined to authorize an offset of overpaid temporary disability benefits during the time that claimant was medically stationary and not participating in a vocational training program.

ORDER

The Referee's order dated September 16, 1992 is modified in part, reversed in part and affirmed in part. The insurer is authorized to offset temporary disability benefits paid between December 6, 1988 and March 26, 1989 against claimant's current and future permanent disability awards in this claim. That portion of the order which awarded an attorney fee payable from the increased compensation for temporary disability awarded during this period is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARK C. WELLS, Claimant
WCB Case No. 92-00547
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Lipton.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that upheld the self-insured employer's denial of claimant's claim for a disorder of the esophagus. On review, the issue is whether the employer's denial is permissible and, if it is, compensability. We reverse.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's abdominal and esophageal symptoms, subsequently diagnosed as achalasia, were accepted on July 11, 1988 as part of his claim for a February 25, 1986 back injury.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that the employer is precluded from denying his esophageal condition on the basis that it had previously accepted that condition. We agree.

The employer accepted claimant's claim by stipulation on July 11, 1988. (Ex. 89). The stipulation sets out claimant's then suspected diagnosis, "reflex esophagitis and esophageal gastric hang-up." (Id). On January 2, 1992, the employer denied claimant's current condition, including his "disorder of the esophagus." (Exs. 120, 121).

Because the denial issued more than two years after the acceptance and there is no claim of fraud, misrepresentation, or other illegal activity, the permissibility of the denial depends on whether the acceptance included the condition subsequently denied. See ORS 656.262(6); Bauman v. SAIF, 295 Or 788 (1983); see also Anthony G. Ford, 44 Van Natta 240 (1992). Whether acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992).

By letter dated March 14, 1988, Dr. Hilles, then treating physician, informed the employer that claimant was suffering from "classic reflux esophagitis-type symptom." (Ex. 83). Hilles also opined that these symptoms were "definitely" related to claimant's work injury, stating: "I do not feel that he would have these symptoms if it were not for his back injury initially." (Id). After receiving Hilles' letter, the employer rescinded its denial by stipulation, i.e., it accepted the claim. (Ex. 89).

Because there is no indication that the employer received additional medical evidence between Hilles' letter and claim acceptance, we find that the employer thus accepted the claim asserted by Hilles on claimant's behalf. (See id). In addition, considering Hilles' explicit reference to claimant's symptoms and the tentative nature of the diagnosis ("esophagitis-type symptoms"), we further find that the claim was for symptoms.

Accordingly, in accepting the claim for symptoms (later diagnosed as achalasia), we conclude that the employer accepted claimant's underlying achalasia condition. See Georgia Pacific v. Piwowar, 305 Or 494 (1988) (acceptance of the compensability of specific symptoms includes acceptance of the compensability of the disease causing the symptoms). In this regard, we find no evidence that claimant had more than one condition causing his ongoing abdominal and esophageal symptoms. Compare Johnson v. Spectra-Physics, 303 Or 49 (1987) (when a single claim encompasses two separate conditions, acceptance of one does not constitute acceptance of the other). Consequently, the employer may not now avoid responsibility for claimant's achalasia condition. See 113 Or App at 452; Karen M. Tull, 42 Van Natta 1976, 1977 (1990); aff'd SAIF v. Tull, 113 Or App 449 (1992).

Claimant is entitled to an assessed attorney fee for prevailing on the back-up denial 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 denial 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 26, 1992 is reversed. The self-insured employer's denial is set aside, and the claim is remanded to the self-insured employer for further processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $4,000, to be paid by the employer.

In the Matter of the Compensation of
RONALD R. WILLARD, Claimant
WCB Case No. 91-17232
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brazeau's order that upheld the insurer's partial denial of claimant's current low back condition. In his brief, claimant seeks to have the insurer's denial limited and to have an assessed attorney fee awarded. On review, the issues are compensability, propriety of the insurer's denial, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

On December 23, 1991, counsel for the insurer sent a letter to claimant's counsel to "clarify" the insurer's earlier written denial. That clarifying letter stated:

> "[T]he November 13, 1991 denial * * * is of claimant's current need for medical treatment on the basis that his current condition is unrelated to the industrial injury." (Ex. 97).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had failed to establish that his current need for treatment is compensable under ORS 656.005(7)(a)(B). We agree and adopt his Conclusions of Law and Opinion on this issue.

Overbroad Denial

Claimant contends that the insurer's denial is overbroad in that it denies that any portion of claimant's current condition is related to his compensable 1984 injury. Claimant further contends, and we agree, that the medical evidence clearly establishes that a component of his current condition remains related to his compensable injury.

In Marsha K. Flanary, 44 Van Natta 393 (1992), the employer denied the claimant's "current treatment and conditions." In Flanary, as here, we concluded that the claimant had failed to establish that her compensable injury was the major cause of her disability and need for treatment. Nevertheless, because the employer had issued a "blanket denial which covers everything including the [compensable injury]," we concluded that the denial was overbroad. The same analysis applies here. The language of the denial, to the effect that claimant's "current condition is unrelated to the industrial injury," is overbroad and, accordingly, improper.

Assessed Attorney Fee

Claimant's counsel is entitled to an insurer-paid attorney fee for obtaining clarification of the insurer's overbroad denial. Marsha K. Flanary, supra; Mickey L. Wood, 40 Van Natta 1860 (1988). 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 clarification of the insurer's denial is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue and the value of the interest involved.

ORDER

The Referee's order dated June 9, 1992 is affirmed in part and modified in part. That portion of the Referee's order that upheld the insurer's denial insofar as it denied claimant's current need for medical treatment is affirmed. That portion of the insurer's denial that stated that claimant's current condition is unrelated to his compensable injury is set aside. For services concerning clarification of the insurer's denial, claimant's counsel is awarded an assessed fee of $750, payable by the insurer.

May 20, 1993 Cite as 45 Van Natta 938 (1993)

In the Matter of the Compensation of
CLAIRREAN BOYD, Claimant
WCB Case No. 89-16057
ORDER ON REMAND
Bischoff & Strooband, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Boyd v. SAIF, 115 Or App 241 (1992). The court has reversed our prior order which held that claimant's right knee injury (which occurred while she was entering her vehicle in the employer's parking lot at the end of the work day) did not arise out of the course and scope of her employment. The court reasoned that claimant had established a sufficient work-connection since her employer controlled the parking lot, instructed its employees to park in the lot, and claimant was on her way home from work when she injured her knee while getting into her parked car. Concluding that we erred in upholding SAIF's compensability denial on the basis that claimant's injury was not within the course and scope of her employment, the court has remanded.

Based on the court's reasoning, we hold that claimant's injury arose out of the course and scope of her employment. Consequently, we conclude her claim is compensable.

Accordingly, SAIF's denial is set aside and the claim is remanded to SAIF for processing pursuant to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE CASTILLO, Claimant
WCB Case Nos. 90-14529, 90-12027 & 90-12098
And, In the Matter of the Complying Status of
WARREN & LOUIS SWENSON, Employer
WCB Case No. 89-21501
ORDER ON RECONSIDERATION
Michael B. Dye, P.C., Claimant Attorneys
Walter Barnes, Attorney
Roberts, et al., Defense Attorneys
Jonathon Liss, Defense Attorney
Bonnie Laux (Saif), Defense Attorney

Warren and Louis Swenson request reconsideration of our April 30, 1993 Order on Review that affirmed a Referee's order which set aside the Director's order finding Warren and Louis Swenson to be noncomplying employers. Specifically, Warren and Louis Swenson request the award of an attorney fee under ORS 656.740(5) for their attorney's services on Board review. In support of the reconsideration request, counsel for the Swensons filed with the Board a petition and affidavit in support of reasonable attorney fees.

We withdraw our April 30, 1993 order for reconsideration. After consideration of the Swenson's request and supporting documents, we find that Warren and Louis Swenson are not entitled to an award of attorney fees under ORS 656.740(5) for their counsel's services on review.

Attorney fees may only be awarded as specifically authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). Here, Warren and Louis Swenson seek an attorney fee pursuant to ORS 656.740(5), which provides:

> "If a person against whom an order is issued pursuant to this section prevails at hearing or on appeal, the person is entitled to reasonable attorney fees to be paid by the director from the Insurance and Finance Fund."

The Director issued an order finding Warren and Louis Swenson to be noncomplying employers. Pursuant to ORS 656.740, the Swensons timely contested the Director's order, and a hearing was held. The Referee set aside the Director's order finding the Swensons to be noncomplying employers. The Referee further found Terry and Timothy Jones to be responsible for the claim.

The Joneses requested Board review. We affirmed the Referee's order with some modification. In addition, pursuant to ORS 656.740(5), we awarded the Swensons a reasonable attorney fee, payable by the Director out of the Insurance and Finance Fund, for their attorney's services at hearing in prevailing against the Director's order.

On review, however, the Swensons did not prevail against the Director's order. The Swensons had already prevailed against the Director's order at the hearing level, and we simply affirmed the Referee's order. The Swensons did not request review of the Referee's order; instead, they sought to have it affirmed on review. Therefore, because Warren and Louis Swenson did not prevail against a Director's order on review, no attorney fee is authorized under ORS 656.740(5). See Sunset Siding Construction, Inc., 44 Van Natta 1476, on recon 44 Van Natta 1587, on recon 44 Van Natta 1662 (1992).

Moreover, we note that a Board rule requires that anything filed with the Board must be simultaneously served on every other party or their attorneys. OAR 438-05-046(2)(a). Here, we find no indication that the request for reconsideration and supporting documents were served on any other party. In particular, the Director was not served with the request for attorney fees, although the Director would be liable to pay the fees if awarded under ORS 656.740(5). Since the Director was not served and has had no opportunity to respond to the attorney fee request, we would decline to authorize an attorney fee to be paid by the Director from the Insurance and Finance Fund.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 30, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATTY A. DURR, Claimant
WCB Case No. 91-15092
ORDER ON REVIEW
Borneman & Rossi, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

The self-insured employer requests review of those portions of Referee Thye's order that: (1) set aside its denial of claimant's fibromyalgia condition; and (2) awarded a penalty for the employer's allegedly unreasonable "back-up" denial. On review, the issues are the procedural validity of the denial and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Procedural Validity of Denial

In May 1991, the employer accepted a "right arm and hand strain." In June 1991, claimant was diagnosed with right arm fibromyalgia. In October 1991, the employer informed claimant by letter that it had "received information indicating that your right arm and hand strain may not have arose [sic] out of and in the course and scope of your employment with [the employer]." (Ex. 22).

Although not entirely clear, at hearing the employer appeared to assert that the fibromyalgia condition had not been included in the original acceptance and that it was denying compensability of the condition. The Referee found that, although the "back-up" denial was invalid, acceptance was limited to the right shoulder and arm tendonitis. However, the Referee concluded that the fibromyalgia condition was compensable. See ORS 656.005(7)(a)(B).

On review, the employer continues to contend that, because fibromyalgia was not accepted when the original acceptance for right arm and hand strain issued, it did not revoke acceptance of the condition under ORS 656.262(6). Instead, the employer asserts that it merely denied the compensability of the fibromyalgia condition, thereby requiring claimant to prove it compensable. As she did at hearing, claimant maintains that fibromyalgia was accepted and that the employer is attempting to revoke acceptance and may do so only with clear and convincing proof that the claim is not compensable, as required by ORS 656.262(6).

A carrier's acceptance of a claimant's symptoms includes acceptance of the compensability of the disease causing those symptoms. Georgia-Pacific Corp. v. Piwowar, 305 Or 494, 501-02 (1988). The parties agree with the Referee's factual finding that the insurer's acceptance was limited to a "right arm and hand strain." Furthermore, there was medical evidence by claimant's treating physician, Dr. Fohrman, rheumatologist, that such terms were "a general categorization of symptomatic pain in those two areas." (Ex. 26-38). However, Dr. Fohrman also indicated only that fibromyalgia "might" fall within the category of right arm and hand strain. (Id. at 39).

We find Dr. Fohrman's use of the word "might" demonstrates only that right arm and hand strain could be symptoms of fibromyalgia. Accordingly, we further find there is insufficient proof that the carrier accepted the symptoms of fibromyalgia when it accepted "right arm and hand strain," since the medical evidence did not demonstrate by a preponderance of evidence that a right arm and hand strain is a symptom of fibromyalgia. Therefore, we conclude that the employer did not accept fibromyalgia and that its denial of such condition was not a revocation under ORS 656.262(6). See Johnson v. Spectra Physics, 303 Or 49 (1987). Consequently, the denial of fibromyalgia was procedurally valid. We proceed to the merits.

Compensability

Claimant has indicated that the onset of symptoms was gradual over a period of time. (Exs. 3, 17). Furthermore, Dr. Fohrman indicated that fibromyalgia is an inherent risk of continued exposure to conditions of claimant's job as a retail checker. (Ex. 26-36). Therefore, we treat the claim for fibromyalgia as an occupational disease. See Valtinson v. SAIF, 56 Or App 184, 187-88 (1982).

In order to prove 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). Here, Dr. Fohrman stated that claimant's work activity did not cause her fibromyalgia. (Exs. 23, 26-22). At most, Dr. Fohrman indicated that claimant's job "probably aggravated" her fibromyalgia. (Ex. 23-1). In view of Dr. Fohrman's additional statements that the fibromyalgia was "chronic but not progressive," but that additional work would cause "further irritation" and "substantially aggravate" the condition, (Ex. 26-35, 26-36), we interpret his opinion as demonstrating that claimant's work made her condition symptomatic, but did not pathologically worsen it. Such a showing is insufficient to prove an occupational disease claim. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991). Therefore, the claim for fibromyalgia fails.

Reasonableness of "Back-up" Denial

The Referee concluded that the "back-up" denial of the "right arm and hand strain" was invalid under ORS 656.262(6). Although the employer does not contest this conclusion, it does challenge the Referee's conclusion that the "back-up" denial was unreasonable. We affirm and adopt the Referee's conclusions regarding this issue. We note that claimant is not entitled to an assessed attorney fee for services on review regarding the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

Attorney Fees at Hearing

Inasmuch as we have reversed that portion of the Referee's order finding that claimant's fibromyalgia condition was compensable, we modify the Referee's attorney fee award of $2,500. We find that a reasonable fee for services at hearing concerning the compensability of the remaining conditions is $1,800. See OAR 438-15-010(4). In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated July 28, 1992 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's denial of claimant's fibromyalgia condition is reversed. The employer's denial insofar as it pertains to fibromyalgia is reinstated and upheld. The remainder of the denial remains set aside pursuant to the Referee's order. In lieu of the Referee's assessed attorney fee award of $2,500, claimant's attorney is awarded $1,800, to be paid by the employer. The remainder of the order is affirmed.

May 20, 1993 Cite as 45 Van Natta 941 (1993)

In the Matter of the Compensation of
KENNETH W. McDONALD, Claimant
WCB Case No. 91-07926
ORDER OF ABATEMENT
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of those portions of our April 22, 1993 Order on Review which: (1) found claimant was entitled to temporary disability benefits on the psychological component of his claim; (2) assessed a 25 percent penalty for the insurer's failure to comply with Referee Crumme's order; and (3) awarded claimant an assessed attorney fee of $1,000. Specifically, the insurer contends that no qualified attending physician authorized temporary disability benefits for the psychological component of the claim. The insurer also requests authorization to offset allegedly overpaid temporary disability benefits on the back injury component of the claim. In addition, the insurer has submitted new evidence which it requests that we consider during our reconsideration.

In order to allow us sufficient time to consider the insurer's motion, we withdraw our April 22, 1993 order. Claimant may submit a response to the motion. To be considered, claimant's response should be submitted within 14 days from the date of this order. Thereafter, we shall proceed with our review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLENN R. NASH, Claimant
WCB Case No. 92-05775
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of those portions of Referee Schultz's order that: (1) set aside its denial of claimant's claim for a left knee condition; (2) awarded claimant an assessed attorney fee under ORS 656.382(1); and (3) found that claimant was entitled to temporary total disability benefits because he had not voluntarily withdrawn from the workforce. On review, the issues are compensability, temporary 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

We affirm and adopt the Referee's conclusions of law concerning the compensability of claimant's left knee condition claim and claimant's entitlement to temporary disability benefits.

Attorney Fees

On April 21, 1992, the insurer issued a denial. The Referee found that the denial pertained to the accepted claim for a left knee strain. We agree. The Referee then concluded that the denial was unreasonable, because the insurer was precluded from denying the compensability of the accepted claim under the doctrine of issue preclusion, and that the denial was an impermissible "back-up" denial under ORS 656.262(6).

For unreasonably denying compensability, the Referee assessed a $250 attorney fee under ORS 656.382(1). For issuing an impermissible "back-up" denial, the Referee assessed an additional $250 attorney fee under ORS 656.382(1). Because a "back-up" denial under ORS 656.262(6) necessarily involves a compensability denial, we conclude that the insurer's April 21, 1992 denial constituted a single processing violation. See Oliver v. Norstar, Inc., 116 Or App 333 (1992). Consequently, only one assessed attorney fee is available under ORS 656.382(1). We therefore modify the Referee's order to award a single $250 assessed attorney fee under ORS 656.382(1) for the insurer's unreasonable April 21, 1992 "back-up" denial.

In concluding that claimant is entitled to an assessed attorney fee under ORS 656.382(1), we note that the Referee also assessed a 25 percent penalty against claimant's unpaid compensation. He based that penalty on the insurer's unreasonable failure to pay temporary disability benefits. Only one 25 percent penalty may be assessed against a claimant's unpaid compensation. See Conagra, Inc., v. Jeffries, 118 Or App 373, 376 (1993); see also Kim L. Haragan, 42 Van Natta 311, 313 (1990). However, the insurer's unreasonable failure to pay temporary disability benefits was conduct separate and distinct from its subsequent unreasonable "back-up"/compensability denial. See Laurie A. Bennion, 45 Van Natta 829 (1993). Consequently, claimant is entitled to a penalty for the insurer's unreasonable failure to pay this compensation, as well as an assessed attorney fee for its unreasonable back-up denial. See Oliver v. Norstar, supra; see also Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review on the issues of compensability and temporary total disability. 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 and temporary disability issues is $1,300, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved. Inasmuch as attorney fees are not compensation, claimant is not entitled to attorney fee for counsel's services on review concerning that issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 9, 1992 is modified in part and affirmed in part. The Referee's order is modified to award claimant a single assessed attorney fee of $250 under ORS 656.382(1), in lieu of the two, $250 fees that the Referee had awarded. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,300 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
EDWARD H. PORRITT, Claimant
WCB Case No. 92-02160
ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Davis & Bostwick, Defense Attorneys

On April 27, 1993, we issued an order which: (1) found claimant's right shoulder condition to be compensable; (2) awarded claimant's counsel a $2,000 attorney fee for services at hearing and on Board review; and (3) affirmed the remaining portions of a Referee's order which found that claimant's lumbar, left leg, right hip, and low back conditions were not compensable. We have received a letter from claimant, pro se. Registering disapproval with our decision, as well as with the services of his counsel, claimant asks that we withdraw our order until such time as he has secured new representation. We treat claimant's letter as a motion for reconsideration. In response, the insurer contends that our attorney fee award is excessive.

Claimant contends that his retainer agreement provided that another attorney would represent him and that his attorney would receive no more than 1/3 of his recovery. The agreement is signed by claimant and another attorney who neither appeared for claimant at hearing nor on review. Nevertheless, the attorney who did appear on claimant's behalf is an associate of the attorney who signed the retainer agreement. Moreover, the retainer agreement provides that claimant's attorney is authorized to associate other counsel to represent claimant. Finally, the attorney fee granted by our order is to be paid by the insurer in addition to (not out of) claimant's compensation. ORS 656.386(1); OAR 438-15-055(2). Therefore, claimant will not be obligated to forward for the fee any portion of his compensation to his attorney. The insurer will pay the attorney fee from the insurer's own funds.

As discussed in our prior order, in determining a reasonable attorney fee for claimant's counsel's services at hearing and on review regarding the compensability of his right shoulder condition, we considered the factors set forth in OAR 438-15-010(4). After applying those factors to this case, we continue to find, for the reasons previously expressed, that a reasonable assessed attorney fee for such services is $2,000, to be paid by the insurer.

Claimant also seeks advice regarding how to petition the court for judicial review of our order. In addition, he requests postponement of our decision to permit him an opportunity to secure new legal counsel. Since we are not authorized to provide legal advice to a particular party, we can only refer claimant to the "Notice" section of our prior order, and the "Notice" section of this order. Under such circumstances and considering claimant's specific request, he is strongly encouraged to immediately seek legal counsel. Should he have further questions regarding appellate court procedures, he may wish to

contact his current attorney-of-record, the Court of Appeals (1-503-378-6046), or the Ombudsman for Injured Workers (1-800-452-0288). Whichever method claimant chooses, he should do so as soon as possible because this order will become final within 30 days of its issuance.

Finally, claimant objects to that portion of our decision which held that the conditions (other than his right shoulder) were not compensable. Specifically, he refers to neurological test results and a MRI of the low back. In our prior order, we agreed with the Referee's conclusions that the medical evidence did not establish that the denied conditions were related to claimant's September 1990 industrial injury. Thus, whatever condition was revealed by the test results and MRI, we are unpersuaded that the condition was caused by claimant's work injury. This conclusion is further confirmed when the MRI results are reviewed. The MRI revealed a mild posterior L5-S1 bulging disc of "doubtful significance" and dehydration of the disc which was "most likely representing mild degenerative disease." Neither finding is supportive of a causal relationship between claimant's work injury and his low back condition.

Accordingly, we withdraw our April 27, 1993 order. On reconsideration, as supplemented herein, we republish our April 27, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 20, 1993 Cite as 45 Van Natta 944 (1993)

In the Matter of the Compensation of
DARRELL L. UHLS, Claimant
WCB Case No. 92-01090
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Neal's order which set aside an Order on Reconsideration as invalid. Claimant contends that his claim was prematurely closed. On review, the issues are jurisdiction and premature closure. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

In setting aside the Order on Reconsideration, the Referee, in effect, found that jurisdiction over all issues raised by the request for hearing on the Order on Reconsideration remained with the Director. See Robert G. Edwards, 44 Van Natta 2368 (1992). Accordingly, before addressing claimant's contention that his claim was prematurely closed by the May 21, 1991 Notice of Closure, we must first establish whether the Referee had jurisdiction over the issue of premature closure.

In vacating the Order on Reconsideration, the Referee cited Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992), for the proposition that the medical arbiter's examination is necessary for a rating of disability. However, because the arbiter did not rate the extent of claimant's disability and the Director did not rely on the arbiter's report, the Referee concluded that the Order on Reconsideration was invalid. We disagree.

ORS 656.268(7) provides, in pertinent 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."

Here, claimant objected to the impairment findings used in rating his disability and the Director referred the claim to a medical arbiter. The arbiter's report was considered by the Director in the reconsideration proceeding. (See Ex. 21). There is no statutory requirement that the arbiter's report be relied upon by the Director, only that the arbiter be appointed and that the report be submitted to the Department for reconsideration. ORS 656.268(7); Olga I. Soto, supra. Accordingly, the Order on Reconsideration is valid and the Referee had jurisdiction to consider the premature closure issue. See Robert G. Edwards, supra.

Premature Closure

We now proceed to the merits of claimant's contention that his right wrist injury claim was prematurely closed by the May 21, 1991 Notice of Closure (NOC). (Ex. 7). Claimant timely requested reconsideration of the NOC, asserting that he was not medically stationary. While reconsideration of the NOC was pending, however, claimant requested a hearing on the insurer's denial of an aggravation of his wrist injury. At the December 30, 1991 hearing, the insurer accepted the aggravation claim. (Ex. 18). The Appellate Review Unit issued its Order on Reconsideration on January 21, 1992, finding that claimant's wrist injury claim had not been prematurely closed. (Ex. 21). Claimant timely requested a hearing from the Order on Reconsideration, again asserting that his claim had been prematurely closed.

Concluding that it was the law of the case that claimant's claim must have been properly closed or he could not have had his claim reopened for an aggravation at the prior hearing, the Referee declined to address the issue of premature closure. We disagree.

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). We conclude that claimant is not barred by issue preclusion from litigating premature closure of his claim.

Pursuant to ORS 656.268(4)(e), claimant requested reconsideration of the NOC by the Director, contending that his claim had been prematurely closed. While reconsideration was pending, claimant properly requested a hearing from the insurer's denial of his aggravation claim. Because the issue of premature closure was pending before the Director, claimant could not have raised that issue before the prior referee in the hearing concerning the aggravation denial. Rather, the prior referee properly noted that the NOC, including the issue of premature closure, was being contested in a different forum, and said nothing further. (Ex. 18-1).

In light of the above circumstances, we conclude that the issue of premature closure was not actually litigated and determined at the prior hearing concerning the aggravation denial. Therefore, the Referee in the instant case was not precluded from addressing the issue of premature closure at hearing. Accordingly, we proceed with our review of that issue.

It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Co., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 21, 1991 NOC. See 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).

In August 1990, claimant's treating physician, Dr. Nathan, orthopedic surgeon, performed a radius bone graft to the right scaphoid in claimant's wrist. (Ex. 3). In January 1991, Dr. Nathan noted that a CT scan revealed a nonunion at the site of the previous surgery. (Ex. 6). Dr. Nathan performed a second surgery. (Ex. 4). Claimant continued to remain symptomatic, and Dr. Nathan referred him to Dr. Gill, hand surgeon, for a second opinion. (Ex. 4A). After consultation with Dr. Gill, Dr. Nathan

reported that he had no further treatment for claimant and that claimant was medically stationary. (Exs. 4C, 5). Based on Dr. Nathan's report, claimant's claim was closed on May 21, 1991.

On May 30, 1991, claimant saw Dr. Nye, hand surgeon. Dr. Nye reported a definite nonunion of the right scaphoid. (Ex. 8A-1). He stated that claimant still had a "significant definite diagnosable problem that is real and undoubtedly causing complaints and interfering with his work." (Ex. 8A-2).

Further examination by Dr. Bump, orthopedist also revealed a nonunion of the right scaphoid. (Exs. 8C, 9, 9B). Conservative treatment by Dr. Bump failed to relieve claimant's symptomatology. In September 1991, Dr. Bump requested authorization for surgery. (Ex. 9).

Subsequent changes in claimant's condition are not considered in determining whether his claim was prematurely closed by the May 1991 Notice of Closure. See Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). Evidence that was not available at the time of closure, however, may be considered to the extent the evidence addresses the condition at the time of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622 (1987). In this case, the evidence establishes that claimant's condition did not change between the date of closure and the time of Dr. Nye's and Dr. Bump's reports and subsequent surgery.

Dr. Nye suggested surgery at the time of his first examination of claimant because of a nonunion that had been present at the time Dr. Nathan performed the closing examination. Dr. Bump treated claimant's wrist conservatively, and eventually suggested surgery for the nonunion. Both physicians recommended surgery for the purpose of improving claimant's wrist problem.

Inasmuch as further improvement was expected from medical treatment, we conclude that claimant's condition was not medically stationary on the date of closure (May 21, 1991).

ORDER

The Referee's order dated April 21, 1992 is reversed. The Order on Reconsideration is reinstated and modified to set aside the May 21, 1991 Notice of Closure as premature. This claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

In the Matter of the Compensation of
NANCY C. GOFF, Claimant
WCB Case Nos. 92-03231 & 92-02737
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of that portion of Referee Brown's order which set aside its denial of claimant's aggravation claim for a current low back condition. Claimant cross-requests review of that portion of the Referee's order which awarded a $1,400 attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant has lumbar disc desiccation and mild to moderate degenerative disc disease at L3-4, L4-5 and L5-S1. (Ex. 22-3).

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded that claimant's current low back condition constituted a compensable aggravation of her July 1989 right knee industrial injury. Specifically, the Referee was persuaded that claimant's low back condition resulted from her December 13, 1991 fall which was caused when her right knee gave way. We conclude that claimant's compensable right knee injury is not the major contributing cause of her current low back condition. ORS 656.005(7)(a)(A). Consequently, we reverse.

In order to prove a compensable aggravation, claimant must show, inter alia, a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be compensable. We determine whether the worker's current condition is compensable and, if it is, whether that condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992).

We first address the compensability of claimant's low back condition. The medical evidence indicates that, to the extent that claimant's low back symptoms are injury-related, they are an indirect, rather than a direct, consequence of the compensable work injury. Accordingly, ORS 656.005(7)(a)(A) applies to this case. Therefore, claimant must prove that her July 1989 compensable right knee injury is the major contributing cause of her back symptoms. See Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 113 Or App 422 (1992).

Because of preexisting degenerative disc disease in her low back, the issue of whether claimant's compensable injury is the major contributing cause of her low back condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant argues that the evidence preponderates in favor of finding that her right knee condition was the major contributing cause of her December 1991 fall. We agree that is true. However, the question to be determined here is whether claimant's right knee injury is the major contributing cause of the consequential condition; that is, claimant's low back disability and need for medical treatment. See ORS 656.005(7)(a)(A). We conclude that it is not.

Claimant's treating physician, Dr. Bert, orthopedist, stated that claimant's "right knee condition was the major contributing cause of the fall she sustained on December 13, 1991." (Ex. 24). However, he offers no opinion concerning the causation of claimant's need for treatment for her low back condition. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Dr. Serbu examined claimant on December 30, 1991. He was not able to determine whether claimant's low back condition was work-related. (Ex. 18-2).

Dr. Woolpert, orthopedic surgeon, conducted an independent medical examination. It was his opinion that, in view of the degree of narrowing in the low back area, and disc changes at three levels, claimant's low back problem was due to underlying degenerative joint disease. (Ex. 19-5).

Claimant was referred to Dr. Gallo, neurosurgeon, by Dr. Falk, D.O. Dr. Gallo stated that claimant fell because of instability of the right knee. (Ex. 22-1). However, it was Dr. Gallo's impression that the cause of claimant's low back pain was her "multilevel disc degenerative disease." (Ex. 22-3).

Finally, claimant was examined by the Medical Consultants Northwest. Referring mainly to claimant's knee condition, the Consultants noted that it was possible that claimant's knee was incompletely rehabilitated and, because she was overweight, her knee continued to give way. However, the Consultants offered no opinion concerning the causation of claimant's low back symptoms. (Ex. 23B-9).

After considering the medical evidence concerning causation of claimant's low back condition, we conclude that she has failed to establish that her compensable right knee injury is the major contributing cause of her low back condition. Drs. Woolpert and Gallo relate claimant's need for treatment in her low back to her underlying degenerative disc disease. The other physicians, including Dr. Bert, claimant's treating physician, do not address the cause of claimant's low back condition. Accordingly, claimant has not established the compensability of her low back condition as a consequence of her compensable right knee injury. Albany General Hospital v. Gasperino, supra.

Attorney Fee

Because we have reversed the Referee's compensability finding, claimant is not entitled to an attorney fee for services at hearing. Therefore, the issue of the amount of the fee is moot.

ORDER

The Referee's order dated July 22, 1992 is reversed in part. The SAIF Corporation's denial of claimant's aggravation claim is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the Referee's order is affirmed.

May 24, 1993 Cite as 45 Van Natta 948 (1993)

In the Matter of the Compensation of
RONALD L. BARTLETT, Claimant
WCB Case No. 92-00946
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The insurer requests review of Referee Myzak's order that granted claimant permanent total disability, whereas an Order on Reconsideration awarded 37 percent (118.4 degrees) unscheduled permanent disability for a back condition, and 24 percent (36 degrees) scheduled permanent disability for left and right leg conditions. On review, the issues are remand and extent of permanent disability, including permanent total disability.

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

Remand

Claimant has included a medical report with his respondent's brief which addresses the causation of his hearing loss condition. This evidence was not submitted at hearing. We treat submission of this additional evidence as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985).

The Board's review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). We consider the proffered evidence only to determine whether remand is appropriate. Here, we conclude that no showing of due diligence has been made. Although the medical report is dated after the date of hearing, there is no showing that a report addressing the causation of claimant's hearing loss condition could not have been obtained at the time of hearing. Therefore, remand is not warranted. The motion to remand is denied.

Permanent Total Disability

On review, the insurer argues that the Referee should not have considered claimant's hearing loss in determining whether claimant was permanently and totally disabled. We agree. A preexisting condition is considered in assessing whether or not a claimant is permanently and totally disabled if the preexisting condition was disabling at the time of the injury. Elder v. Rosboro Lumber Co., 106 Or App 16 (1991); Weyerhaeuser Company v. Rees, 85 Or App 325 (1987). Here, there is no evidence that the hearing loss condition was disabling at the time of injury in 1983. Accordingly, we do not consider claimant's bilateral hearing loss in determining whether or not he is permanently and totally disabled. However, even excluding the hearing loss condition from consideration, we still conclude that claimant is permanently and totally disabled and we adopt the Referee's conclusions and reasoning with this modification.

We further note that the vocational evidence supports a conclusion that claimant needs retraining in order to be employable. Whether claimant is permanently and totally disabled must be decided upon conditions existing at the time of decision without consideration of the possibility of later retraining. Gettman v. SAIF, 289 Or 609, 614 (1980); Cora M. Watson, 42 Van Natta 294 (1990). Accordingly, based on this record, we agree with the Referee that claimant is permanently and totally disabled and that it would be futile to seek work.

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 issue, and the value of the interest involved.

ORDER

The Referee's order dated April 30, 1992 is affirmed. For services on review, claimant's attorney is awarded $1,500 payable by the insurer.

In the Matter of the Compensation of
LARRY D. BURLESON, Claimant
WCB Case No. 91-16752
ORDER ON REVIEW
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant, pro se, requests review of Referee Black's order that affirmed a Director's order which dismissed claimant's request for reinstatement of eligibility for vocational assistance. On review, the issues are timeliness and vocational assistance.

We affirm and adopt the Referee's order with the following correction and supplementation. The citations in the "Conclusions of Law and Reasoning" section to OAR 436-120-045 should be cited as OAR 436-120-050. WCD Admin. Order 11-1987.

The Director's order dismissed claimant's request for reinstatement of eligibility for vocational assistance on the ground that the request for Director review was untimely. ORS 656.283(2) provides that a worker who is dissatisfied with an action of the insurer regarding vocational assistance must apply for review to the Director "not later than the 60th day after the date the worker was notified of the action." We agree with the Referee that there is no statute or rule which would allow an extension of the 60-day time period to request Director review regarding vocational assistance actions. ORS 656.283(2); OAR 436-120-210(1).

In comparison, ORS 656.319(1)(b) provides for an exception to the requirement that a hearing request on a denial of a claim must be filed no later than the 60th day after the claimant is notified of the denial. ORS 656.319(1)(b) provides that the request for hearing on a denial may be filed no later than the 180th day after notification of the denial, if the claimant establishes "good cause" for the failure to request a hearing within 60 days. If it chose to do so, the legislature could have provided a "good cause" or other exception in regard to requests for Director review of vocational assistance matters. The Board has no authority to supply what the legislature has chosen not to provide.

ORS 656.283(2) provides that the Director's decision as to vocational assistance matters may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized by an abuse of discretion or clearly unwarranted exercise of discretion. A finding of one of the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order may be modified. See Colclasure v. Washington Co. School District No. 48-J, 117 Or App 128 (1992); SAIF v. Severson, 105 Or App 67 (1990); Lasley v. Ontario Rendering, 114 Or App 543 (1992). Here, the Director acted lawfully by dismissing claimant's request for review for being untimely. Therefore, there is no basis on which to modify the Director's order. James J. Kitchin, 44 Van Natta 532 (1992).

On review, claimant argues that the expiration of the 60-day period in which to request Director review is irrelevant because the SAIF Corporation did not place him in "suitable employment" before this time limit came into play. We understand claimant to argue, in effect, that the termination of vocational assistance prior to receiving "suitable employment" was without effect and, therefore, the running of the 60-day period prior to requesting Director review was irrelevant. Claimant cites former OAR 436-110-042(1)(b) in support of his argument. However, this rule does not support claimant's argument. Former OAR 436-110-042(1) provides that return-to-work incentives shall be provided only for suitable employment and lists the requirements of "suitable employment." However, it does not provide reinstatement of subsequently terminated vocational assistance in the event that suitable employment is not provided. Instead, the employer is not eligible for return-to-work incentives if the work offered is not "suitable employment." Former OAR 436-110-040(2).

In any event, we disagree with the basic premise of claimant's argument. As discussed above, the expiration of the 60-day period to request Director review is far from irrelevant. Instead, it is the deciding factor. ORS 656.283(2); OAR 436-120-210(1).

ORDER

The Referee's order dated September 4, 1992 is affirmed.

In the Matter of the Compensation of
DOTTY C. FOWLER, Claimant
WCB Case No. 91-15570
ORDER ON REVIEW
Scott McNutt, Claimant Attorney
Foss, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Brown's order that increased claimant's unscheduled permanent disability award from 43 percent (137.6 degrees), as awarded by Order on Reconsideration, to 53 percent (169.6 degrees). On review, the issue is extent of unscheduled 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 unscheduled permanent disability award from 43 percent (137.6 degrees), as awarded by Order on Reconsideration, to 53 percent (169.6 degrees). The Referee also held that since the insurer had failed to cross-appeal the Order on Reconsideration, claimant's permanent disability award could not be reduced.

A Determination Order (DO) which issued on April 9, 1991, awarded 43 percent unscheduled permanent disability. Claimant requested reconsideration, raising the issue of extent of permanent partial disability. The insurer also requested reconsideration, but raised only the issue of temporary disability. A June 25, 1991 Order on Reconsideration corrected a typographical error in the DO's temporary disability award, but otherwise affirmed the DO award of permanent disability. Claimant requested a hearing from the Reconsideration Order. The insurer did not file a cross-request for hearing.

The hearing was originally convened before Referee Livesley on January 23, 1992. At that time, the insurer moved for dismissal of claimant's hearing request on the grounds that the April 9, 1991 DO was void because it rated an unaccepted low back condition. Referee Livesley denied the insurer's motion on February 11, 1992, basing his conclusion on the grounds that the insurer did not request reconsideration of the Determination Order's finding of "compensability" of the low back condition. Referee Livesley characterized the insurer's payment of the DO award as an "acceptance" of the low back condition.

The insurer requested and claimant cross-requested Board review of Referee Livesley's order. On February 27, 1992, we issued an Order of Dismissal remanding the case to the Hearings Division. Dotty C. Fowler, 44 Van Natta 349 (1992). In our dismissal order, we concluded that since further action before the Hearings Division was required, Referee Livesley's order was not a final order. The hearing was then re-scheduled and held before the present Referee.

On review, the insurer contends that its payment of the DO award did not constitute an "acceptance" of the low back condition. We agree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompassess only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9).

Here, the record does not establish that the insurer accepted the low back condition specifically or officially in writing. Further, the mere payment of the permanent disability award does not constitute an acceptance of the low back condition. See Cecilia A. Wahl, 44 Van Natta 2505 (1992) (on reconsideration). Accordingly, the insurer's failure to challenge the DO and Order on Reconsideration awards of permanent disability does not constitute an acceptance of the low back condition.

Although we agree with the insurer that payment of the permanent disability award does not constitute an acceptance of the claim, we nevertheless conclude that the insurer is barred from contesting the DO award of permanent disability. Recently, in Raymond L. Mackey, 45 Van Natta 776 (1993),[1] we held that a party is barred from raising an issue which stems from a notice of closure or determination order if that issue was not first raised on reconsideration. Specifically, in Mackey, we held that since the claimant had failed to raise the adaptability issue in his request for reconsideration, he was barred from raising that issue at hearing. In the present case, the insurer sought reconsideration only of the temporary disability issue. It did not raise the issue of unscheduled permanent disability in its reconsideration request. Under such circumstances, the insurer may not subsequently raise the unscheduled disability issue for the first time at hearing or on Board review.

Although we conclude that the carrier is barred from challenging the DO award of unscheduled permanent disability, claimant raised the issue of entitlement to an increased unscheduled award in her request for reconsideration and the Referee subsequently increased the unscheduled award. Under such circumstances, we conclude that the insurer may contest that portion of the unscheduled award altered by the Referee's order. See Todd M. Brodigan, 45 Van Natta 438, 439 (1993).

In Brodigan, we held that an insurer which failed to contest a DO award during the reconsideration process was prohibited from subsequently challenging the award at hearing. However, we envisioned a "qualification" to our holding in Brodigan. Specifically, we noted that where a claimant seeks reconsideration and the award is increased or a carrier seeks reconsideration and the award is decreased, the party who did not request reconsideration could contest the portion of the award altered by the reconsideration order. We conclude that the same reasoning should apply here. Although the insurer is barred from challenging the DO award since it did not seek reconsideration of the permanent disability award, we conclude that the insurer may challenge the portion of the award which was altered by the Referee's order.

The only dispute raised by the parties at hearing concerning the extent of claimant's unscheduled disability was the correct value for the adaptability factor. The Referee applied the standards in effect on the date of the April 9, 1991 DO. (WCD Admin. Order 2-1991).

The June 25, 1991 Order on Reconsideration found that claimant was capable of sedentary work and had been working at medium work at the time of injury. Based on these findings, the reconsideration order found claimant's adaptability factor to be 5. The Referee found that claimant's residual functional capacity (RFC) was sedentary with restrictions, and that consequently, her adaptability factor should be rated at 6 pursuant to former OAR 436-35-310(3). We disagree and affirm the Reconsideration Order.

Pursuant to former OAR 436-35-270(3)(e), sedentary RFC restrictions means that by a preponderance of the medical evidence, the worker is 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." Here, a physical capacities evaluation (which the treating physician approved) indicates that claimant can use her arms for repetitive pushing/pulling and grasping, and may use her hands for repetitive fine manipulation. A second physical capacities examination (with which the treating physician concurred) also did not reveal any inability to reach, handle, finger or feel. In addition, there is no evidence that claimant cannot talk, see or hear. Based on this record, we are unable to find that claimant's residual functional capacity is sedentary with restrictions.

Instead, the medical evidence supports a finding that claimant is capable of work in the sedentary range. The strength requirement of claimant's job at injury was medium. Therefore, claimant's residual functional capacity (RFC) is sedentary. Accordingly, based on former OAR 436-35-310(3), claimant's adaptability factor is 5.

ORDER

The Referee's order dated May 15, 1992 is reversed. In lieu of the Referee's increased unscheduled permanent disability award, the June 25, 1991 Order on Reconsideration award of 43 percent (137.6 degrees) unscheduled permanent partial disability is reinstated and affirmed. Claimant's "out-of-compensation" attorney fee is reversed.

[1] Although signatory to this order Member Gunn directs the parties to his dissent in Mackey, supra.

In the Matter of the Compensation of
SHERRY L. LOW, Claimant
WCB Case No. 90-09533
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee McWilliams's order which increased claimant's unscheduled permanent disability award for a contact dermatitis condition from 8 percent (25.6 degrees), as awarded by prior Determination Order, to 47 percent (150.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's allergic contact hand dermatitis condition became medically stationary on March 19, 1990. Therefore, the rules in effect from January 1, 1989 through September 30, 1990 (WCD Admin. Order 6-1988) apply. OAR 438-10-010(1)(eff. 11/7/91).

The employer only contests the impairment value awarded by the Referee for claimant's contact dermatitis. The Referee found that claimant's impairment fell within Class 3 (25-50 percent impairment) under former OAR 436-35-440 and awarded 38 percent impairment, thereby increasing claimant's unscheduled permanent disability award for a skin condition from 8 percent to 47 percent. The employer contends that claimant's impairment should be rated under Class 1 (0-5 percent impairment).

Former OAR 436-35-440 provides that a Class 1 rating is appropriate where:

> "Signs or symptoms of skin disorder are present; AND
>
> "With treatment, there is no limitation, or minimal limitation, in the performance of the activities of daily living, although exposure to certain physical or chemical agents might increase limitation temporarily."

Whereas a Class 3 rating is appropriate where:

> "Signs and symptoms of skin disorder are present; AND
>
> "Continuous treatment is required; AND
>
> "There is limitation in the performance of many activities of daily living."

The employer contends that claimant's impairment should be rated under Class 1 based on the independent medical examination by Drs. Haberman and Storrs, which reported that claimant had Class 1 impairment, and on Dr. Moha-jerin's check-the-box concurrences with that opinion. We find these opinions conclusory and therefore unpersuasive. Joe Fernandez, Jr., 44 Van Natta 7 (1992).

As did the Referee, we rely on the January 6, 1992 report by Dr. Moha-jerin, claimant's treating physician. He opined that claimant would "need rather continuous treatment, in the form of preventive measures as well as active therapy" and that "many of her activities which [would] need use of her hands [would] be limited especially during flare-ups and exacerbations of her hand eczema." (Ex. 51). Because Dr. Moha-jerin gave explanations of his opinion in his January 6, 1992 report, we find that opinion persuasive.

Claimant's testimony supports Dr. Moha-jerin's opinion that continuous treatment is required. Claimant treated with Dr. Moha-jerin from May 1989 to May 1990 and again on April 24, 1991. She now self-treats with medications (creams and bromium) prescribed by Dr. Moha-jerin. (Tr. 10, 15-16). Such circumstances persuade us that claimant requires continuous treatment to control her dermatitis. Claimant can control her current condition with medication and by preventive measures, i.e., avoiding excessive hand use, and irritants. (Ex. 44, Tr. 12, 13, 17). As such, claimant has been able to work without dramatic changes in her condition. (Exs. 43, 49-2).

Under such circumstances, we conclude that claimant's condition constitutes a Class 3 impairment. However, in light of Dr. Moha-jerin's qualification that claimant's treatment and limitations fluctuated and depended on activities, we rate claimant's impairment at the low end of the 25-50 percent range (25 percent).

The 25 percent impairment rating is combined with the 5 percent impairment rating for chronic condition limiting repetitive use for a total value of 29 percent impairment. This sum added to claimant's non-impairment factors (6) totals 35 percent. Accordingly, we modify claimant's unscheduled permanent disability for a skin condition from the Referee's 47 percent award to 35 percent unscheduled permanent disability.

ORDER

The Referee's order dated September 3, 1992 is modified. In lieu of the Referee's award and in addition to the Determination Order award of 8 percent (25.6 degrees), claimant is awarded an additional 27 percent (86.4 degrees) unscheduled permanent disability, for a total award of 35 percent (112 degrees) unscheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee award shall be adjusted accordingly.

In the Matter of the Compensation of
KATHYRON D. PARSONS, Claimant
WCB Case No. 92-04305
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Ray Myers (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Holtan's order that affirmed an Order on Reconsideration which awarded 16 percent (51.2 degrees) unscheduled permanent disability for a cervical and lumbosacral injury. On review, the issue is extent of unscheduled permanent disability.

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

Both at hearing and on review, only the value of the adaptability factor was at issue. The Referee correctly applied the standards in effect on the date the Notice of Closure was mailed, September 13, 1991. (WCD Admin. Order 2-1991). He found that the applicable version of the Dictionary of Occupational Titles (DOT) was the Fourth Edition, 1977 with the 1986 Supplement. Former OAR 436-35-270(3). Using that version, he determined that claimant's at-injury job of "cutting-machine operator" was rated as a "medium" strength job. (DOT 640.682-018). Comparing claimant's at-injury job strength of "medium" with her maximum residual functional capacity (RFC) of "light to medium," the Referee calculated an adaptability value of 2. Former OAR 436-35-310(3).

Claimant does not contest the RFC of "light to medium," the classification of her at-injury job as a "cutting-machine operator," or the Referee's finding regarding the applicable version of the DOT. However, she argues that the applicable version of the DOT does not adequately describe the job she did as a cutting machine operator. Therefore, she argues, the Board should apply the strength factors set forth at former OAR 436-35-270(3)(h) to determine that her at-injury job was a "heavy" strength job based on her credible testimony. We disagree.

In determining the extent of unscheduled permanent disability, the adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1). Former OAR 436-35-270(3)(h) provides that "'[s]trength' means the physical demands of each job as described by the SCODDOT [Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles]. Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's at-injury job." Former OAR 436-35-270(3)(h).

Contrary to claimant's argument, former OAR 436-35-270(3)(h) requires that the strength category for the at-injury job be determined by the category assigned in the DOT. Although former OAR 436-35-270(3)(h) lists the various strength factors, it does not provide an alternative means to determine the strength category of an at-injury job.

In addition, we have recently held that, while we consider the record as a whole, including the job duties and the physical demands of the at-injury job, in determining which DOT is most applicable, the fact remains that the most applicable DOT determines the strength category of the at-injury job. See William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993). In other words, claimant's testimony is relevant to the determination of which DOT most accurately describes her at-injury job. However, claimant may not rely on her testimony to determine that no DOT description accurately describes her at-injury job and, therefore, her at-injury strength category must be determined without regard to the DOT. See Delores A. Williams, 45 Van Natta 517 (1993); see also Vickie M. Libel, 44 Van Natta 294, 295, on recon 44 Van Natta 413 (1992) (applying a substantially similar earlier version of the rule).

Here, claimant testified that 99 percent of her time was spent in production operating a cutting machine, although she also did some office work and some loading and unloading of the van. (Tr. 15, 18). We find that claimant's at-injury job is most appropriately defined as "cutting-machine operator." DOT 640.682-018. The applicable DOT identifies "cutting-machine operator" as being in the "medium" category. Because claimant is now limited to performing "light to medium" work, her adaptability value is 2, as found by the Appellate Unit and the Referee. Former OAR 436-35-310(3); see Robin G. Whitfield, 44 Van Natta 2128 (1992).

ORDER

The Referee's order dated September 14, 1992 is affirmed.

May 25, 1993 Cite as 45 Van Natta 955 (1993)

In the Matter of the Compensation of
LINDA L. DAVIS, Claimant
WCB Case No. 90-04449
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of those portions of Referee Kinsley's order that: (1) upheld the insurer's "back-up" denial of her left buttock and hip condition; (2) declined to address the issue of premature claim closure; (3) upheld the insurer's denials of chiropractic care; and (4) declined to award penalties and attorney fees for an allegedly unreasonable denial. In her brief, claimant argues that the Referee abused her discretion by admitting Exhibits 1x through 9x, 2A, 2B, 36A, 36B, 36C, 37A, 40A, 41B, 41C, 42, and 43 into evidence. Claimant also contends that the Referee abused her discretion by allowing the employer's witness, Mr. Lowder, to testify at hearing. On review, the issues are evidence, compensability, 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

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

On review, claimant argues that the Referee abused her discretion by admitting exhibits regarding claimant's welfare claims into evidence. Claimant also contends that the Referee should not have allowed Mr. Lowder, her landlord, to testify at the hearing.

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." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See e.g. Brown v. SAIF, 51 Or App 389 (1981). Evidence, however, is relevant if it has any tendency to make the existence of any fact that is of consequence to the determination more or less probable. See Brian D. Lindstrom, 45 Van Natta 543 (1993).

We conclude that, because the exhibits cited by claimant pertained to the element of misrepresentation, the exhibits were relevant and the Referee did not abuse her discretion in admitting them into evidence. Additionally, we do not agree that the testimony of Mr. Lowder was irrelevant or improper impeachment evidence. The witness' testimony was offered to show that claimant paid rent, although she had previously claimed, for purposes of receiving welfare benefits, that she was not working and that the use of the house had been donated to her. Mr. Lowder also testified with regard to the timeframe of claimant's back complaints. Under the circumstances, we find that his testimony was relevant and that it was not an abuse of discretion for the Referee to allow the testimony.

Accordingly, we do not find that the Referee abused her discretion by admitting Exhibits 1x through 19x, 2A, 2B, 35, 36A, 36B, 36C, 37A, 40A, 41B, 41C, 42, and 43 into evidence. We further find that the Referee properly overruled objections to the testimony of the employer's witness, Mr. Lowder.

ORDER

The Referee's order dated June 26, 1992 is affirmed.

May 25, 1993 Cite as 45 Van Natta 956 (1993)

In the Matter of the Compensation of
GEORGE F. HENSLE, II, Claimant
WCB Case Nos. 92-01705, 91-18310 & 91-17990
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney
Richard C. Pearce, Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

The SAIF Corporation requests review of Referee Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for his asthma condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's claim for the same condition; and (3) upheld Universal Underwriters Insurance Company's denial of claimant's claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant first became disabled while SAIF was on the risk, SAIF was responsible for his asthma condition. We agree that SAIF is responsible, and we add the following supplementation.

We conclude that ORS 656.308 does not apply in this responsibility case as claimant does not have an accepted asthma condition. See Fred A. Nutter, 44 Van Natta 854 (1992) (application of ORS 656.308 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 an occupational disease case, the "onset of disability" is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date upon which he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); 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).

On review, SAIF contends that claimant's first date of disability was actually in August 1989, while Liberty was on the risk. SAIF argues that claimant was treated for asthma with bronchitis and was taken off work for four days by Dr. Henry, his treating physician. SAIF notes that Dr. Henry believed that claimant's "asthmatic bronchitis" was caused by "sensitization from work exposure." Finally, SAIF contends that, as claimant's treating physician, Dr. Henry is in the best position to provide an opinion with regard to the date of disability. We disagree.

Dr. Henry, claimant's family physician, referred him to Dr. Keppel, an expert in lung diseases. In addressing the chartnote of August 1989, Dr. Keppel responded that, in his opinion, claimant's symptoms were due to a virus rather than exposure to isocyanates at work. Dr. Keppel believed that the January 1991 exposure was the "trigger," as claimant had daily symptoms and difficulty breathing at night. Claimant also testified that his symptoms in August 1989 were different from those in January 1991.

Under the circumstances, we defer to the expert opinion of Dr. Keppel, rather than to the conclusory opinion of Dr. Henry. Accordingly, because claimant's condition gradually worsened until September 1991, when he finally sought treatment and was taken off work, we find that claimant was first disabled while SAIF was on the risk.

We therefore agree with the Referee's conclusion that claimant first became disabled in September 1991, while SAIF was on the risk. Accordingly, SAIF is responsible for claimant's condition.

Finally, we conclude that SAIF would be responsible even if claimant was first disabled while Liberty was on the risk in August 1989. Claimant continued to work as an auto painter and continued to be exposed to chemicals after SAIF came on the risk in July 1991. Dr. Keppel agreed that claimant's condition had become more serious in the three-month period prior to the time he saw him in September 1991. Furthermore, Dr. Keppel testified that increased exposures following claimant's sensitization would have contributed to a worsening of his condition.

Accordingly, because claimant's work as an auto painter after July 1, 1991 (during SAIF's coverage) contributed to the disease, we conclude that even if Liberty were initially responsible, responsibility would shift to SAIF.

Under the circumstances, we affirm the Referee and find that SAIF is responsible for claimant's asthma condition.

ORDER

The Referee's order dated July 28, 1992 is affirmed.

In the Matter of the Compensation of
KAI MAINVILLE, Claimant
WCB Case No. 92-00579
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Gruber's order that: (1) declined to grant claimant's motion to remand the matter to the Director for adoption of a temporary "standards" rule; and (2) affirmed an Order on Reconsideration that awarded 67 percent (12.06 degrees) scheduled permanent disability for the loss of use or function of claimant's right great toe. On review, the issues are whether a Referee or the Board are authorized to remand to the Director for rulemaking and extent of scheduled permanent disability.

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

Relying on a "post-reconsideration order" supplemental report from the medical arbiter, claimant contends that his scheduled permanent disability award should be increased from the reconsideration order award of 67 percent for the great right toe. The Referee declined to consider the supplemental report. Claimant challenges the Referee's ruling, asserting that ORS 656.268(7) does not prohibit consideration of the supplemental medical arbiter's report.

We need not resolve this question because, even if the report was considered, claimant's scheduled permanent disability award would not be altered. We base this conclusion on the following reasoning.

Claimant compensably injured his right foot. The Determination Order awarded 28 percent scheduled permanent disability for the loss of use or function of his great toe, which was increased to 67 percent by the Order on Reconsideration. Based on the medical arbiter's supplemental report, claimant alleges that he proved a chronic condition limiting repetitive use of his right foot, entitling him to 5 percent impairment, and that his present award should be converted and combined with the 5 percent.

In his supplemental report, Dr. Gritzka, the medical arbiter, stated that claimant "has pain with weight-bearing and stiffness in the right foot" and attempted to address whether or not claimant "has ratable impairment of the foot as well as the great toe." (Ex. 9-1). After stating that the injury caused no loss of range of motion in the foot, Dr. Gritzka reported that claimant's "injury caused chronic and permanent [impairment] to the myotatic unit of the right great toe and first and second rays of the foot." (Id). However, Dr. Gritzka could not state whether or not the standards could "rate impairment due to pain and stiffness." (Id. at 2).

We find Dr. Gritzka's report insufficient to prove that claimant is entitled to an award for scheduled chronic condition impairment. Under former OAR 436-35-010(6), such an award is warranted "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[.]" (WCD Admin. Order 2-1991). Even if we found that impairment to the great toe and first and second rays of the foot constituted impairment to the foot, at most Dr. Gritzka indicated that claimant suffers from chronic stiffness and pain. Such complaints do not establish that this claimant is "unable to repetitively use" his right foot. Furthermore, the remaining medical evidence showed only that claimant has a chronic condition in the great toe, which does not constitute a "body part" under former OAR 436-35-010(6).

Finally, in the alternative, claimant seeks remand to the Director for promulgation of a rule under ORS 656.726(3)(f)(C) to address claimant's disability. The Referee denied the motion.

Subsequent to the Referee's order, we held that only the Director has the authority to determine whether or not a claimant's disability is addressed by the standards and, therefore, the Hearings Division and the Board lacked authority to remand an order on reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C). Gary D. Gallino, 44 Van Natta 2506 (1992). In accordance with Gallino, we likewise deny claimant's motion to remand.

ORDER

The Referee's order dated May 1, 1992 is affirmed.

In the Matter of the Compensation of
MARTIN E. MENDEZ-ESQUIBEL, Claimant
WCB Case No. 92-06352
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Michael V. Johnson's order that awarded a $160 attorney fee for claimant's counsel's services in obtaining the pre-hearing rescission of the SAIF Corporation's denial of claimant's injury claim. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

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

On May 6, 1992, claimant's attorney filed a request for hearing. SAIF verbally agreed to rescind its denial of claimant's injury claim on May 7, 1992. SAIF did not formally accept the claim until June 26, 1992.

Claimant's counsel was instrumental in obtaining compensation for claimant without a hearing.

Although the parties proceeded to hearing, the only issue litigated at hearing was attorney fees.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee/Pre-Hearing Rescission

The Referee held that claimant's attorney was entitled to a $160 attorney fee for services rendered in prompting the pre-hearing rescission of SAIF's denial. Claimant contends that the Referee failed to consider or compensate claimant's counsel for all efforts expended in this matter. We agree that the attorney fee award should be increased.

The record establishes that SAIF's decision to rescind its denial was not the result of any direct efforts by claimant's attorney. However, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without benefit of a hearing. In this regard, we note that although SAIF verbally agreed to rescind its denial on May 7, 1991, that rescission was not formalized and the claim was not officially accepted until SAIF formally accepted the claim in writing on June 26, 1992.

Consequently, by requesting a hearing at a time when SAIF had not yet formally rescinded its denial, claimant's counsel's efforts in corresponding with SAIF and requesting a hearing, demonstrate that claimant's attorney was instrumental in obtaining compensation for claimant without benefit of a hearing. Under these circumstances, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1). See e.g., Deborah K. Atchley, 44 Van Natta 1435 (1992); Euzella Smith, 44 Van Natta 778 (1992); Kimberly Wayne, 44 Van Natta 328 (1992).

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services prior to hearing before the rescission of SAIF's denial is $620, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's Affidavit in Support of Attorney's Fees) and the value of the interest to claimant.

Attorney Fee/At Hearing

Claimant also contends that the Referee erred in not awarding his counsel an additional fee for 5 hours spent in preparation for, travel to, and attendance at hearing. Before the hearing, the parties had resolved all issues on the claim except for the attorney fee issue. That was the only issue presented to the Referee. An attorney's efforts pertaining to post-rescission matters are not considered in determining a reasonable assessed attorney fee. See Amador Mendez, 44 Van Natta 736 (1992); Ernest C. Richter, 44 Van Natta 101, on recon 44 Van Natta 118 (1992). The Referee did not err.

Finally, because attorney fees do not constitute compensation, claimant's counsel is not entitled to a fee for services before the Board concerning the attorney fee issue at hearing. See Amador Mendez, supra.

ORDER

The Referee's order dated August 12, 1992 is modified. In lieu of the Referee's attorney fee award of $160, claimant's counsel is awarded an assessed fee of $620, payable by the SAIF Corporation, for her services concerning SAIF's acceptance of claimant's injury claim prior to hearing. The remainder of the order is affirmed.

In the Matter of the Compensation of
DEBRA L. ROLLINI, Claimant
WCB Case No. 91-16255
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of that portion of Referee Garaventa's order that set aside its "back-up" denial of claimant's right knee injury claim. Claimant cross-requests review of that portion of the Referee's order that declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

Claimant objects to the Referee's conclusion that the issuance of the employer's denial was "legally proper" under ORS 656.262(6). A "back-up" denial must be prompted by new material (something other than the evidence that the carrier had at the time of the initial acceptance). CNA Insurance Companies v. Magnuson, 119 Or App 282 (1993); Ralph E. Murphy, 45 Van Natta 725 (1993). Here, the record supports a conclusion that the employer's assistant manager received an anonymous phone call (approximately two months after the acceptance of the claim) in which the caller stated that claimant had faked her injury. This phone call constitutes new evidence which was obtained after claim acceptance. Therefore, this statutory prerequisite for issuance of a "back-up" denial has been met. Because the other requirements of ORS 656.262(6) have been met, we conclude that the "back-up" denial was "legally proper."

However, on the merits, we agree with the Referee that the employer has failed to establish by clear and convincing evidence that claimant's injury claim is not compensable.

Turning to the penalty issue, a penalty is assessable when a carrier unreasonably delays or unreasonably refuses to pay compensation. ORS 656.262(10). In determining if a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). This analysis is made in the first instance by examining the facts and circumstances as they existed when the carrier denied the claim. Hutchison v. Fred Meyer, Inc., 118 Or App 288 (1993). In light of a carrier's burden to prove its "back-up" denial by clear and convincing evidence under ORS 656.262(6), the evidence necessary to establish legitimate doubt supporting a reasonable "back-up" denial is more demanding than that required to support the reasonableness of a denial of an unaccepted claim. Laurie A. Bennion, 45 Van Natta 829 (1993).

Thus, we examine the information available to the employer at the time of its denial, including the "new" evidence, to determine whether its denial was based on a legitimate doubt concerning its liability for the claim.

The substance of the anonymous call concerned the authenticity of claimant's injury claim. In addition, viewed in light of the call, alleged inconsistencies concerning claimant's history of the injury and her ensuing knee complaints caused the employer to further question the authenticity of the claim. Although we have concluded that neither the call nor the alleged inconsistencies establish clearly and convincingly that the claim is not compensable, we are persuaded that such circumstances established a legitimate doubt regarding the employer's liability for the previously accepted claim. Consequently, we do not find a basis to assess a penalty for an unreasonable denial.

Inasmuch as claimant's compensation awarded by the Referee's order has not been disallowed or reduced, claimant is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we 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. We further note that claimant is not entitled to an attorney fee for services on review regarding her unsuccessful cross-request for review.

ORDER

The Referee's order dated September 15, 1992 is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded $1,000, to be paid by the self-insured employer.

May 25, 1993 Cite as 45 Van Natta 961 (1993)

In the Matter of the Compensation of
MICHAEL M. TAYLOR, Claimant
WCB Case No. 92-08265
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The SAIF Corporation requests review of Referee Galton's order that modified a Director's order on the ground that the Director had abused his discretion in finding that claimant was not eligible for vocational assistance. On review, the issue is whether the Director's order should be modified. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the second to last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Director had abused his discretion by finding that claimant was released to return to his regular work, and therefore, was not eligible for vocational assistance. Consequently, the Referee set aside the Director's order and concluded that claimant was entitled to vocational assistance. We disagree.

ORS 656.283(2) provides that, as to the decision of the Director regarding vocational assistance:

> "[T]he 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 an abuse of discretion or clearly unwarranted exercise of discretion."

A finding of one of the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order regarding vocational assistance may be changed by a Referee. Here, the Referee found, and claimant contends, that the Director's decision constituted an abuse of discretion.

Two court decisions discuss the scope of review by the referee and the Board in such cases. In Lasley v. Ontario Rendering, 114 Or App 543 (1992), the court concluded that, under ORS 656.283(2), the hearing to which a claimant is entitled in such cases must be for the purpose of determining the historical facts relevant to the dispute. Accordingly, the court concluded that the referee could make findings of ultimate fact to determine whether the Director's order was subject to modification pursuant to the statute. The court also found that, on review, the Board reviewed the record made by the referee, but could make findings of ultimate fact different from those made by the referee. Id at 836.

In Colclasure v. Washington County School Dist. No 48-J, 117 Or App 128 (1992), a referee modified a Director's order which had found that the claimant was not eligible for vocational assistance because he had left his job for reasons unrelated to the compensable injury. The referee made a finding that the claimant had left his job for reasons related to the injury, and he concluded that the claimant was eligible for vocational assistance. On review, the Board reversed and concluded that the referee had exceeded his review authority, as the evidentiary record before the referee supplied a reasonable basis for the Director's finding, whether or not it also supported the opposite finding of the referee. See Richard A. Colclasure, 42 Van Natta 2454 (1990).

Finally, the court affirmed the Board and agreed that the Director did not abuse his discretion. The court rejected the claimant's argument that a Director's decision can be reversed if the referee or Board find facts different from the ones found or relied on by the Director. The court reiterated that an error of fact cannot serve as a basis in itself for reversing a Director's decision. Colclasure v. Washington County, id at 132.

In the present case, the Referee found that, on June 3, 1992, claimant's treating doctor opined that claimant was capable of returning to his at-injury job and could do heavy work. The Director's order, issued June 5, 1992, relied upon the report of claimant's treating doctor and found claimant ineligible for vocational assistance because he had received a regular work release.

Under the circumstances, we conclude that the evidence before the Referee supplied a reasonable basis for the Director's decision, insofar as the Director relied upon the opinion provided by claimant's treating physician. Even though a medical arbiter subsequently found that claimant was capable of working in the light to light/medium category, an error of fact cannot serve as a basis in itself for modification of the Director's order. See John R. Coyle, 45 Van Natta 325 (1993). Consequently, because the only error that can be asserted here is that the Director was incorrect in his fact-finding, we conclude that the Director's order cannot be modified. Colclasure v. Washington County, surpa.

Claimant has failed to establish any of the four circumstances provided by ORS 656.283(2). Therefore, we reverse the Referee's modification and reinstate the Director's order.

ORDER

The Referee's order dated September 24, 1992 is reversed. The Director's order is reinstated in its entirety. The Referee's approved attorney fee award is also reversed.

In the Matter of the Compensation of
BETTY M. TYRE, Claimant
WCB Case No. 92-05191
ORDER ON REVIEW
Foss, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

The self-insured employer requests review of those portions of Referee Nichols' order that: (1) set aside its partial denial of claimant's occupational disease claim for left carpal tunnel syndrome; and (2) assessed a penalty for the employer's allegedly unreasonable denial. The employer also contends that the Referee should have determined issues regarding claimant's right thumb degenerative condition, current condition, and her need for left thumb surgery. In her brief, claimant contends that the Referee should have addressed the issue of compensability of her right carpal tunnel condition. On review, the issues are compensability, medical services, and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Left carpal tunnel condition

The Referee concluded that claimant had established compensability of her occupational disease claim for her left carpal tunnel condition. We adopt the Referee's Conclusions of Law and Opinion, with the following supplementation.

On review, the employer argues that claimant has not established a compensable occupational disease. Alternatively, the employer argues that pursuant to ORS 656.005(7)(a)(B), claimant's preexisting degenerative condition is the major cause of her disability or need for treatment.

We conclude that the Referee properly analyzed claimant's left carpal tunnel condition as an occupational disease. Dr. Nye, who first saw claimant in an independent medical exam and then later became her treating surgeon, testified that the April 4, 1991 incident at work was not a material cause of claimant's degenerative condition or her carpal tunnel syndrome. Rather, Dr. Nye stated that claimant's overall work activities over her years with the employer were the major cause of her carpal tunnel syndrome condition.

Moreover, although the employer contends that claimant's disability or treatment was actually due to her degenerative condition, we find that claimant received separate, distinct testing, examinations and treatment for her carpal tunnel condition. Claimant was diagnosed initially with de Quervain's syndrome, and then with carpal tunnel syndrome. She received treatment in the form of splints and an injection. Additionally, nerve conduction studies were performed, and although the studies were normal, Dr. Nye nonetheless found clinical symptoms and a "clear history" of median nerve compression at the wrist. Because of claimant's symptoms, Dr. Nye recommended and performed carpal tunnel decompression surgery.

Under the circumstances, we agree with the Referee that claimant has established a compensable left carpal tunnel condition.

Left thumb condition

The Referee concluded that claimant's preexisting degenerative disease of the left thumb was not compensable. We agree, and we therefore adopt the Referee's Conclusions of Law and Opinion on the issue.

Surgery

The Referee concluded that she did not have jurisdiction over the issue of whether claimant's surgery was reasonable and necessary. We agree. See Stanley Meyers, 43 Van Natta 2643 (1991). However, to the extent that the employer has denied that claimant's surgery is not causally related to her compensable injury, we conclude that we have jurisdiction over this matter. See Michael A. Jaquay, 44 Van Natta 173 (1992).

On review, the employer argues that claimant's surgery is not compensable because the surgery was performed primarily for the noncompensable degenerative thumb condition, rather than for the carpal tunnel condition. We agree.

Claimant underwent two surgical procedures at the same time. Dr. Nye agreed that the primary purpose of the operation was for the degenerative arthritis (thumb) condition. He performed claimant's decompression surgery at that time because it minimized the cost and lessened the "additional insult to the patient." Dr. Nye stated that if it were not for the degenerative condition operation, he would not have performed carpal tunnel surgery at that time, and he doubted that "the carpal tunnel would require an operation independently, since the nerve conductions were normal."

Under the circumstances, we conclude that claimant has failed to establish that her need for carpal tunnel surgery is related to her compensable condition. That portion of the employer's denial is upheld.

Right carpal tunnel condition

On review, claimant argues that the Referee should have addressed the issue of compensability of her right carpal tunnel condition. Subsequent to filing her request for hearing, claimant's counsel wrote to the employer to clarify that the issues being raised included "bilateral carpal tunnel compression syndrome." At hearing, claimant's counsel stated that one of the issues was "compensability of bilateral carpal tunnel compression syndrome." The employer's counsel essentially agreed with claimant's statement of the issues.

Under the circumstances, we find that claimant's bilateral carpal tunnel condition was at issue before the Referee. Because we find the record sufficiently developed in this matter, we proceed to address the issue on review.

We have above agreed that the Referee properly relied upon the opinion of Dr. Nye regarding causation of claimant's carpal tunnel condition. On June 2, 1992, Dr. Nye stated that claimant's work as a dryer feeder was the major cause of her bilateral carpal tunnel compression syndrome. Dr. Nye reiterated his statement in a September 15, 1992 deposition. He further stated that there was no evidence that claimant's bilateral carpal tunnel syndrome preexisted her injury.

We find Dr. Nye's opinion persuasive and rely upon it for the reasons stated above and in the Referee's order. We, therefore, conclude that claimant has established compensability of her right carpal tunnel syndrome condition.

Right thumb condition

At hearing, the Referee addressed the issue of compensability of claimant's left thumb degenerative condition. On review, both the employer and claimant contend that the issue of compensability of claimant's right thumb degenerative condition was also an issue before the Referee. We agree.

The employer's March 18, 1992 denial referenced claimant's "bilateral carpal metacarpal joint degenerative arthritis." Claimant appealed that denial, and later clarified that she was claiming "compensability of the degenerative disease in (claimant's) hands." At hearing, claimant's counsel stated that the issues included "compensability of bilateral carpal and metacarpal joint degenerative arthritis." Additionally, the employer agreed with claimant's statement of the issues.

Under the circumstances, we find that compensability of claimant's right thumb degenerative condition was an issue before the Referee. Because we find the record to be sufficiently developed on the issue, we proceed to determine compensability on review.

We have above adopted the Referee's conclusions on the issue of compensability of claimant's left thumb condition. Because we agree with the Referee's reliance upon the opinion of Dr. Nye, and Dr. Nye's testimony addresses claimant's bilateral degenerative thumb condition, we conclude, based on the same reasoning, that claimant has failed to establish the compensability of her right thumb condition.

Current condition

On review, both parties agree that the issue of the compensability of claimant's current condition was before the Referee at hearing. After reviewing the denial and the record, we agree with the parties that the issue was raised at hearing. Because we find the record to be sufficiently developed on the issue, we proceed to our review.

The employer's denial was based upon claimant's current claimed need for medical treatment. Specifically, the employer denied payment for treatment or disability related to claimant's ligament reconstruction and surgery. Because we have above concluded that claimant's degenerative condition is not compensable and the carpal tunnel surgery is not related to the compensable carpal tunnel condition, we find that the medical treatment issue has been resolved. Although we make no finding regarding whether such surgery is reasonable or necessary, we conclude that the surgery is not causally related to the compensable condition.

Penalties and attorney fees

We adopt the Referee's Conclusions of Law and Opinion on the penalty issue.

Claimant is entitled to an attorney fee, payable by the employer, for her counsel's services on review and at hearing concerning the issue of compensability of her right carpal tunnel condition. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $1,200 is a reasonable assessed fee for claimant's counsel's efforts at hearing and on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's briefs), the complexity of the issue and the value of the interest involved. We note that no attorney fee is available for claimant's successful defense of the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

Claimant is also entitled to an attorney fee, payable by the employer, for her counsel's services on review for successfully defending against the employer's request for review on the issue of compensability of her left carpal tunnel syndrome. 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 $800 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the left carpal tunnel syndrome. 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 October 8, 1992 is modified in part and affirmed in part. The self-insured employer's denials of claimant's right thumb degenerative condition and left carpal tunnel condition surgery are upheld. The employer's denial of claimant's right carpal tunnel condition is set aside and the claim is remanded for acceptance and processing according to law. For services at hearing and on review concerning compensability of claimant's right carpal tunnel condition, claimant is awarded an additional assessed attorney fee of $1,200, to be paid by the employer. For services on review concerning compensability of claimant's left carpal tunnel syndrome, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DORIS DAVIS, Claimant
WCB Case No. 91-09353
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Herman's order that upheld the insurer's denial of claimant's psychological claim. On review, the issue is compensability.

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

The Referee found that employment conditions were the major contributing cause of claimant's psychological condition. See ORS 656.802(2). However, the Referee further concluded that the employment conditions producing the mental disorder constituted reasonable disciplinary or corrective actions by the employer and, therefore, the claim was not compensable. See ORS 656.802(3)(b).

On January 1, 1991, the employer instituted a "Progressive Discipline Program" to correct and improve behavior. The first step is a verbal warning to inform the employee of a performance problem. (Ex. 6-2). If the problem is not corrected, then a written warning can be given to the employee. (Id.) The third step is to place the employee on probation and then terminate. (Id.) Although claimant does not disagree with the Referee's finding that the discipline program was reasonable in the abstract, she contends that it was not followed by the employer in claimant's case. By failing to properly implement its policy for disciplining claimant, claimant asserts that its actions were not reasonable.

First, claimant specifically argues that the employer did not issue a verbal warning. We find that the weight of the evidence in the record is to the contrary and that the Referee correctly found that, during an April 15, 1991 meeting between claimant and Tom Shuhart, an assistant vice-president, claimant was informed of performance problems. (Tr. 126-27, 186-87).

Because we have found that claimant was given a verbal warning, we also reject claimant's contention that the written warning she received was unreasonable because it was not preceded by a verbal warning. Furthermore, we note that the employer's disciplinary procedure provides that a worker may be placed initially at any level of the program if warranted by circumstances. (Ex. 6-1).

Claimant also criticizes the reasonableness of the verbal and written warnings on the basis that they do not describe the needed improvement or expected date of improvement, as required by the disciplinary policy. We disagree. The written warning, which summarized specific performance problems discussed during the verbal warning, clearly indicates that claimant's "negative attitude" had to improve (Ex. 8). Furthermore, the written warning provides that claimant's progress would be monitored for the next 30 days, (id.), which we find provided a timetable for expected improvement. Although there is no evidence that such a timetable was provided for the verbal warning, we find that this omission is not fatal to the reasonableness of the discipline.

Claimant next contends that she was terminated prior to the 30-day timetable provided by the terms of probation and that this action was not consistent with the disciplinary procedure. We agree that the policy indicated that termination could occur at the end of the probationary period if improvement was not accomplished. (Ex. 6-2). However, because the policy also provides that some behavior could warrant immediate dismissal, (id.), we find that the policy is not necessarily contravened if termination occurs before probation ends.

Finally, based on her testimony and medical reports, we reject claimant's argument that her mental disorder was caused by "the inconsistency between praise and criticism for the same telephone behavior" rather than the employer's disciplinary actions. (Tr. 70, Exs. 25-2, 28-40).

ORDER

The Referee's order dated August 6, 1992 is affirmed.

In the Matter of the Compensation of
VICTORIA C. KOLNICK, Claimant
WCB Case No. 92-05823
ORDER ON RECONSIDERATION
Frank J. Susak, Claimant Attorney
VavRosky, et al., Defense Attorneys

The self-insured employer requests reconsideration of our April 27, 1993 Order on Review that affirmed and adopted the Referee's order which set aside its denial of claimant's current low back condition. Specifically, the employer contends that we did not address its argument that the Referee should have "delineated the scope" of the employer's acceptance.

The employer argues that the Referee should have specified the scope of the claim which he remanded to the employer for acceptance and processing. The employer argues that the Referee should have provided that the "claim" in this case was for a "tailbone" injury, rather than for a low back injury. We disagree.

Chartnotes provide that claimant landed on her left buttock and low back. Dr. Smith diagnosed claimant's injury as a "soft tissue injury." A Form 827, signed by Dr. Eubanks, D.O., provided that the nature and location of the injury was "soft tissue tenderness (and) induration over sacrum but not coccyx." Additionally, claimant's 801 Form listed the body part affected as "tailbone."

On April 20, 1992, the employer acknowledged a claim filed for a "lumbar muscular skeletal strain." The employer denied that claimant's "current low back condition" arose out of her work with the employer.

On reconsideration, we conclude that the Referee was required to do no more than to set aside the employer's denial. Should the employer have wished to clarify or further delineate its denial, it could have done so up to the date of hearing. See Lloyd L. Crockett, 43 Van Natta 1767 (1991)(Amendments of issues are liberally permitted under Board rules). OAR 438-06-031.

Consequently, because there is no evidence that the employer attempted to amend its denial, we conclude that the Referee correctly set aside the denial of claimant's "current low back condition."

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 27, 1993 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
JEANNE E. ROWE, Claimant
WCB Case Nos. 92-08302 & 92-14788
SECOND ORDER OF DISMISSAL
Ackerman, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Lundeen, et al., Defense Attorneys

Liberty Northwest Insurance Corporation requests reconsideration of our April 29, 1993 order which dismissed its request for Board review. Concluding that Liberty had neglected to timely provide notice of its request for review to all parties to the Referee's order, we determined that we lacked jurisdiction to consider Liberty's appeal.

In seeking reconsideration, Liberty acknowledges that it failed to provide notice to Aetna Casualty & Surety Company (a party to the Referee's order). Nevertheless, noting that it timely provided notice of its appeal to claimant, Liberty contends that we have authority to consider its appeal insofar as it pertains to the compensability issue between Liberty and claimant. We disagree.

A party requesting Board review cannot limit the scope of that review by seeking review of only selected cases out of a group of cases consolidated in the same proceeding before a referee, because an appeal is for Board review of a referee's order not just particular claims. Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992). Thus, if all parties to a proceeding before a referee do not timely receive notice of a party's request for Board review of that referee's order, the request for review must be dismissed. Id.

Here, as in Mosley, the party requesting Board review has failed to timely provide notice of its request to all parties to the proceeding before the Referee. Under such circumstances, we lack jurisdiction to review the Referee's order. See ORS 656.295(2); Mosley v. Sacred Heart Hospital, supra.

Accordingly, we withdraw our April 29, 1993 order. On reconsideration, as supplemented herein, we republish our April 29, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TAMERA FROLANDER, Claimant
Own Motion No. 93-0200M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for her compensable right arm injury which resulted in an above-elbow amputation. Claimant's aggravation rights expired on January 22, 1990. The employer asks the Board to authorize the reopening of claimant's claim.

The employer voluntarily reopened claimant's claim for the payment of temporary disability compensation. However, claimant is entitled to benefits for temporary total disability only if she qualifies for those benefits under the relevant statutory provisions. Wausau Ins. Companies v. Morris, 103 Or App 270 (1990). Pursuant to ORS 656.278(1)(a), temporary disability compensation may be awarded only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On March 17, 1993, Dr. German, treating orthopedist, referred claimant to Dr. Gleeson, M. D., for a sympathetic nerve block to treat her right arm pain. This treatment involves a series of injections to be given over a period of three weeks. Claimant requested timeloss during this time. A copy of a March 24, 1993 phone message to Dr. German from claimant states: "Does not have time to run back and forth while under treatment for [a] nerve block. Can she be on time loss for 2-3 weeks until after treatment is complete." A March 31, 1993 memo from the employer states that Dr. German indicated that claimant would need to be off work for three weeks for this series of injections.

We interpret "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. Fred E. Smith, 42 Van Natta 1538 (1990). Here, the record submitted to us fails to demonstrate that claimant requires surgery or that the sympathetic nerve block procedure involves surgery. Accordingly, these injections do not qualify as "surgeries" within the meaning of ORS 656.278(1)(a). Moreover, because the injections were done on an outpatient basis and did not require an overnight stay in the hospital, we do not regard the procedure as "hospitalization" sufficient to justify claim reopening. Fred E. Smith, supra.

Accordingly, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim. Accordingly, we deny the request for own motion relief. Id.

The employer's gratuitous payment of temporary disability compensation is permitted by statute and is within the employer's discretion. See ORS 656.278(4); Allen E. Orton, 42 Van Natta 924 (1990). However, inasmuch as those benefits were not properly paid pursuant to the Board's Own Motion authority, the Board shall not authorize the reopening of the claim. ORS 656.278(1)(a).

IT IS SO ORDERED.

Board Member Gunn specially concurring.

My colleagues' decision is in accordance with current law. However, I write separately because this decision represents bad policy and denies the insurer reimbursement for time loss payments which were provided in good faith.

As recited in the majority opinion, claimant underwent a series of injections over a period of three weeks. After receiving medical verification from claimant's treating physician concerning claimant's inability to work during this three week period, the insurer paid time loss. The majority declines to award temporary disability under ORS 656.278(1)(a) because the series of injections: (1) does not represent "an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker"; and (2) were performed on an outpatient basis not requiring hospitalization.

To begin, as a past recipient of an injection while in the military, I can vouch for the fact that an injection is an "invasive procedure" rendering one temporarily disabled. However, in light of the Board's limited statutory authority under ORS 656.278(1)(a) to award temporary disability only in situations involving surgery or hospitalization, I acknowledge that the majority's decision is consistent with the statute and subsequent case law.

I am disturbed by the message sent through this decision to Oregon carriers. That message is think twice before you voluntarily open a claim because you may not be able to obtain reimbursement for those payments.

Here, under the majority's rationale, the only way the insurer could have recouped its time loss would have been to request claimant's hospitalization during the treatment. If granted, such a request would have been infinitely more expensive and time consuming for everyone. Nevertheless, under the current state of the law, outpatient treatment (with the exception of outpatient surgeries) which is the least expensive and most common form of medical treatment, does not qualify for time loss authorization under ORS 656.278(1)(a).

Such a conclusion is an insult to common sense and bad policy. The end result of such a policy is that carriers are going to reject those claims that involve outpatient medical treatments or require the more expensive hospitalization. In either case, there are no winners; not the claimant, the insurer nor the employer. It is my hope that the law can be changed because I suspect that the current interpretation of our statutory authority pursuant to ORS 656.278(1)(a) is correct.

May 27, 1993 Cite as 45 Van Natta 969 (1993)

In the Matter of the Compensation of
DOLORES M. IRELAND, Claimant
WCB Case No. 91-17967
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Barber's order that decreased her scheduled permanent disability award from 11 percent (14.85 degrees), as awarded by Order on Reconsideration, to 5 percent (6.75 degrees) for a right foot (ankle) condition. In its respondent's brief, the insurer contends that claimant's scheduled permanent disability award should be reduced. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence of the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of Dr. Cook, claimant's attending physician, and Dr. Becker, the medical arbiter, the Referee found that the lost ranges of motion in claimant's ankles and toes, upon which the Appellate Unit based its award of scheduled permanent disability, were not related to the compensable injury. On this basis, the Referee concluded that claimant was not entitled to the 11 percent (14.85 percent) scheduled permanent disability awarded by the Order on Reconsideration. Instead, the Referee awarded claimant 5 percent (6.75 degrees) scheduled permanent disability for a chronic condition limiting repetitive use of claimant's right foot/ankle.

Extent of Scheduled Disability

Claimant's claim was closed by Determination Order dated August 27, 1991. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. WCD Admin. Order 2-1991.

On review, claimant contends that the reconsideration order award should be reinstated and also contends that she is entitled to the Referee's 5 percent chronic condition award. The insurer contends that the Referee's order should be reduced.

We agree with the Referee that claimant has not proved that the lost ranges of motion, for which she received the Order on Reconsideration award, are related to the compensable injury. Dr. Cook, the attending physician, indicated that claimant did not have any lost range of motion due to the compensable injury and surgery. Nevertheless, Cook opined that if there was such a loss, it would be due to the injury. Dr. Becker, the medical arbiter, felt that claimant had lost ranges of motion, but opined that these findings were not attributable to the injury or compensable fusion surgery.

Claimant argues that we should combine Dr. Cook's "causal relationship" opinion with Dr. Becker's "lost range of motion" opinion and conclude that the 11 percent Order on Reconsideration award is appropriate. We decline to apply claimant's analysis. The record indicates that neither Dr. Becker nor Dr. Cook believed that claimant had impairment related to the injury. Under such circumstances, we agree with the Referee that claimant has not established entitlement to an award for lost ranges of motion.

Claimant also argues that she is entitled to an award for a chronic condition limiting repetitive use of her right foot/ankle. Former OAR 436-35-010(6) provides:

> "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." (Emphasis added).

Here, the record contains no medical opinion that indicates that claimant is unable to repetitively use her foot or ankle as a result of the compensable injury. Former OAR 436-35-010(6) requires medical evidence that a worker has a chronic condition. See also former OAR 436-35-005(5) ("impairment" must be measured by a physician). Accordingly, based on the record, we conclude that claimant is not entitled to a chronic condition award.

Rate of Scheduled Pemanent Disability

The Referee concluded that the correct rate of scheduled permanent disability was $145 per degree. Inasmuch as we have concluded that claimant is not entitled to a scheduled award, the rate of scheduled permanent disability issue is moot. Therefore, we do not address the rate issue.

ORDER

The Referee's order dated August 25, 1992 is reversed. The Referee's 5 percent (6.75 degrees) scheduled permanent disability award for a chronic condition is reversed. The Order on Reconsideration is modified to affirm the Determination Order which awarded no permanent disability.

In the Matter of the Compensation of
FRED D. JUSTICE, Claimant
WCB Case No. 90-05033
ORDER ON REVIEW (REMANDING)
Malagon, Moore & Johnson, Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of those portions of Referee Herman's order that: (1) upheld the self-insured employer's denial of his aggravation claim for a low back condition; (2) declined to grant him permanent total disability benefits; and (3) increased his unscheduled permanent disability award for the low back condition from 51 percent (163.2 degrees), as awarded by Determination Order, to 70 percent (224 degrees). In its brief, the employer seeks a reduction of claimant's unscheduled permanent disability award. On review, the issues are aggravation and extent of unscheduled permanent disability, including permanent total disability. We vacate.

We agree with the Referee's findings and conclusions regarding the aggravation issue. Therefore, we proceed to address the permanent total disability (PTD) issue. In determining that claimant is not permanently and totally disabled, the Referee found that claimant is capable of regularly performing part-time work in several sedentary occupations, such as a retail gift shop cashier, trailer rental clerk, auto rental clerk, customer service clerk, ticket seller, security guard and telephone solicitor. On review, claimant argues that these occupations are not "gainful" within the meaning of ORS 656.206(1)(a) and, therefore, should not preclude PTD benefits.

Subsequent to the Referee's order, in Tee v. Albertsons Inc., 314 Or 633 (1992), the Supreme Court held that the term "gainful occupation" in ORS 656.206(1)(a) means "profitable remuneration." Inasmuch as the Referee did not have the benefit of the Court's opinion in Tee, we must determine whether the aforementioned part-time occupations would provide claimant "profitable remuneration."

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, 45 n. 3 (1983). 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).

Here, inasmuch as the record was developed prior to the Court's decision in Tee, the record concerning whether the jobs in question represent employments for "profitable remuneration" is inadequate.[1] Finally, in light of the Court's only recent pronouncement, it is understandable that the parties would not have been prepared to present evidence on this question.

We conclude that the current record regarding this "profitable remuneration" issue is incompletely and insufficiently developed. Moreover, based on the foregoing reasoning, we are persuaded that evidence concerning this issue was unobtainable with the exercise of due diligence at the time of hearing. Consequently, under these particular circumstances (where claimant's entitlement to PTD depends on whether the part-time jobs constitute "gainful occupation" under ORS 656.206(1)(a)), we find that there is a compelling reason to remand for the submission of additional evidence on this issue. See Betty S. Tee, 45 Van Natta 289 (1993).

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[1] The record on this issue consists of testimony from a vocational counselor, McGowan, that the aforementioned part-time jobs pay hourly wages ranging from minimum wage to $1 over minimum wage. (Tr. 125-126). Although such evidence establishes a projected income from the employments, the record is lacking regarding the financial expenditures (if any) that claimant would realize were he to accept such employment. (For example, transportation costs, supplies/uniform expenses, child/dependent care costs, etc.).

Accordingly, we vacate the Referee's order and remand this case to Referee Herman with instructions to admit further evidence bearing on the issue of whether the aforementioned part-time jobs constitute employments for profitable remuneration. The Referee shall conduct further proceedings to admit this evidence in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order resolving all issues in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES B. TYLER, Claimant
WCB Case No. 92-02720
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Crumme's order which declined to reclassify claimant's injury claim as disabling. On review, the issue is reclassification. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction regarding finding number seven. On March 11, 1991, the SAIF Corporation issued a "Notice of Claim Acceptance" whereby SAIF accepted claimant's cervical strain condition and classified the injury as nondisabling.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to reclassify claimant's claim as disabling. The Referee reasoned that neither the Director nor the Hearings Division had jurisdiction to redetermine the classification of the claim because the request for redetermination was made more than one year after the date of injury. We agree.

On February 19, 1991, a prior referee determined that claimant had sustained a work-related cervical injury on July 23, 1990 and ordered SAIF to accept that injury. (Ex. 10). On March 11, 1991, SAIF accepted the injury as nondisabling and sent a copy of the acceptance to claimant. (Ex. 12). SAIF did not send a copy of the acceptance to claimant's attorney. On March 5, 1992, claimant's attorney requested the Evaluation Section to reclassify the claim as disabling. The Evaluation Section concluded that it could take no action regarding claimant's request for reclassification because the request was made more than a year after the date of injury. (Ex. 26).

ORS 656.277 provides:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving such a claim, shall report the claim to the director for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation.

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

"(a) When notice of claim denial is filed;

"(b) When the status of the claim is as described in subsection (1) or (2) of this section;

"(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon; or

"(d) When otherwise required by the director."

Claimant concedes that his request for reclassification was made more than a year after the date of injury. However, he argues that there is no time limit for a worker to object to the initial classification of an injury as nondisabling. In support of his argument, he relies on our decision in Christine A. DeGrauw, 44 Van Natta 91, on recon 44 Van Natta 273 (1992).

In DeGrauw, the insurer reclassified an accepted disabling claim as nondisabling more than a year after the date of injury. We held that neither the Hearings Division nor the Board had jurisdiction over the matter because the claimant had not first exhausted the administrative remedies provided in ORS 656.277(3)(c) by requesting reclassification from the Evaluation Division. Id. at 92. We also held that ORS 656.277(3)(c) did not restrict claimant to a time limit in which to contend that a nondisabling claim is disabling. Id. at 92.

In DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993), the court reversed our decision and remanded the case with instructions to order the employer to process the claim as disabling. The court held that, although there was no statute that specifically prohibited reclassification of a disabling claim to nondisabling more than one year after the date of injury, that procedure was contrary to the statutory scheme contemplated by ORS 656.262(6) and ORS 656.268. Id. at 281. The court reasoned that if the reclassification is made more than a year after the date of injury, it would preclude the claimant, through no fault of her own, from seeking reconsideration by the Evaluation Section. Id. Therefore, the court concluded:

"[I]f an employer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of injury. If, as here, it does not act within one year, then it must process the claim to closure. The notice of closure or determination order can then be reconsidered by DIF pursuant to ORS 656.268(4)(e) or (5)." Id.

Because the Court of Appeals reversed our decision in Christine A. DeGrauw, supra, that decision has no precedential value. Thus, any reliance on our prior decision is misplaced. We further note that DeGrauw v. Columbia Knit, Inc., supra, may be factually distinguishable in that the present case does not involve a reclassification of an accepted disabling claim as nondisabling more than a year after the date of injury. However, even setting aside that factual distinction, a more important distinction is apparent. Here, claimant was not precluded from requesting reclassification of his claim within a year from the date of injury.

Claimant sustained a cervical injury on July 23, 1990. On March 11, 1991, the claim was accepted as nondisabling and a copy of the acceptance was mailed to claimant. Thus, claimant had more than four months in which to request reclassification before a year had passed since the date of injury. In DeGrauw v. Columbia Knit, Inc., supra, the court held that a claimant must be given sufficient time to challenge the reclassification within one year from the date of injury. Here, although dealing with an initial classification rather than a reclassification, we consider a period of more than four months to be sufficient time for claimant to challenge the classification of his injury.

We note that in Robert E. Wolford, 45 Van Natta 435 (1993), the Board recently held that the "date of injury" for classification purposes is the date the insurer accepted the claimant's occupational disease claim. In reaching that conclusion, the Board relied on Thomas L. Runft, 43 Van Natta 69 (1991). Both Wolford and Runft involved occupational disease claims, where there is no "date of injury" per se. Because of the uncertainty in determining a precise "date of injury" in an occupational disease claim, the Board found that, if "date of injury" was interpreted "literally", (e.g., the date of the claimant's first exposure to chemicals which, in Wolford, was several years before claim acceptance), the claimant would be unable to challenge the nondisabling classification even if he immediately objected to the classification. Like the court in DeGrauw, the Board found that such an interpretation would be inconsistent with the statutory scheme contemplated by ORS 656.262(6) and ORS 656.268.

However, the same concern and reasoning does not apply here, since this is not an occupational disease claim. Instead, it involves a cervical injury which occurred on a certain date. Moreover, the classification of the injury as nondisabling was made within sufficient time to allow claimant to challenge the classification within the one year period. Therefore, in the present case, we find no basis in fact or law to give the "date of injury" something other than its plain and usual meaning.

Here, the injury occurred on July 23, 1990 and claimant did not request reclassification until March 5, 1992, more than a year after the date of injury. Thus, claimant's request for reclassification was untimely, and he must make the claim as a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) & (2). Claimant makes no argument regarding an aggravation claim.

Finally, claimant argues that, if he does not have unlimited time to request reclassification of his claim, the time for such a request was tolled because SAIF did not send a copy of the claim acceptance to his attorney. In support of his argument, claimant cites SAIF v. Tull, 113 Or App 449, 451 (1992). However, that case is inapposite. It involves timeliness of a hearing request from a denial. There, the court repeated its earlier holding that, when an employer fails to offer proof of when it mailed its denial, the claimant's hearing request is deemed timely. Tull does not involve reclassification of a claim.

We can find no authority for claimant's argument that SAIF's failure to copy claimant's attorney with the notice of acceptance tolls the time to request reclassification from the Evaluation Section. On March 11, 1991, the claim was accepted as nondisabling and the notice of acceptance was sent to claimant, although no copy was sent to claimant's attorney. This notice of acceptance included a statement of claimant's right to request reclassification as required by ORS 656.262(6). Claimant does not argue that he did not understand the notice, or that a period of more than four months was not sufficient time in which to consult his attorney or request reclassification.

Accordingly, we conclude that, because claimant requested reclassification of his claim more than a year after the date of injury, neither the Director, the Hearings Division, nor the Board has jurisdiction over the request. Instead, claimant must make his claim as a claim for an aggravation, which he has failed to do. See Corinne K. Freeman, 44 Van Natta 495 (1992).

ORDER

The Referee's order dated June 26, 1992 is affirmed.

May 27, 1993 Cite as 45 Van Natta 974 (1993)

In the Matter of the Compensation of
JESSE R. WALKER, Claimant
WCB Case No. 91-03714
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Larry Dawson, Defense Attorney

Reviewed by Board Members Brazeau and Gunn.

Claimant requests review of those portions of Referee Hoguet's order which: (1) found that claimant's low back claim had been closed by a prior Opinion and Order; (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing; (3) declined to find that the insurer's alleged nonpayment of medical treatment was a "de facto" denial of medical services; and (4) found that the Hearings Division lacked jurisdiction to set aside the insurer's denial of reimbursement for medical treatment sought after July 1, 1990. Claimant also contends the Referee's assessed attorney fee of $500 for the insurer's allegedly late payment of medical bills was inadequate. In its brief, the insurer contends that the Referee lacked jurisdiction to set aside its denial of reimbursement for medical treatment sought prior to July 1, 1990. On review, the issues are claim closure, claim processing, jurisdiction, medical services, and penalties and attorney fees. We modify in part, vacate in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

Claimant did not appear or testify at the present hearing. He did, however, appear and testify in an earlier hearing before the present Referee. Pursuant to that hearing, the Referee issued an Opinion and Order on August 10, 1990, wherein the Referee made a positive credibility finding with regard to claimant.

As part of his review of the present case, the Referee reviewed not only his August 1990 Opinion and Order, which was entered into the present record as Exhibit 28, but also an audio recording of the prior hearing. Based on his review of both, the Referee concluded that claimant's claim had been closed by way of the prior Opinion and Order. He also found that there was no evidence that claimant's credibility had changed since the time of the prior hearing. The Referee, therefore, opined that claimant remained credible as of the time of the present hearing.

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). Therefore, we review the Referee's consideration of the prior audio tape for abuse of discretion.

We have no authority to consider additional evidence not admitted at the hearing and not a part of the record. ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). We may, however, take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(b). The Board has previously taken official notice of hearing requests, agency orders and medical treatises. See Susan Teeters, 40 Van Natta 1115 (1988); Dennis Fraser, 35 Van Natta 271 (1983); Juanita M. DesJardins, 34 Van Natta 595 (1982).

We consider an audio tape of a hearing to be similar to a transcript of a prior hearing. Previously, we have declined to take official notice of a hearing transcript which had not been admitted into evidence. See Davey L. Odle, 44 Van Natta 2464 (1992). Neither will we take official notice of the present audio tape, inasmuch as we find that it contains such facts from a source not subject to confrontation or cross-examination, and which deprives either party of an opportunity to challenge those facts. Groshong v. Montgomery Ward Co., supra; Rodney J. Thompson, 44 Van Natta 1572 (1992). Moreover, in the present case, although the audio tape may be admissible, no party sought its admission. Consequently, we conclude that the Referee abused his discretion by attempting to cure any alleged failure of proof. See Davey L. Odle, supra; John A. Ames, 44 Van Natta 684, 686 (1992).

Finally, after reviewing the evidence, we conclude that the present record was complete without the Referee's review of the audio tape. We, therefore, proceed with our review without considering the Referee's references thereto.

Claim Closure

Claimant asserts that his claim was never properly closed. The Referee found that it was closed by the prior hearing, as memorialized in the August 10, 1990 Opinion and Order. We disagree with both claimant and the Referee.

On May 30, 1990, a Determination Order found claimant medically stationary as of March 1, 1990 and awarded temporary disability and unscheduled permanent disability compensation. Claimant's claim was in denied status at the time of the Determination Order. Although the Department was not required to close claimant's claim while it was in denied status, it was not error for it to do so because claimant was medically stationary. See Vip's Restaurant v. Krause, 89 Or App 214, 217, adhered to on recon, 91 Or App 472 (1988). Thus, we conclude that it was the May 30, 1990 Determination Order, rather than the Referee's August 10, 1990 Opinion and Order, that constituted the closure of claimant's claim. Accordingly, that portion of the Referee's order that found that claimant's claim was closed by a prior hearing is modified.

Unreasonable Claim Processing

Claimant contends that the insurer unreasonably failed to close claimant's claim by Notice of Closure or to submit it for closure. Because we have found that claimant's claim was properly closed by the May 1990 Determination Order, however, neither penalties nor attorney fees are assessable.

Medical Authorization

The Referee found that the insurer had not denied injection therapy and that no prior authorization from the insurer was needed for that treatment. Thus, the Referee concluded that the insurer's failure to authorize the treatment did not constitute a "de facto" denial. We vacate.

ORS 656.327 provides a procedure for the resolution of disputes between a carrier and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services." The present dispute is controlled by the aforementioned statute. Its resolution, therefore, rests exclusively within the jurisdiction of the Medical Director. We, therefore, vacate that portion of the Referee's order pertaining to the medical services dispute. Stanley Meyers, 43 Van Natta 2643 (1991).

Penalties and Attorney Fees - Alleged Late Payment

Because we lack jurisdiction over the present medical services dispute, we also lack jurisdiction to award penalties and attorney fees for any untimely payment that may have occurred.

Jurisdiction - Palliative Care

The Referee concluded that the Hearings Division lacked jurisdiction to consider claimant's entitlement to palliative care, including the payment of Dr. Strassi's medical bills, after July 1, 1990. He further concluded, however, that he retained jurisdiction with regard to palliative care for the period prior to that date. Specifically, the Referee retained jurisdiction to consider treatment provided by Dr. Strassi for the period of April 24, 1990 through June 30, 1990. We agree.

We have previously declined to apply amended ORS 656.245(1) retroactively to palliative care treatment rendered before the July 1, 1990 effective date of the Act. See Michele M. Walker-Wyatt, 45 Van Natta 482 (1993); Ida M. Walker, 43 Van Natta 1402 (1991). Therefore, although amended ORS 656.245(1) applies to the treatment claimant received after July 1, 1990, it does not apply to the medical services he received prior to July 1, 1990. We, therefore, may proceed with our review as to those services received between April 24, 1990 and June 30, 1990.

On the merits of claimant's entitlement to palliative care prior to July 1, 1990, we affirm and adopt the conclusions of the Referee.

Attorney Fees

We affirm and adopt the Referee's award of a $500 assessed attorney fee for the insurer's untimely payment of the pre-July 1, 1990 medical bills. In doing so, we have specifically considered the factors set forth in OAR 438-15-010(4) and have applied them to this case. Further, we find that a reasonable assessed fee for claimant's counsel's services on Board review concerning the compensability of the pre-July 1, 1990 medical bills issue is $350, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 27, 1991 is modified in part, vacated in part and affirmed in part. That portion of the Referee's order which found that claimant's claim had been closed by an August 10, 1990 Opinion and Order is modified to reflect that closure was effected by the May 1990 Determination Order. That portion of the Referee's order that declined to find the insurer's alleged nonpayment of medical treatment to be a "de facto" denial of medical services is vacated. The remainder of the Referee's order is affirmed. For services on Board review concerning the insurer's jurisdictional contention regarding claimant's pre-July 1, 1990 medical bills, claimant's attorney is awarded $350, to be paid by the insurer.

In the Matter of the Compensation of
NANCY L. COOK, Claimant
WCB Case No. 92-04610
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of that portion of Referee Livesley's order that dismissed her request for hearing from the self-insured employer's "back-up" denial. The employer cross-requests review of that portion of the order that denied its motion to impose sanctions against claimant. On review, the issues are validity of the Referee's dismissal order and whether sanctions should have been imposed. We remand.

FINDINGS OF FACT

Claimant filed a claim for an injury to her right arm. (Ex. 2). The employer accepted the claim for traumatic lateral epicondylitis of the right elbow. (Ex. 8). On March 24, 1992, the employer issued a partial denial of cervical strain, carpal tunnel syndrome, ulnar nerve entrapment and shoulder strain/pain. (Ex. 35-1). On May 13, 1992, the employer issued a "back-up" denial based on an allegation that claimant's injury did not occur in the course of her employment. (Ex. 42). Claimant first filed a request for hearing from the partial denial, and then a supplemental request from the "back-up" denial.

Claimant did not appear at hearing, although her attorney did appear. The employer's attorney moved to dismiss the initial and supplemental requests for hearing, asserting that it was prepared to present testimony from five witnesses demonstrating that claimant was not injured in the course of her employment. (Tr. 3-4). Claimant's attorney withdrew the request for hearing from the partial denial, but continued to assert objections to the "back-up" denial. (Id. at 24). The employer's counsel then made an "offer of proof" with testimony from the employer's claims examiner that, after accepting claimant's claim, she received information from an investigator that claimant had related histories about her injury to her roommate and co-workers that differed from the 801 form. (Id. at 26-30).

The Referee granted the employer's motion to dismiss. The Referee, however, denied the employer's motion to impose sanctions against claimant and her attorney for pursuing an allegedly frivolous claim.

CONCLUSIONS OF LAW AND OPINION

In dismissing claimant's request for hearing, the Referee accepted employer's counsel's representation that the employer would provide testimony that would clearly satisfy the employer's burden to prove that claimant's claim was not compensable. The Referee found it "clear" that the employer would prevail. He, therefore, did not require the employer to produce the testimony that the employer represented was available. Instead, he issued an order dismissing claimant's request for hearing.

When a carrier revokes a previously accepted claim under ORS 656.262(6) and that revocation is procedurally valid under the statute, the carrier must prove by clear and convincing evidence that the claim is not compensable if the worker requests a hearing from the "back-up" denial. In order to carry this burden, the carrier may present documentary or testimonial evidence showing that the claim is not compensable. See ORS 656.310(2). The Referee's role is to evaluate the entire record and produce an order containing an organized set of facts and conclusions of law with an explanation why the facts supported by evidence lead to the conclusion. See Armstrong v. Asten-Hill Co., 90 Or App 200 (1988).

In this case, the Referee did not require the employer to present evidence, but instead, relied on counsel's representation that evidence was available from several witnesses, even though the witnesses were not present at the hearing. We conclude that it was error for the Referee to so rely; rather, the employer should have been required to present its evidence and the Referee should have considered the entire record before making a decision on the merits. Therefore, we reinstate claimant's request for hearing. See Ana R. Sanchez, 45 Van Natta 753 (1993).

We also find that claimant's failure to appear at the hearing had no effect on whether the employer carried its burden of proof. First, where a worker's attorney appears on his or her behalf at a hearing, dismissal of the worker's request for hearing is not appropriate. Williams v. SAIF, 99 Or App 367 (1989). In this case, although claimant did not appear at the hearing and, thereby chose not to rebut the employer's case, her failure to appear did not obviate the employer's need to present clear and convincing evidence that claimant's employment did not cause her injury. See Zurita v. Canby Nursery, 115 Or App 330 (1992).

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). Here, we have only the employer's claims examiner's testimony, presented as an offer of proof that evidence of noncompensability was "later obtained", regarding an investigator's reports. Because the Referee found that the employer was not required to offer additional evidence, we conclude that the record is incompletely developed. Therefore, we remand this case to the Referee for the admission of additional evidence required to complete the record. In addition, the Referee shall allow claimant the opportunity of rebuttal. However, each party may only present documentary and testimonial evidence which it was prepared to offer at the June 24, 1992 hearing. See Mario Miranda, 42 Van Natta 405 (1990).

Furthermore, although the Referee agreed with the employer that claimant's request for hearing was "frivolous," he found that he was without authority to impose sanctions. Regardless of the Referee's authority to impose sanctions, because he failed to hear evidence, the Referee had no basis to determine whether or not claimant's request for hearing was frivolous. Therefore, we also remand on the issue of sanctions.

Accordingly, we vacate the Referee's September 21, 1992 order. Claimant's request for hearing is reinstated. The matter is remanded to Referee Livesley for further proceedings consistent with this order. Following those further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

May 28, 1993 Cite as 45 Van Natta 978 (1993)

In the Matter of the Compensation of
JAMES A. EDWARDS, Claimant
WCB Case No. 91-10431
ORDER ON REVIEW (REMANDING)
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of those portions of Referee Hazelett's order that: (1) affirmed an Order on Reconsideration which awarded no permanent disability for claimant's throat and chest condition; and (2) did not address his claim for a psychological condition. On review, the issues are extent of permanent disability and scope of review. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the second sentence of the section entitled "Stipulated Facts."

CONCLUSIONS OF LAW AND OPINION

The Referee found, as a "Stipulated Fact," that "[c]ompensability of an alleged psychological condition is not an issue in this case." (O&O p. 2). In his request for review, claimant argues that he has a work-related psychological condition.

We interpret claimant's reference to the compensability of his psychological condition on review as a contention that the Referee should have addressed the merits of that claim. Thus, the Referee's finding that the issue was not raised at hearing is presently disputed.

In July 1991, claimant filed hearing requests regarding a July 18, 1991 Order on Reconsideration and a November 27, 1990 Determination Order. In August 1991, claimant filed supplemental hearing requests contesting the insurer's denials of claimant's current throat, chest and internal bleeding conditions. These requests were further supplemented in October 1991, when claimant raised a "De facto denial" and sought penalties and attorney fees for failure to accept or deny the psychological component of the claim. The raising of this psychological claim prompted the postponement of the hearing.

At the outset of the rescheduled hearing, claimant's counsel identified the issues as premature closure, compensability of claimant's current condition, per the insurer's written partial denial of the claim for a throat and chest condition (but not the reasonableness of that denial), compensability of the claim for internal bleeding (if that claim was denied), and the alleged unreasonableness of the insurer's failure to accept or deny the psychological component of the claim. (See Tr. 4-5).

As we have noted, the Referee's finding that the compensability of claimant's claim for a psychological condition was not an issue at hearing, is contested on review. Under these circumstances, we must first determine whether the issue was before the Referee and if it was, whether it ceased to be an issue, pursuant to an agreement between the parties. See Alan B. Cooper, 40 Van Natta 1915 (1988) (A Referee's scope of review is properly limited to the issues raised by the parties).

As we read the pleadings, specifically the October 1991 supplemental hearing request and the subsequent postponement of the hearing, the "de facto" denial of the claim for a psychological condition was raised prior to hearing. Consequently, the issue was properly before the Referee, at least initially. See Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458 (1991). However, that does not end our inquiry. In light of the Referee's "Stipulated Finding," we must determine whether the parties stipulated that the compensability of the psychological claim would not be litigated.

Because we are unable to find evidence in the record concerning this alleged stipulation, we cannot determine whether the Referee should have addressed the compensability of the psychological claim. Without such a determination, we are unable to conclude whether the issue is properly before us. Under these circumstances, we find that the record is incompletely and insufficiently developed.

We may remand to the Referee if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Because this record is insufficiently developed to determine the proper scope of our review, we find a compelling basis for remand. See Edwin L. Carson, 43 Van Natta 107, on recon 43 Van Natta 835 (1991) (Remand appropriate where claimant disputes stipulation and record at hearing insufficient to determine whether claimant understood and freely entered into the agreement).

ORDER

The Referee's order dated June 26, 1992 is vacated. This matter is remanded to Referee Hazelett with instructions to take additional evidence from both parties regarding the "psychological claim" stipulation, if any, and proceed in any manner that he determines will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order regarding any and all issues raised in this case.

In the Matter of the Compensation of
JOE GILLETT, Claimant
WCB Case No. 91-07492
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of that portion of Referee Garaventa's order that affirmed a Determination Order which: (1) terminated claimant's PTD award; and (2) awarded 49 percent (156.8 degrees) unscheduled permanent partial disability for a back condition, 23 percent (34.5 degrees) scheduled permanent disability for loss of use of the right leg, and 17 percent (25.5 degrees) for loss of use of the left leg. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the last sentence and the "Findings of Ultimate Fact," with the following supplementation.

ULTIMATE FINDINGS OF FACT

Claimant's physical condition has improved since he was first awarded permanent total disability. However, other circumstances affecting his employability have changed unfavorably during the same time period.

Claimant is permanently incapacitated from regular employment at a gainful and suitable occupation due to a combination of medical and nonmedical factors.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed a Determination Order which found that claimant is no longer permanently and totally disabled (PTD). In reaching this result, the Referee relied on the opinions of Dr. Steinbauer, treating physician, and Byron McNaught, vocational counselor. Although we agree that Steinbauer and McNaught are persuasive, we conclude that their opinions support the opposite result.

Claimant contends that his medical and nonmedical circumstances have not improved since his 1978 PTD determination. Thus, he argues, he is not currently employable in the competitive labor market, without the necessity of retraining. We agree that claimant is not presently able to work at a gainful and suitable occupation.

> "'Permanent total disability' means the loss, including preexisting disability, of use or function or any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a).

To terminate claimant's PTD award, SAIF "has the burden of proving 'a change of circumstances sufficient to warrant the relief sought.'" Harris v. SAIF, 292 Or 683 (1982); see ORS 656.206(5). A "change of circumstances" can be shown by proof of improvement in a worker's medical condition or by circumstantial evidence of employability. Kytola v. Boise Cascade Corp., 78 Or App 108, 111 (1986). The evidence must demonstrate that claimant is employable in a recognized segment of the labor market. Harris v. SAIF, supra.

PTD status may arise from evidence of complete physical incapacity, or from evidence establishing that the physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985); see Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

In this case, the medical evidence indicates that claimant's physical condition has changed since he was determined totally disabled in 1978. As of the 1978 PTD hearing, 5 years post-injury, claimant suffered from chronic, almost constant, low back pain which extended into his right hip and leg. He also experienced numbness in his right leg, associated with standing. He was functionally precluded from lifting, bending, stooping, twisting and prolonged sitting and walking. Although believed to have a residual functional capacity to perform light work activity, claimant was also considered unable to work or participate in retraining, except on a sporadic basis. (See Exs. 34, 36, 54, 58).

Psychological tests strongly suggested that claimant was "clinically depressed" in 1978. (Ex. 47-2). A 1978 report apparently authored by Dr. Duvall, psychologist, (see Exs. 53, 83 & 1Tr. 191), indicated that claimant had significant depression upon admission to the Portland Pain Center that year. (Ex. 53). After the program, Dr. Vizzard, clinical psychologist, noted claimant's "moderately effective adjustment to his pain situation" despite continued depression and strongly recommended prompt vocational counseling. (Ex. 56-2).

The Referee for the 1978 "PTD" hearing found that claimant's then-current health problems were "complicated by heavy drinking and a significant state of depression." (Ex. 58-2). He relied on the opinions of Dr. Vizzard and Byron McNaught, vocational counselor, regarding the cause, extent, and effect of claimant's depression. Specifically, the Referee noted Vizzard's opinion that claimant's depression was "more related to the fact that [claimant] is forced to sit around and unable to work" and McNaught's conclusion that claimant's potential for retraining hinges on "pain control and medical stability, and on recognizing and coping with his emotional problems." (Ex. 58-2-3). Further noting Vizzard's opinion that claimant's potential vocational rehabilitation would be contingent upon successful pain management and McNaught's opinion that claimant was not then employable and not ready to participate in retraining, the Referee concluded that claimant was PTD in 1978. (Ex. 58-3-5).

In 1990, Dr. Steinhauer, who evaluated claimant at the Emmanual Pain Center, opined that claimant "should be capable of at least sedentary employment full-time, providing he can alternate sitting and standing." (Ex. 81-3). This opinion issued "strictly from a physical standpoint." (Id.; see also Ex. 82-7). After viewing a videotape of claimant's "fairly good physical functioning," Steinhauer opined that claimant is capable of full-time employment in the light lifting category." (Ex. 86-2; see 1Tr. 124-26, 159, 171). In evaluating claimant's current physical status, Steinhauer noted that claimant has fewer headaches and muscle spasms than in 1978, as well as improved bending, lifting and twisting capabilities. Although claimant still has pain most of the time, he is able to stand for longer periods than in 1978. (See 1Tr. 128-30; Ex. 80). Based on Steinhauer's uncontroverted opinion, we find that claimant's physical condition has improved since he became PTD.

However, Steinhauer expressed reservations regarding claimant's ability to return to the work force. Specifically, Steinhauer cautioned that a two-hour physical capacities evaluation, such as claimant had, is not a reliable indicator of a person's physical ability to work full-time. (1Tr. 127, 159-60). He further acknowledged that claimant's ability to return to work is "certainly not purely a medical question." (1Tr. 152). In light of Steinhauer's reservations about claimant's physical capacities in a job setting and the existence of other factors affecting claimant's potential return to work, we turn to the current psychological and vocational evidence to determine whether claimant remains PTD.

In October 1990, Dr. Duvall, psychologist, re-interviewed claimant, reviewed his history, administered psychological tests and diagnosed "chronic neurotic depression." (Ex. 83). Duvall's 1990 opinion, like Vizzard's 1978 opinion, indicates that claimant's depression is related to his compensable injury. (See Exs. 56, 83; see also Ex. 58-2). Duvall concluded that claimant was "a poor prospect for utilizing vocational rehabilitation services" in 1990. (Ex. 83-7). No qualified medical opinion addresses claimant's employability from a psychological standpoint subsequent to Duvall's 1990 evaluation.

Accordingly, on this evidence, we cannot say that claimant's psychological condition improved since 1978. Instead, the record suggests that these problems continued unabated. Moreover, based on the persuasive vocational evidence, we find that claimant's psychological condition, combined with nonmedical factors, continues to preclude claimant from performing work at a gainful and suitable occupation. We reach this conclusion for the following reasons.

At the outset, we note that numerous nonmedical factors affecting claimant's job prospects have not changed since 1978. He still has limited math and reading skills, no education beyond his GED and no skills transferable from his former occupation as a truck driver. Since the 1978 PTD award, claimant has received no retraining. His preexisting hearing loss and limited manual dexterity are apparently as they were in 1978.

On the other hand, some things have changed since 1978. Claimant reached 63 years of age by 1992 and has been unemployed for eighteen years, i.e., he is now older and he has been out of the workforce longer than when he became PTD. Such factors are clearly identified as barriers impeding claimant's return to work. (See 1Tr. 186-87, 192, 227).

The vocational evidence is provided by Aaron Hughes, Raymond Reese, Scott Stipe and Byron McNaught. The Referee relied on the opinions of McNaught and Stipe, rather than those of Hughes and Reese, and concluded that claimant is presently employable. We agree that McNaught's evaluation of claimant's employability is the most persuasive, but conclude that it supports a finding that claimant remains PTD.

McNaught stated that, from a physical standpoint, claimant is presently employable in the light to sedentary range. (Tr. 183, see also Tr. 194-99). Based on his observation of claimant at hearing, McNaught opined that claimant's "stability" had improved since 1978. Assuming claimant was able to sustain work activity and stability, McNaught opined that claimant would be employable. (Tr. 184). Again based solely on observing claimant at hearing, McNaught stated that he would not hesitate to try placing claimant at an entry level unskilled job. (1Tr. 185-6).

McNaught then recalled his opinion that claimant was unemployable in 1978, because his pain level and emotional problems made him an undependable worker. (1Tr. 183, 194-99). Assuming the same level of depression and emotional instability now as in 1978, McNaught eventually concluded that claimant is as unemployable now as he was in 1978. (1Tr. 193, 201). As discussed above, there is no competent evidence that claimant's psychological problems have lessened since 1978. He still has chronic neurotic depression. Thus, inasmuch as claimant's psychological condition is the same as when he became PTD, we interpret McNaught's essential conclusion to be that claimant remains unemployable. (See 1Tr. 190-92, 200-01).

The only vocational opinion suggesting that claimant is employable is provided by Stipe, who was present at the hearing, (see 3Tr. 2), but never met or interviewed claimant. Stipe acknowledged that his conclusion is based in part on claimant's calm demeanor at hearing. In this regard, we note that claimant did present himself well at hearing. Nonetheless, considering Duvall's specialized expertise as a psychologist and his uncontradicted unchanged diagnosis, which is contrary to Stipe's evaluation of claimant's emotional status, we do not find Stipe's conclusion particularly persuasive.

Unlike the other vocational experts, McNaught had the advantage of evaluating claimant's 1992 employability in light of a firsthand 1978 working relationship with claimant. In addition, McNaught's opinion regarding claimant's employability is thoughtful, well-reasoned and based on an accurate, complete history. For these reasons, particularly McNaught's familiarity with claimant's circumstances and his advantageous perspective, we rely on McNaught's observations.

In summary, although claimant's physical condition has improved since he became PTD in 1978, his psychological residuals remain a significant barrier to employment. Considering claimant's age, long absence from the workforce, continuing psychological problems and current physical limitations, we conclude that SAIF has not proved that claimant's circumstances have changed since 1978 such that he is presently employable in the competitive labor market. Consequently, claimant remains entitled to benefits for permanent and total disability. See ORS 656.206(5); Harris v. SAIF, supra.

ORDER

The Referee's order dated July 13, 1992 is reversed. Claimant's permanent total disability is reinstated as of May, 8, 1992, the date of hearing. Claimant's attorney is awarded an approved attorney fee of 25 percent of the increased compensation awarded by this order, not to exceed $6,000.

In the Matter of the Compensation of
JACK C. GRILE, Claimant
WCB Case Nos. 91-05074 & 91-05746
ORDER ON REVIEW
Frank Susak, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of those portions of Referee Hazelett's order that: (1) set aside its denial of claimant's L3-4 disc injury claim; (2) set aside its denial of claimant's aggravation claim for the same condition; and (3) increased claimant's unscheduled permanent disability award for a low back condition from 9 percent (28.8 degrees), as awarded by an Order on Reconsideration, to 16 percent (51.2 degrees). On review, the issues are compensability, aggravation, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's conclusion and reasoning on this issue, with the following comment.

Claimant sustained a compensable low back strain while working in California in February 1987. His condition was found to be permanent and stationary on October 7, 1987, and his claim was closed. After our review of the record, we find that claimant sustained a new injury while working for an Oregon employer on April 25, 1990, and that the injury caused a herniated disc on the right at L3-4 and required surgery.

On review, the insurer contends that claimant's out-of-state injury represents a "preexisting condition" and that claimant must, therefore, prove that his Oregon injury is the major contributing cause of his disability or need for treatment. Assuming, without deciding, that ORS 656.005(7)(a)(B) is applicable, we would still find claimant's current condition to be compensable, based on the persuasive opinion of treating physician L. Gambee. See Michael R. Holt, 45 Van Natta 849 (1993). We conclude that claimant has established the compensability of his current L3-4 disc condition under either the material or major contributing cause standard.

Aggravation

We also affirm and adopt the Referee's conclusion and reasoning on this issue with the following supplementation.

The insurer argues that the event which necessitated claimant's back surgery was a coughing episode in February 1991. Therefore, it contends, claimant needed to prove that the injury, rather than the coughing episode, was the major cause of his need for surgery. We disagree. If an insurer denies an aggravation claim on the grounds that an off-the-job injury or incident 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, 44 Van Natta 2189 (1992). We find that the insurer failed to meet its burden in the present case.

Dr. L. Gambee noted that claimant experienced increased low back pain in October 1990 after returning to modified work. He obtained MRI and EMG testing, which indicated nerve root compression, and requested authorization for surgery from the insurer. Nevertheless, claimant continued working. After claimant's symptoms suddenly worsened in February 1991, he was unable to continue working at his modified job, and Dr. Gambee authorized time loss. Dr. Gambee's opinion is that claimant's herniated L3-4 disc and need for surgery are attributable to his compensable April 1990 work injury. Like the Referee, we are persuaded by his opinion.

On this record, we find that the insurer has failed to meet its burden of proof. Accordingly, we agree with the Referee that claimant has established a compensable aggravation claim.

Extent of Permanent Disability

Finally, we affirm and adopt the Referee's conclusion and reasoning on this issue, with the following comment concerning the value assigned for the impairment factor, which is the sole value disputed by the insurer.

The insurer argues that the Referee should not have increased claimant's impairment rating, because claimant's reduced lumbar ranges of motion are due to noncompensable L3-4 and L4-5 disc herniations. We have herein affirmed the Referee's conclusion that claimant's L3-4 disc is compensable. Moreover, we note that the Referee upheld the insurer's denial of claimant's L4-5 disc, and relied on claimant's range of motion findings before his condition worsened. Under these circumstances, we agree with the impairment value assigned by the Referee.

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, aggravation, and extent of unscheduled permanent disability issues 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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 26, 1992 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

May 28, 1993 Cite as 45 Van Natta 984 (1993)

In the Matter of the Compensation of
LAURIE JOHNSON, Claimant
WCB Case No. 92-07220
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Spangler's order which increased claimant's unscheduled permanent disability award for a neck, right shoulder, and back injury from 17 percent (54.4 degrees), as awarded by Order on Reconsideration, to 23 percent (73.6 degrees). Claimant cross-requests review seeking additional unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's condition became medically stationary on November 25, 1991, and her claim was closed by Notice of Closure dated January 30, 1992. The standards in effect on the date of the Notice of Closure control. Thus, the standards that became effective April 1, 1991 apply.

The parties only dispute the Referee's award for adaptability. The Referee found that, although a typical CNA job would be classified in the medium category, based on claimant's credible testimony that she frequently lifted weights averaging 130 pounds, her job at injury fell within the very heavy category. He further found that claimant's Residual Functional Capacity (RFC) was in the medium/light category. Accordingly, the Referee rated claimant's adaptability as a value of 4.

Subsequent to the Referee's decision, we issued our decision in Raymond L. Mackey,[1] 45 Van Natta 776 (1993). In Mackey, we held that the claimant was precluded from challenging the adaptability factor at the time of hearing or Board review when he had failed to challenge the adaptability factor at the time of reconsideration. Id.

In this case, the insurer's Notice of Closure worksheet indicated that the DOT code for a nurses aide, 355.674-014, was used in calculating claimant's strength factor (medium) and adaptability value (2). The appropriate DOT or strength factor were issues raisable at the time of reconsideration. See Mackey, 45 Van Natta at 777 (1993). At the reconsideration proceeding, the parties are allowed an opportunity to submit "any information and documentation deemed necessary to correct any part of the claim record the party believes to be erroneous." Id.; OAR 436-30-050(4)(e); see also ORS 656.268(5). The Appellate Unit Worksheet indicated that claimant did not raise adaptability as an issue on reconsideration. (Ex. 48-3). Thus, we find that the record has been sufficiently developed to conclude that claimant is precluded from subsequently raising the issue of adaptability for the first time at the Hearing or Board levels. cf. Peter L. Galiano, 44 Van Natta 1197 (1992) (Board remanded where the record was insufficiently developed, in absence of the claimant's request for reconsideration, to determine whether or not the claimant objected to the medical findings of impairment, in order to determine whether the Director's failure to appoint a medical arbiter rendered the Order on Reconsideration invalid); see also Stephen Schaff, 44 Van Natta 2205 (1992); Jorge Bedolla, 44 Van Natta 1500 (1992).

We affirm and adopt the Referee's conclusion that claimant is entitled to 11 percent impairment. Consequently, the sum of claimant's age, education, and adaptability values (6) and impairment value (11) totals 17 percent.

ORDER

The Referee's order dated September 2, 1992 is reversed. The May 26, 1992 Order on Reconsideration, affirming the January 30, 1992 Notice of Closure award of 17 percent (54.4 degrees) unscheduled permanent disability, is affirmed.

[1] Although signatory to this order, Member Gunn directs the parties to his dissent in Mackey, supra.

May 28, 1993 Cite as 45 Van Natta 985 (1993)

In the Matter of the Compensation of
BEVERLY A. MARTELL, Claimant
WCB Case Nos. 92-04416 & 92-04228
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Michael V. Johnson's order that: (1) admitted post-closure medical reports; (2) set aside its "de facto" compensability denial of claimant's claim for a psychological condition; and (3) found that claimant's low back and cervical injury claims were prematurely closed. On review, the issues are the evidentiary ruling, premature closure and compensability. We affirm.

FINDINGS OF FACT AND OF ULTIMATE FACT

We adopt the Referee's findings of fact and of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The employer objected to the admission of two medical reports, exhibits 73 and 75, because those reports were prepared post-closure. The Referee admitted those exhibits, partly because they pertained to the compensability of claimant's psychological condition. We agree.

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." That statute has been interpreted as giving the Referee broad discretion in regards to the admissibility of evidence. See e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Specifically, a referee's decision to admit an exhibit will be upheld as long as the evidence has some probative value and achieves substantial justice. See Lucke v. Compensation Dept., 254 Or 439, 442-43 (1969). We review the Referee's evidentiary determinations for abuse of discretion. William J. Bos, 44 Van Natta 1691 (1992).

Here, the subject exhibits had some relevance to the compensability and premature closure issues. Although those particular exhibits might not be persuasive on those issues, the weight of a piece of evidence does not determine its admissibility. Consequently, we conclude that the Referee did not abuse his discretion by admitting those exhibits.

Premature Closure

The Referee concluded that claimant's low-back and cervical injury claims were prematurely closed, because neither the September 26, 1991 Determination Order or the November 20, 1991 Notice of Closure considered claimant's injury-related psychological condition. We agree.

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. Utera v. Dept of General Services, 89 Or App 114, 116 (1987).

At the time of both closures, the medical reports established that claimant was medically stationary from a physical standpoint. In December of 1990, however, a psychological examination revealed that claimant was experiencing "psychological factors underlying her physical symptoms." (Ex 47). Moreover, on June 11, 1991, the Orthopaedic Consultants reported that claimant suffered from psychological factors affecting her recovery. (Ex 60). Claimant's treating physicians, Dr. Bulger, M.D., and Dr. Brett, M.D., concurred with that report. (Ex 62, 63). We have concluded that such pre-closure references to psychological problems are sufficient to require the consideration of whether that condition is medically stationary prior to claim closure. See Saura C. Stewart, 44 Van Natta 2595 (1992). Nevertheless, neither the Notice of Closure or the Determination Order considered claimant's psychological condition. See Gene E. Elliott, 45 Van Natta 80, 81 (1993). Moreover, no doctor stated that claimant was psychologically stationary at or prior to claim closure. Under those circumstances, we agree with the Referee that claimant's injury claims were prematurely closed.

Compensability

We affirm and adopt the Referee's reasoning and conclusions of law on the compensability issue.

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-15-010(4) and applying them to this case, we find a reasonable fee for claimant's attorney's services on review concerning the compensability and premature closure issues 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 case, and the value of the interest involved.

ORDER

The Referee's order dated October 5, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
KEVIN D. SILER, Claimant
WCB Case No. 91-13914
ORDER ON REVIEW
Kennedy, Bowles, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Hoguet's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Stipulated facts" and "Findings of Fact" with the exception of the last sentence in the first paragraph of "Stipulated facts" and with the following supplementation.

On September 9, 1991, claimant was a subject worker for the employer. Claimant's low back injury resulted from his work activities as the working shop foreman for the employer.

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties stipulated that claimant was a non-subject worker by virtue of his corporate officer status and failure to elect coverage pursuant to ORS 656.039(1). Therefore, the issue, as framed by the parties, was whether SAIF was estopped from denying claimant's claim on the basis that it had accepted premiums related to claimant's employment. The Referee concluded that despite claimant's failure to file a separate election, his claim was compensable on the basis that SAIF accepted premiums for claimant's coverage.

The parties' stipulation that claimant was a non-subject worker is not a stipulation of fact, but rather is a legal conclusion to which we are not bound. Based on our review of the facts and pertinent law, we do not accept the parties' stipulation that claimant was a non-subject worker. Moreover, we conclude that the claim is compensable.

Subsequent to the Referee's order, we issued our decision in Kenneth G. Mize, 45 Van Natta 477 (1993). In Mize, we held that the claimant, a corporate officer, was not excluded from the definition of a subject worker under amended ORS 656.027(9) because his claim arose from his work activities as an employee, rather than from his corporate officer duties. Relying on Erzen v. SAIF, 40 Or App 771, rev den 287 Or 507 (1979), we applied the "dual capacity doctrine" which focuses on the nature of the work, rather than the title of the individual, to determine whether the claimant is a subject worker. Id. at 478. In other words, if at the time of the injury, the claimant was performing labor as an ordinary worker (as opposed to a corporate officer), the claimant would be considered to be a subject worker. Id.

Claimant's injury occurred after May 7, 1990; therefore, amended ORS 656.027(9) is applicable. See Or Laws 1990, ch. 2, §55. Claimant's injury occurred as a result of his work as the working shop foreman and not as a result of his corporate officer duties. Under these circumstances, we conclude that ORS 656.027(9) does not apply. Claimant was therefore a subject worker at the time of his "injury." See ORS 656.027.

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 $750, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 15, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, payable by the SAIF Corporation.

In the Matter of the Compensation of
CORI D. SIMPSON, Claimant
WCB Case No. 91-16864
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of Referee Myers' order which: (1) found claimant's claim had been prematurely closed by an August 21, 1991 Notice of Closure; (2) set aside its denial of claimant's current condition; and (3) assessed penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are premature closure, extent of scheduled and unscheduled permanent disability, 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."

CONCLUSIONS OF LAW AND OPINION

Premature Closure

ORS 656.268(4)(e) provides that a worker who objects to a notice of closure first must request reconsideration by the Department. Similarly, ORS 656.268(5) requires that reconsideration of a determination order must be requested by a party who objects to the determination order. At the reconsideration proceeding, the parties are allowed an opportunity to correct erroneous information in the record or to submit medical evidence that should have been submitted by the attending physician at the time of claim closure. ORS 656.268(5).

Subsequent to the Referee's order, we held that where an issue is not specifically raised on reconsideration, the issue may not subsequently be raised for the first time at the Hearings Division or Board level. Raymond L. Mackey, 45 Van Natta 776 (1993). Similarly, in Chester L. Schulze, 44 Van Natta 1493 (1992) and Charlene J. Erspamer, 44 Van Natta 1214 (1992), we held that the issues of premature closure and rate of payment of scheduled permanent impairment will not be considered at hearing or on review unless reconsideration was first requested on such issues.

Here, claimant failed to specifically raise the issue of premature closure at the time of reconsideration. Therefore, we find that she was precluded from doing so at the time of hearing. See Raymond L. Mackey, supra. Accordingly, we vacate that portion of the Referee's order that found claimant's claim had been prematurely closed.

Extent of Scheduled/Unscheduled 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 was precluded from raising the issue of premature closure at hearing, and since the record is sufficiently developed regarding the issue of extent of permanent disability, we proceed to address the latter issue.

Scheduled disability is determined by rating the permanent loss of use of function of a body part due to an on-the-job injury. Former OAR 436-35-010(2)(a); 436-35-270(2). If there is no measurable impairment, no award of permanent disability shall be allowed. OAR 436-35-270(2); see Susan L. Ferguson, 42 Van Natta 2382 (1990); Jack L. Newberry, 44 Van Natta 1517 (1992). Impairment is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). 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 injury.

After reviewing the record, we conclude that the medical evidence regarding permanent impairment is, at best, speculative. See Rossi v. Zidell Explorations, Inc., 40 Or App 417 (1979). Accordingly, we conclude that claimant has sustained no permanent impairment. She, therefore, is not entitled to an award of scheduled permanent partial disability. OAR 436-35-270(2); SAIF v. Bement, 109 Or App 387 (1991). Thus, we affirm the August 1991 Notice of Closure and December 1991 Order on Reconsideration.

Compensability

Because he found claimant's claim to have been prematurely closed, the Referee did not address the issue of compensability. The record, however, is sufficiently developed in that regard and we proceed to address the issue on review.

Claimant sustained a compensable lumbar, thoracic and cervical strain on April 12, 1991. The Referee concluded that claimant's current condition, for which she sought treatment on October 1, 1991, was also compensably related to the on-the-job injury. The Referee, therefore, set aside the employer's denial. We affirm.

In order to establish compensability of her current condition, claimant must establish, by medical evidence supported by objective findings, that the April 12, 1991 injury was a material contributing cause of her disability and need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). We find that the causation of claimant's current condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

With regard to causal issues, 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 no persuasive reasons not to defer to the opinion of Dr. Altrocchi.

Dr. Altrocchi opined that "all of [claimant's] symptoms still are job-related, basically an overuse syndrome of her total body for work harder than she should be doing." (Ex. 21). Claimant's chiropractor, Dr. Hirsky, concurred with Dr. Altrocchi, reporting that "the major cause for [claimant's] present condition and need for treatment is due to an injury sustained from an industrial claim in April of 1991." (Ex. 22). There is no persuasive contrary medical opinion.

Accordingly, we conclude that claimant has established the compensability of her current condition.

Penalties and Attorney Fees

We affirm and adopt the Referee on the issue of penalties and attorney fees.

Claimant is entitled to an assessed attorney fee for services on Board review. After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee concerning the compensability issue is $900, 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 rendered on review concerning the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 29, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the August 21, 1991 Notice of Closure and December 16, 1991 Order on Reconsideration as premature is reversed. The August 1991 Notice of Closure and December 1991 Order on Reconsideration are reinstated and affirmed. The remainder of the order is affirmed. For services concerning compensability on Board review, claimant's counsel is awarded an assessed attorney fee in the amount of $900, to be paid by the self-insured employer.

In the Matter of the Compensation of
MIKE D. SULLIVAN, Claimant
WCB Case No. 92-06827
ORDER ON REVIEW
Cummins, et al., Defense Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant, pro se, requests review of Referee Daughtry's order that dismissed claimant's hearing request. Asserting that claimant has not alleged a basis for his appeal, the employer has moved for dismissal of his request for review. On review, the issues are the motion to dismiss and the propriety of the Referee's dismissal order.

We first address the motion to dismiss. Claimant has timely requested review of the Referee's dismissal order. ORS 656.289(3). The employer does not contend that its notice of claimant's request was defective. See ORS 656.295(2). Rather, the employer seeks dismissal of claimant's request, asserting that claimant has failed to assert a basis for his appeal.

We have previously ruled that we are without authority to dismiss a timely appeal based on a party's failure to state a reason for the request for Board review. See Kimberly L. Murphy, 41 Van Natta 847 (1989). Likewise, a party's failure to submit an appellate brief does not result in the dismissal of that party's request for Board review. OAR 438-11-020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987).

Here, claimant's request for Board review does not expressly challenge the Referee's dismissal order. Rather, he seeks the opportunity to obtain a "more defined medical report" from a consulting physician (Dr. Tiley). Regardless of the basis for claimant's appeal, since he timely requested Board review, the Referee's order has not become final. ORS 656.289(3). Moreover, after conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6).

Under such circumstances, the propriety of the Referee's dismissal order remains a viable issue on Board review. See Donald L. Lowe, 41 Van Natta 1873 (1989). Consequently, the motion to dismiss claimant's appeal is denied, and we proceed to our review of the propriety of the Referee's decision.

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

In May 1992, claimant, through his then-attorney of record, requested a hearing. The request raised issues regarding a May 1992 denial, including compensability, medical services, temporary disability, penalties and attorney fees. In July 1992, a scheduled hearing was postponed to permit claimant time to obtain new legal counsel. In August 1992, claimant retained new legal representation.

A hearing was eventually scheduled for January 14, 1993. Claimant was not present at the commencement of the hearing. His then-attorney moved for postponement of the hearing. The motion was based on claimant's inability to attend the hearing due to inclement weather. The employer and its insured (the SAIF Corporation) objected to the motion, noting that the hearing had already been postponed previously and that witnesses from the town where claimant resided had been able to attend the hearing.

The motion to postpone the hearing was temporarily deferred to determine whether claimant would be able to attend the hearing later in the day. When it was determined that claimant could attend the hearing, the motion for postponement was withdrawn. Thereafter, the Referee granted the employer's motion to freeze the medical record as of the date of hearing. However, the Referee declined the employer's and SAIF's motions to rule on the compensability of claimant's low back claim without taking lay testimony.

When claimant appeared at the hearing, his counsel requested that the Referee reconsider the decision to freeze the medical record. The Referee adhered to his prior decision that (considering the amount of time before the hearing that claimant had to obtain a complete medical report from Dr. Tiley) claimant would not be permitted to submit a "clarification" report from Dr. Tiley. Based on the Referee's ruling, claimant, through his then-attorney of record, withdrew his hearing request.

On January 15, 1993, the Referee issued an Order of Dismissal, dismissing claimant's hearing request. On January 22, 1993, the Board received a letter from claimant. Expressing dissatisfaction with the Referee's evidentiary ruling, claimant, without benefit of legal representation, requested review of the Referee's order. Specifically, claimant seeks the opportunity to confer with Dr. Tiley and to "present a complete and more defined medical report" concerning his claim.

Turning to the evidentiary ruling, we note that the authority to continue a hearing rests within the discretion of the referee. David F. Grant, 42 Van Natta 865 (1990). Considering that the scheduled hearing had previously been postponed and since Dr. Tiley had examined claimant some five months prior to the January 1993 hearing, we do not find it to be an abuse of discretion for the Referee to have denied claimant's motion to keep the record open to obtain a "clarification" report from Dr. Tiley.

Other than his objections to the Referee's evidentiary ruling, claimant does not dispute the fact that his hearing request was dismissed in direct response to claimant's then-attorney's express withdrawal of the request. Under such circumstances, we find no reason to alter the Referee's dismissal order. If claimant disagrees with his prior counsel's decision to withdraw his hearing request (which was made in claimant's presence and with claimant's implicit approval), he must present this matter to his former attorney, rather than this forum.

ORDER

The Referee's order dated January 15, 1993 is affirmed.

May 28, 1993 Cite as 45 Van Natta 991 (1993)

In the Matter of the Compensation of
ROBERT WINKEL, Claimant
WCB Case No. 91-15918
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Williams, et al., Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brazeau's order that upheld the self-insured employer's denial of claimant's injury claim for a myocardial infarction. On review, the issue is compensability.

We affirm and adopt the Referee's order as supplemented below.

The Referee concluded that claimant's injury claim should not be analyzed under ORS 656.802(3), which creates a presumption of compensability for cardiovascular diseases suffered by fire fighters. The Referee further concluded that, absent this presumption, claimant could not establish compensability of his claim.

We agree that claimant has not established a compensable myocardial infarction unless ORS 656.802(3) applies to his claim. ORS 656.802(3) provides:

> "Death, disability or impairment of health of fire fighters of any political division who have completed five or more years of employment as fire fighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a fire fighter's employment. However, any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the fire fighter's employment."

The Referee concluded that the presumption created by ORS 656.802(3) did not apply in this case because claimant had not undergone the requisite preemployment examination. The Court of Appeals recently concluded that this examination must be "rigid and competent" and "of the type that would reveal any evidence of heart disease." SAIF v. Bales, 107 Or App 198, on rem 43 Van Natta 1866 (1991).

Here, claimant became a fire fighter in 1963 and suffered a myocardial infarction in June 1991. He contends that tests performed on December 31, 1988 prove that he was free of heart disease at that time. On that date, claimant went to a hospital emergency room. His vital signs were taken and he underwent an EKG, both of which were reported as normal. Claimant was released the same day he was admitted with a diagnosis of acute vertigo. Between 1988 and mid-1991, claimant occasionally experienced shortness of breath and chest tightness, but no angina pain.

The record is devoid of any medical opinion discussing the significance of the December 1988 examination and EKG in determining whether claimant had a heart problem at that time. In light of the absence of such opinion, the Referee concluded that claimant had not established that he had undergone the type of rigid and competent preemployment examination required by ORS 656.802(3).

Claimant contends that the examination and EKG performed in December 1988 would have revealed any evidence of heart disease. Claimant urges the Board to take judicial notice of the fact that the EKG is routinely used to diagnose heart disease.

Whether this type of medical fact is a proper subject for judicial notice is questionable. Compare Fidela O. Durgan, 39 Van Natta 316 (1987) (Referee erred in relying on a definition of a disease in a medical treatise to diagnose a claimant's condition.) Moreover, the fact that the EKG is an important tool in diagnosing cardiovascular disease does not necessarily mean that it would reveal any evidence of a heart problem in this particular claimant. The single EKG and limited examination in December 1988 may be dispositive in determining the existence of heart disease, without further examination or testing. However, that is a complex medical question that must be resolved by expert medical opinion. There is no such medical opinion in this record discussing the significance of a normal EKG and vital signs, either generally or in claimant's particular case. Such a discussion is particularly important here, given the fact that claimant had clinical symptoms consistent with heart disease in 1988.

In summary, we conclude that the record does not contain sufficient medical opinion to determine that claimant underwent the type of rigid and competent preemployment examination required by ORS 656.802(3). Absent such medical opinion, claimant has not established that the fire fighter's presumption is applicable in his case. Accordingly, he has not proven a compensable claim.

ORDER

The Referee's order dated April 28, 1992, is affirmed.

In the Matter of the Compensation of
DARRELL R. EVANS, Claimant
WCB Case No. 91-10991
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Claimant has requested reconsideration of our May 4, 1993 Order on Review that affirmed a Referee's order which: (1) found the claim to be prematurely closed; and (2) awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by the Referee's order, not to exceed $1,050. Specifically, claimant contends that we erred in declining to grant his counsel an extraordinary approved attorney fee.

In order to allow us sufficient time to consider claimant's motion, we withdraw our May 4, 1993 order. The self-insured employer may submit a response. In order to be considered, the employer's response should be submitted within 14 days from date of this order. Thereafter, we shall proceed with our review of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
KURT E. HANSEN, Claimant
WCB Case No. 92-02086
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of Referee Holtan's order that upheld the SAIF Corporation's "back-up" denial of his claim for a right knee injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF denied claimant's claim for a right knee patellofemoral contusion approximately 5 years after accepting the claim. The denial was based on the fact that claimant, as a corporate officer, had not elected personal workers' compensation coverage and, therefore, was not covered at the time of the injury.

The Referee found that SAIF was not bound by its acceptance since its "back-up" denial was based on a lack of coverage. Accordingly, the Referee upheld SAIF's denial. We disagree.

At the outset, we note that ORS 656.262(6) is inapplicable to the present case. That provision allows for a "back-up" denial within two years of claim acceptance. Here, SAIF's denial was issued approximately 5 years after claim acceptance. Therefore, by its terms, ORS 656.262(6) does not apply.

Prior to 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 (1993). The former were not. Oak Crest Care Center v. Bond, 101 Or App 15 (1990).

Although "back-up" denials based on lack of coverage are generally permissible, there are some exceptions and limitations. In Garcia v. SAIF, 108 Or App 653 (1991), the court explained that the rule only applies where the injured worker's right to receive compensation is not at risk; that is, were 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 is simply not to be permitted. Id.

While SAIF's denial is based on a "lack of coverage," the fact is that it did provide coverage for the employer at the time claimant was injured. Therefore, its "back-up" denial is not based on a lack of coverage of the employer, but rather the contention that this specific claimant was not "covered." In these circumstances, the rule concerning "back-up" denials for lack of coverage, as set forth in Oak Crest Care Center v. Bond, supra is not applicable. Accordingly, the only method by which SAIF could permissibly deny the claim is found in ORS 656.262(6). However, as noted above, SAIF cannot avail itself of that provision.

Moreover, assuming that SAIF's denial was a permissable "back-up" denial for lack of coverage, it would be subject to the exception set forth in Garcia v. SAIF, supra, inasmuch as claimant's right to receive compensation would be placed in risk. See Myron R. Schaffer, 44 Van Natta 2490 (1992).

For these reasons, SAIF's denial must be set aside.

Claimant is entitled to an assessed attorney fee for prevailing on SAIF'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 $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 the appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 28, 1992 is reversed. The SAIF Corporation's denial is set aside and the case 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 $2,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
SCOTT TURO, Claimant
WCB Case No. TP-92012
THIRD PARTY DISTRIBUTION ORDER
Steven J. Pierce, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board en banc.

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, claimant objects to those portions of the SAIF Corporation's lien which pertain to claim costs attributable to vocational assistance expenses and claim disposition agreement (CDA) payments. We hold that SAIF is entitled to reimbursement for these incurred claim costs.

FINDINGS OF FACT

In December 1989, claimant sustained a compensable crush injury to both of his feet while performing his work activities as a shaft miner. His feet were pinned beneath a backhoe. Treatment included casting of both feet.

SAIF accepted the claim and has provided compensation. In October 1990, SAIF closed the claim by a Notice of Closure. Claimant requested reconsideration, seeking an additional award of permanent disability. Pursuant to a May 2, 1991 Order on Reconsideration, claimant was granted awards totalling 15 percent scheduled permanent disability for loss of use or function of the left foot (ankle) and 20 percent scheduled permanent disability for loss of use or function of the right foot (ankle).

In approximately October 1990, vocational assistance measures were initiated. Prior to the implementation of this assistance, claimant had expressed an interest in helicopter pilot training. To that end, at his own expense, claimant obtained a pilot's license.

Following the completion of his vocational testing, claimant was advised by his counselor that SAIF was not inclined to approve a helicopter training program. Noting that such training facilities were located in Florida, Texas, or California, SAIF suggested that the counselor present less costly Oregon-based vocational options to claimant. Claimant's suggestion for commercial pilot training program received a similar response from his vocational counselor.

In January 1991, claimant sought Director review of SAIF's position regarding his commercial pilot training program. In February 1991, a vocational consultant for the Rehabilitation Review Section of the Workers' Compensation Division responded to claimant's request. Enclosing a copy of a prior Director's order regarding a similar petition, the consultant requested that claimant notify the Department if he wished to proceed further with his appeal.

In March 1991, claimant's petition was dismissed. Noting that claimant was pursuing a new training goal with his vocational counselor, the dismissal order stated that claimant had withdrawn his petition for administrative review.

Thereafter, claimant expressed an interest in aircraft avionics (the repair and maintenance of aircraft instrumentation systems). Claimant located an avionics program in Colorado. His counselor suggested a program in Tacoma, Washington. However, on further investigation, claimant determined that the Washington program pertained to marine, rather than aircraft, avionics.

When claimant's interests in the avionics program were forwarded to SAIF, he was advised that the 19-month program was not in compliance with administrative regulations. Claimant offered to sponsor himself for the first two months of the program. In reply, SAIF authorized the counselor to perform a labor market research to determine the suitability of an avionics goal. In addition, SAIF stated that it would not expend relocation costs or for a second residence subsidy in Colorado.

Once again, claimant sought administrative review of SAIF's vocational assistance practices. In April 1991, a "Letter of Agreement" issued from a vocational consultant for the Workers' Compensation Division. Noting that claimant was exploring several vocational options with his counselor, the letter acknowledged claimant's understanding that such efforts were designed to return claimant to work at wages as close as possible to his wage at injury.

In June 1991, a vocational consultant for the Workers' Compensation Division acknowledged another request for administrative review from claimant concerning SAIF's vocational assistance practices. On July 31, 1991, the consultant issued another "Letter of Agreement." Stating that claimant would investigate computer skill training classes at a local community college, the letter concluded that any eventual training program would require SAIF's review.

Thereafter, a program designed to train claimant in computerized drafting was identified. Although the training period exceeded the time an insurer was obligated to provide benefits, claimant was willing to pay for the extra period. In August 1991, assuming that SAIF would approve such a program, claimant enrolled in the program which was conducted by a local community college.

In October 1991, SAIF notified claimant's vocational counselor that the proposed vocational assistance plan was unacceptable. After citing some eight deficiencies in the proposal, SAIF concluded that it was unlikely that the plan would provide suitable employment for claimant. Claimant learned of SAIF's rejection of the plan in approximately January 1992.

Claimant had previously retained legal counsel to pursue a third party lawsuit against three entities arising from his compensable injury. (His counsel had also represented him in each of his requests for "vocational assistance" administrative review). The trial was initially scheduled to convene in February 1992, but was rescheduled for April 1992.

In February 1992, claimant, his attorney, and SAIF executed a Claim Disposition Agreement (CDA). In entering into the CDA, claimant believed that SAIF had no intention of ever providing him with vocational assistance.

Pursuant to the CDA, the parties agreed to "settle claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services, for the total sum of $15,000." "Compensation and payments of any kind due or claimed" was defined in the CDA as including "all past, present and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services." The CDA further provided that the settlement was "reasonable." Finally, the CDA directed that $3,375 of the $15,000 in proceeds would be distributed to claimant's attorney. The CDA received Board approval on March 31, 1992.

In April 1992, claimant's trial against the third parties began. During the second day of trial, claimant and the third parties reached a $220,000 settlement. SAIF approved the settlement. Inasmuch as claimant was objecting to the full recovery of SAIF's lien, the parties agreed that the disputed portion of the settlement proceeds would be held by claimant's attorney in trust pending resolution of their dispute.

SAIF's lien is confined to actual claim costs totalling $49,151.99. These costs are composed of the following expenses: (1) $13,141.63 for temporary disability; (2) $6,448.63 for medical bills; (3) $7,710.48 for vocational assistance; (4) $6,851.25 for permanent disability; and (5) $15,000 for CDA payments.

Claimant does not object to those portions of SAIF's lien which pertain to reimbursement for temporary disability, permanent disability, and medical expenses. However, in light of his vocational assistance difficulties, claimant contends that SAIF should not be permitted to recover its costs for vocational assistance nor its CDA payments. Unable to resolve this dispute, claimant has petitioned the Board for resolution.

SAIF's recovery of its claim costs for vocational assistance and CDA payments is "just and proper." See ORS 656.593(3).

CONCLUSIONS OF LAW

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

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(l), 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). Finding no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1), we proceed with our analysis.

Pursuant to ORS 656.593(l)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(l)(b).

The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 and 656.794. See ORS 656.593(1)(c). Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278. Following the aforementioned distribution of a third party recovery, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, claimant objects to SAIF's reimbursement for claim costs related to vocational assistance expenses. Contending that he did not receive meaningful vocational assistance, claimant asserts that SAIF should be prohibited from recovering this portion of its lien.

We have previously held that the recovery of actual claim costs is not contingent on the success or failure of a particular service. Robert E. Greer, II, 43 Van Natta 650 (1991). Instead, we have reasoned that our inquiry is confined to whether a paying agency has actually incurred expenses for compensation provided to the worker who has received a third party recovery. Id. We continue to adhere to that rationale. In any event, even assuming that our inquiry in third party distribution disputes extended to preventing paying agencies from recovering otherwise recoverable claim costs, we would reject claimant's proposed distribution.

Claimant's objections to SAIF's "vocational" lien primarily center on his dissatisfaction with SAIF's actions or inactions during the development of, and eventual rejection of, a vocational assistance program. Yet, the appropriate forum for consideration of such disputes rests with the Director. See ORS 656.340; OAR 436-120-001, et seq. In this regard, we note that, on three separate occasions, claimant exercised his right to contest SAIF's conduct regarding the processing of his vocational assistance claim. Each of these requests for administrative review were resolved (one via dismissal order and two via "Letter of Agreement"). Moreover, claimant entered into a CDA, which provided that claimant was releasing his past, present, and future rights to a number of benefits, one of which was vocational assistance.

As detailed in our findings of fact, each of these administrative actions involved claimant's vocational assistance benefits. Furthermore, all of these procedures were conducted and completed in advance of the third party settlement. We note claimant's frustrations with the vocational rehabilitation system in general and SAIF's practices in particular. Yet, if claimant wished to challenge SAIF's conduct regarding the processing of his vocational assistance claim, he had several opportunities to do so prior to the settlement of his third party action and his subsequent objection to SAIF's "vocational" lien.

Inasmuch as claimant chose not to fully pursue the appropriate statutory and administrative avenues for resolution of his vocational assistance disputes and also actually disposed of his past, present, and future vocational assistance rights through the approved CDA, we decline claimant's invitation to prohibit SAIF from receiving reimbursement for its vocational assistance costs which were actually incurred during the processing of claimant's compensable injury claim.

Turning to the amount of SAIF's "vocational" lien, claimant does not contest SAIF's assertion that it expended $7,710.48 in vocational claim costs. Inasmuch as it is undisputed that SAIF actually incurred such compensation expenditures while processing the claim, we conclude that it is "just and proper" that SAIF receive reimbursement for these costs from claimant's third party recovery. Robert E. Greer, supra.

We also disagree with claimant's argument that SAIF is foreclosed from recovering reimbursement for its claim costs attributable to the CDA ($15,000). The underlying public policy of the third party distribution statutes and the purpose of the statutory liens is to allocate whatever the claimant recovers between him and the paying agency and to provide reimbursement to those responsible for statutory compensation of injured workers when damages for settlements are obtained against the persons whose act caused the injuries. Allen v. American Hardwoods, 102 Or App 562, 567 (1990), rev den 310 Or 547 (1990); Schlecht v. SAIF, 60 Or App 449, 456 (1982) (emphasis in original). In other words, the tortfeasor or wrongdoer should bear the burden of claimant's workers' compensation claim costs to the greatest extent possible.

Since the advent of the CDA, it is not unusual for such dispositions to include as full or partial consideration the paying agency's waiver or reduction of its lien against a specific and ascertainable third party recovery. See generally Kenneth Hoag, 43 Van Natta 991 (1991). In this way, the claimant releases his rights to past, present and future compensation in return for a greater share of his third party recovery. Such a procedure is in keeping with the aforementioned goal of the third party statutes in that the party ultimately responsible for the injury (the third party) is providing the future compensation needs of the claimant.

Here, while claimant's third party action remained pending, he and SAIF entered into a CDA. Pursuant to that agreement, claimant released his past, present and future rights to compensation (with the exception of medical services) resulting from his compensable injury. In return, claimant received $15,000. No mention was made of the third party action nor did SAIF waive all or any part of its lien.

In essence, by objecting to SAIF's recovery of its $40,000 CDA payment, claimant is now seeking modification of the disposition itself. In other words, notwithstanding his receipt of the $15,000 payment, claimant requests that SAIF's recoverable lien be limited to claim costs incurred prior to that payment. In the absence of a provision foreclosing SAIF from recovering reimbursement for such a payment, we are not prepared to alter a final and nonreviewable order. See ORS 656.236(2).

Resolution of this issue primarily centers on whether CDA proceeds constitute "compensation" as statutorily defined. Pursuant to ORS 656.593(1)(c), a paying agency is entitled to a share of the third party recovery to the extent that the paying agency is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the workers' beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8); Howard v. Liberty Northwest, 94 Or App 283, 286 (1988).

Although the Howard court was not presented with the specific issue which is currently before us, its reasoning provides some guidance. The issues in Howard were whether the Hearings Division had jurisdiction to enforce a DCS and whether penalities could be assessed for a carrier's delay in paying DCS proceeds. The Howard court held that enforcement of a DCS constituted a "matter concerning a claim," thereby entitling the claimant to request a hearing under ORS 656.283. Nevertheless, reasoning that the DCS resolved a denied claim and noting that such proceeds were "in lieu of any and all compensation claimed by claimant," the court further determined that DCS proceeds were not "compensation" under ORS 656.005(8) (then numbered subsection (9)). Consequently, the Howard court concluded that penalties were not assessable.

Here, in contrast to a DCS, a CDA does not pertain to a denied claim. Instead, a CDA provides for the disposition of matters regarding an accepted claim. See ORS 656.236(1); OAR 436-60-145(4)(a). In short, a CDA does not extinguish a claim. Rather, since the statute prohibits the disposition of claimant's medical services, SAIF remains responsible for ongoing claim processing obligations for such services. ORS 656.245; 656.327.[1]

Moreover, CDA proceeds are not "in lieu of" an injured worker's compensation. To the contrary, a CDA payment represents an advancement of benefits to claimant; i.e., a "lump sum" or "accelerated" payment of compensation. That is, in return for a stated amount as consideration, a claimant releases his/her specified rights to past, present and future compensation.[2]

Based on the aforementioned reasoning, we conclude that because this CDA payment is being provided for an accepted compensable injury to a subject worker in accordance with a statute under ORS Chapter 656, the payment constitutes "compensation." This reasoning is further confirmed by a review of the statute pertaining to CDAs.

ORS 656.236(1) provides that the parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Director may prescribe. Section (6) of the statute further states that a claim disposition agreement shall not be eligible for reimbursement from several enumerated reserve funds without the Director's prior approval.

One of these enumerated funds is the Reopened Claims Reserve. That fund authorizes the Director to provide reimbursement to a carrier for additional amounts of compensation payable to injured workers resulting from post-January 1, 1988 Board awards made under ORS 656.278. ORS 656.625. Inasmuch as this statute envisions reimbursement for compensation and since ORS 656.236(6) requires prior Director approval of a CDA in order for a carrier to be eligible for such reimbursement, it follows that CDA proceeds constitute compensation within ORS Chapter 656.

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[1] Relying on SAIF v. Wright, 113 Or App 267 (1992), Member Gunn contends that CDA proceeds cannot constitute compensation because SAIF is not a "paying agency" since it is not providing benefits at the time of the third party settlement or distribution. We disagree.

Wright is distinguishable. In Wright, SAIF asserted a lien against claimant's "third party" settlement at a time that SAIF was also disputing the compensability of claimant's injury claim. Reasoning that there was no entity paying benefits at the time of the settlement and that there was no certainty that there would be an entity paying benefits in the future, the court agreed with the Board that SAIF was not a "paying agency" under ORS 656.576.

Here, in contrast, the compensability of the claim is not disputed. To the contrary, the claim has been accepted. Thus, compensation has been provided to claimant. Since SAIF has provided those benefits, it is a paying agency. ORS 656.576. Moreover, despite the CDA, SAIF is statutorily obligated to provide medical services. ORS 656.236; 656.245; 656.327. Since "compensation" includes medical services, SAIF maintains its status as a paying agency, irrespective of the CDA. ORS 656.005(8); 656.576.

[2] We recognize that future claim costs for aggravation claims (ORS 656.273(1)) and own motion claims (ORS 656.278(1)) are not lienable under ORS 656.593(1)(c). See Verne E. Davis, 43 Van Natta 1726, 1729 (1991) (Paying agency prohibited from recovering the present value of expenditures attributable to future reopenings of the claim). Nevertheless, actual CDA payments expended and in existence at the time of a third party settlement do not retain any specific identity with any or all of the future rights extinguished in the CDA. Instead, once expended, CDA proceeds represent actual claim costs for compensation paid to a worker. As such, these actual claim costs are fully reimbursable.

Alternatively, even if we were to examine whether the $15,000 in consideration pertained to future aggravation or own motion claims, the record would not support such a finding. With the exception of medical services, claimant released all of his rights to compensation. These rights included temporary and permanent disability benefits. The CDA did not apportion the consideration among the various released benefits. Since claimant's claim was closed and no litigation was pending regarding a closure order at the time of the CDA, it could be contended that such benefits might originate from aggravation or own motion claims arising after claimant's third party settlement.

However, claimant's petition for third party relief and accompanying affidavit suggest that the CDA payment was designed to resolve his ongoing vocational assistance disputes. Inasmuch as such expenditures would be recoverable under ORS 656.593(1)(c), an investigation into the specific allocation of consideration among particular benefits would not alter our ultimate conclusion that SAIF is entitled to reimbursement for its CDA payments.

In conclusion, since CDA payments constitute compensation which has been actually expended by the paying agency while processing a worker's claim, we hold that such payments are reimbursable claim costs from the worker's third party recovery. ORS 656.593(1)(c).

Finally, claimant contests SAIF's entitlement to recover that portion of its "CDA" lien which is attributable to a fee paid to claimant's attorney for services regarding the CDA. We disagree with this contention.

Attorney fees in claim disposition agreements are payable in the manner prescribed by the Board. ORS 656.236(4). In accordance with this statutory authority, the Board rules provide for an attorney fee payable from the CDA proceeds. OAR 438-15-052.

We have previously held that an out-of-compensation attorney fee retains its identity as "compensation" and is reimbursable from a third party recovery. David A. Steiner, 43 Van Natta 817 (1991). The court has agreed with our analysis, reasoning that an out-of-compensation attorney fee award is not a separate carrier-paid attorney fee award but rather an authorization for claimant's attorney to charge claimant a certain amount for services rendered. Steiner v. E. J. Bartells Co., 114 Or App 22, 25 (1992).

Here, pursuant to OAR 438-15-052, the parties' approved CDA awarded claimant's attorney a $3,375 fee from the $15,000 proceeds. Inasmuch as we have already determined that such proceeds constitute compensation and since claimant's attorney fee was payable from those proceeds, we conclude that the attorney fee retains its identity as compensation. See Steiner v. E. J. Bartells Co., supra. Consequently, SAIF is also entitled to reimbursement for these $3,375 in claim costs from claimant's third party recovery. ORS 656.593(1)(c).

Accordingly, we hold that the SAIF Corporation is entitled to recover its entire $49,151.99 lien from the remaining balance of the $220,000 third party settlement as its "just and proper" share. ORS 656.593(3). Therefore, claimant's attorney is directed to forward the aforementioned sum to SAIF as reimbursement for its lien. Any remaining balance of the settlement proceeds after this disbursement shall be distributed to claimant in accordance with ORS 656.593(1)(d).

IT IS SO ORDERED.

Member Lipton, specially concurring.

I agree with the result in this case. However, as Footnote 1 implies, under different facts I would not agree that all of the CDA proceeds are lienable. I write, therefore, to illuminate a potential problem where CDAs and third-party settlements meet.

As Footnote 2 states, future claim costs for aggravation claims [ORS 656.273(1)] and Own Motion claims [ORS 656.278(1)] are not lienable under ORS 656.593(1)(c). The majority alternatively finds that the CDA proceeds in this case were viewed as a resolution of vocational assistance disputes. Hence, they are all recoverable under the lien. In most cases, however, the Board cannot identify what, if any, portion of the CDA proceeds are attributable to future claim costs for aggravation claims and Own Motion claims. Consequently, it could prove difficult to approve a lien including CDA proceeds in which the character of the proceeds cannot be identified.

When parties enter into a CDA where the potential for a third party settlement of the underlying claim exists, the parties might consider identifying the proceeds of the CDA consistent with ORS 656.593(1)(c) in order to avoid delay in the processing of third party distribution orders.

Board member Hooton concurring and dissenting.

I agree with the majority that a CDA represents compensation as that term is defined at ORS 656.005(8). I would also agree, under specific limited circumstances, that the proceeds of a CDA, or some portion thereof, are lienable. I do not, however, agree, that the CDA proceeds are lienable in this instance. Further, I am unable to conclude that allowing the recovery of costs paid for "vocational services" in the present claim is "just and proper".

CLAIMS DISPOSITION AGREEMENT

I am unable to agree that the insurer is entitled to recover all of the costs paid for the CDA on this claim. The majority opinion appears to take the position that the basis for a CDA is the acceleration of future benefits potentially due on the claim, with a present "lump sum" payment removing the insurer's obligation to provide those benefits in the future. I do not disagree. However, the future benefits relinquished by claimant in this instance are all benefits which would be free from the insurer's lien. Those benefits derive from ORS 656.273(1) and ORS 656.278(1) and are not recoverable under ORS 656.593(1). The majority appears to conclude that by virtue of the acceleration the nature of the payment has changed and the present "lump sum" payment becomes a lienable expense.

While I do not doubt that the insurer hoped that the majority would view the CDA proceeds in this light at the time of making the settlement, the conclusion allows the insurer to assert by a back door expenses which we have already concluded are not assessable in the lien. See, Verne E. Davis, 43 Van Natta 1726, 1729 (1991). The majority here allows exactly the activity prohibited in ORS 656.593(1)(c) and discussed in Davis. It acknowledges the nature of the request for reimbursement when it notes that CDA payments are "lump sum" payments of "accelerated" future benefits.

In addition both the majority, and member Lipton in concurrence, argue that, even if a CDA is not fully lienable in every case, it is in this one. The basis for that conclusion is that the CDA primarily represents a settlement of the vocational dispute ongoing between SAIF and the claimant. Apart from the discussion above regarding SAIF's failure to provide reasonable vocational services in light of the circumstances of this claim, I would still find that SAIF is entitled to only a small portion of the CDA costs.

The majority, and member Lipton, conclude that the claimant and the insurer intended the CDA as a settlement of the vocational issue, which is a lienable expense under ORS 656.593(1). Unfortunately, the evidence does not substantiate that conclusion. The motive expressed for entering into a CDA was indeed, the belief that SAIF would never honor its obligation to provide vocational assistance. All that means is that the claimant felt inspired to settled his claim because he did not believe that he could trust SAIF to deal with him in good faith. It does not mean that the only portion of his claim that he intended to settle was the vocational dispute, or that he considered all of the proceeds of the CDA to be related to SAIF's vocational obligations. The motives of a party in seeking settlement are not necessarily the same as the consideration for the release of rights.

The CDA document indicates that the claimant gave up rights to temporary disability, permanent disability, own motion rights, permanent total disability and vocational services. Some consideration must have been provided for the relinquishment of each of these rights. By assigning all of the consideration to vocational services, the majority appears to argue that claimant gave up significant rights without the concurrent receipt of consideration, a result that would make the CDA unreasonable on its face as a matter of law.

Because the claimant gave up rights for which the insurer has no lienable interest, and because the justification for finding the CDA to be "compensation" derives from the fact that it represents a present "payment" of that future interest, the present payment is, and should be, no more lienable than the interest to which the present payment applies as consideration. Because there must be consideration for each of the interests relinquished, and because the record provides no indication what that consideration is, in each individual case, I would apply the consideration to each interest as a strict percentage of the total involved. In other words, claimant gave up five specific rights for a total of $15,000.00. In establishing the lienable interest I would attribute 20% of the total consideration, or $3,000.00 to each of the interests or rights released.

Because the CDA was accomplished on a closed claim, the relinquished right to temporary disability, total disability and permanent disability as well as for own motion obligations are all rights which would arise in the future under either ORS 656.273 or ORS 656.278. Those obligations of the insurer are not lienable in a third party recovery. ORS 656.593(1). Consequently, I would disallow any recovery for the consideration paid for the relinquishment of those rights. Only the right to vocational services remained a present and lienable interest. To the extent that a "just and proper" distribution requires that vocational services be included in the lien, I would allow the insurer to recover $3,000.00 of the CDA costs.

Board Member Kinsley dissenting in part.

I disagree with that portion of the majority's opinion which holds that the amount paid by the insurer to the claimant as a result of their claim disposition agreement (CDA) may be claimed as "compensation" paid and, therefore, may be fully recovered by the insurer through its lien on claimant's third party civil suit settlement proceeds. In order to reach this result, the majority has modified and supplemented the terms of the parties' CDA even though the CDA has become final and even though no party has challenged the validity of the CDA. Because I believe it is improper for this forum to alter a valid and final settlement agreement between the parties, I dissent.

The facts and law of this case are simple. ORS 656.236(1) allows claimants and insurers to compromise and release all claim matters, except for medical benefits. These compromise and release agreements are commonly referred to as CDAs. The parties here entered into such an agreement in which the insurer agreed to pay claimant the sum of $15,000 in exchange for claimant's release of his right to receive worker's compensation benefits, except for medical benefits:

> "SAIF Corporation certifies that it has paid all benefits due and payable up to the date this Disposition was sent to the claimant.
>
> "Pursuant to ORS 656.236, the parties have agreed to settle claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services, for the total sum of $15,000, to be paid in the manner provided herein. "Compensation and payments of any kind due or claimed" includes all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services." (CDA, approved March 31, 1992, p. 3; emphasis added).

In a separate document entitled "Notice to Claimant per OAR 436-60-145", which was incorporated into the CDA by reference, the parties agreed to the following:

> "If the Claim Disposition Agreement is approved, you will be paid the amount of money stated in the agreement. You will permanently give up your right to receive additional temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and "Own Motion" rights per ORS 656.278. You will, however, retain your right to receive compensable medical services." (CDA, approved March 31, 1992, p. 6, emphasis added).

The plain language above shows that the parties agreed that claimant had been paid all compensation due him up to that point, and that, in return for $15,000 from SAIF, claimant released all rights to further payment for compensation, except for medical benefits. There was nothing in the CDA which characterized the sum paid by SAIF as an advance payment or accelerated payment of future compensation.[1] Rather, the sum paid by SAIF was the antithesis of "compensation" as that term is used in chapter 656, since it paid for claimant's relinquishment of his right to receive compensation. See ORS 656.005(8)(definition of "compensation").

Subsequent to the execution of the CDA, claimant was successful in obtaining a settlement in a civil suit against a third party that was involved in his original work injury. SAIF then sought to enforce its lien against the settlement amount as provided in ORS 656.593. Section (1)(c) of that statute allows the insurer (who is the "paying agency") to be reimbursed for certain benefits that it has paid or will pay on the claim:

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[1] There is no provision in chapter 656 which allows for advance payment or accelerated payment of future compensation, except as allowed in ORS 656.230. Rather, the statutes and relevant rules set out specific, regular time schedules for payment of compensation. There is nothing in ORS 656.593(1)(c) which indicates that the parties may agree in a CDA to circumvent the payment schedules otherwise found in the statutes. Rather, the purpose of that statute is to allow the parties to settle and dispose of obligations to pay compensation. The majority does not cite, and I am unable to find, any legislative history which would support its view of the purpose of CDAs allowed under ORS 656.236.

> "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." (ORS 656.593(1)(c), emphasis added).

SAIF now seeks to recover the $15,000 it paid to claimant through the CDA by characterizing that sum as "compensation" and including it in its lien on claimant's third party recovery. As explained above, the CDA amount was not "compensation." It was the antithesis of compensation, in that it represented the amount SAIF paid to claimant so it would not have to pay compensation. ORS 656.593(1)(c) does not provide for a lien on these kind of payments.

In the alternative, SAIF argues that, if the CDA proceeds are not "compensation," then the proceeds qualify as "other costs of the worker's claim" under ORS 656.593(1)(c). Even if I were to accept the premise that CDA payments are claim "costs," the statute does not allow a lien for a past cost, but only for the present value of future costs. Here, the CDA payment was made in the past. Therefore, it could not be subject to SAIF's lien.

In conclusion, I find that neither ORS 656.236[2] nor 656.593 characterizes amounts paid in CDAs for the compromise and release of the right to receive compensation as "compensation" as that term is defined in ORS 656.005(8). Further, unlike the characterization of the majority, the CDA agreement did not characterize the amount paid as an advance payment or an acceleration of "compensation" payments due to claimant. Rather, the parties agreement involved claimant's relinquishment of his right to receive compensation in return for a flat sum paid by SAIF. Therefore, the CDA amount may not be included in SAIF's lien on the third party settlement.

Parties to CDA settlements, as well as other kinds of settlements of workers' compensation matters, have their own valid reasons for agreeing to the types of settlements, the terms of settlements and the timing of those settlements. The Board is setting a dangerous precedent by altering and recharacterizing the terms of a final and valid settlement so as to change the rights and obligations of the parties. As Member Gunn points out in his dissent, the majority's holding has allowed SAIF to recover its $15,000 from the claimant, and has left claimant in the position of relinquishing his right to receive compensation in return for nothing.

I believe that the Board should be enforcing this final and valid settlement, rather than nullifying the obligations of one party to the detriment of another party. Therefore, for this reason and for the other reasons presented above, I dissent.

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[2] The majority has cited ORS 656.236(6) as supporting authority for its holding. It is somewhat difficult to follow the underlying logic of that citation as it relates to ORS 656.278 and ORS 656.625. Again, I would point out that, by the terms of the CDA, the claimant has specifically relinquished his right to receive compensation pursuant to ORS 656.278. The $15,000 from SAIF paid for that relinquishment as well as the relinquishment of claimant's other rights to receive compensation (except for medical benefits). The $15,000 paid for the right not to pay compensation, that sum was not in itself payment of "compensation."

Board Member Gunn dissenting.

Up here on the seventh floor of the Bank Tower building resides the Worker's Compensation Board and after this dissent and the concurrences, you will probably rename it the Tower Of Babel (if you haven't already). We will try to explain the concepts of lienable proceeds and compensation as it applies to the instant case. I will speculate further that the mere presence of a Claims Disposition Agreement (CDA) would remove any lien the insurer may have against a third party settlement.

I am not sure about my respected colleagues' discussion about what is lienable and what isn't. I think if it's compensation, it is lienable. If it's not compensation, it is not lienable. I don't believe the proceeds from a CDA are compensation; thus, they should not be lienable. Although a CDA references that the settlement is for temporary disability benefits, permanent disability benefits, and aggravation

rights (which are forms of compensation), no specific sum is apportioned to any specific compensation. Rather, the CDA amount is an aggregate of all rights to compensable and potentially compensable items which claimant is selling and the insurer is buying. With a CDA, the insurer is paying for claimant's rights to certain potential liabilities of the insurer. In sum, the proceeds of a CDA are not compensation, but the purchase of rights to various liabilities. If a CDA was simply the payment of future claim costs, we would only need an actuarial statement and claimant's signature on a waiver form and the check.

In the instant case, I am sure that the $15,000 paid for this CDA may have had as it's genesis some projection of future compensation costs, but clearly not all, as the $220,000 third party settlement would seem to indicate. I am also sure that the $15,000 is not the actual and total compensation costs. If the $15,000 represented only future compensation, then why would the insurer bother to pay it out in a lump sum? No, a CDA represents what an management adversary described as an "accommodation of diverse interests." In other words, a compromise of both parties' positions so that claimant could get some money and the insurer could eliminate potential liabilities. It is the price of peace and resolution, but not compensation.

Finally, I note the majority's point that, "it is not unusual for such dispositions to include as full or partial consideration the paying agency's waiver or reduction of its lien against specific and ascertainable third party recovery." Therefore, I question that if a waiver of third party rights can constitute consideration for a release of rights, then how can an insurer be allowed to take back claimant's consideration (via a lien) and thereby reduce the CDA to an "agreement" where claimant releases his rights to compensation in exchange for no sum of money, nor even a waiver (i.e., an increase in his third party settlement). I agree with claimant. That is, this was not the purpose for his entering into the compromise and release, since obviously, by the majority's ruling, the end result is that the insurer has compromised nothing, while claimant has released his rights, but for nothing.

The only way around this folly is to determine that a CDA is a final settlement of the claim and as such extinguishes the insurer's status as a paying agent. The actual title "Claims Disposition Agreement" is a statement that the agreement is intended as a final settlement. Specifically, "disposition" is defined as an "act of disposing; transferring to the care or possession of another. The parting with, alienation of, or giving up property. The final settlement of a matter." Black's Law Dictionary, Sixth Edition.

Therefore, if the CDA represents a final settlement of a claim, then how can an insurer remain a "paying agency" as defined by ORS 656.576. In SAIF v. Wright, 113 Or 267, 272 (1992), the court found that: "An insurer must be paying benefits at the time of the settlement or distribution in order to qualify as a 'paying agency' under ORS 656.576. Accordingly, only the self-insured employer or insurer paying benefits to the worker or beneficiaries can be a "paying agency." ORS 656.576; SAIF v. Wright, supra at 270.

Here, at the time of settlement and distribution, the insurer was no longer paying benefits and had disposed of future compensation liabilities by way of a CDA. Since the insurer can no longer qualify as a "paying agent," they must be unable to assert a lien or compel distribution.

Therefore, I must respectfully dissent.

In the Matter of the Compensation of
RONNIE E. TAYLOR, Claimant
WCB Case Nos. 91-08984, 91-03910, 91-03909, 91-08983 & 91-08982
ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Julie Bolt (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Claimant requests reconsideration of our May 13, 1993 order which affirmed the Referee's order that upheld the SAIF Corporation's denial of his back injury claim. In reaching our decision, we concluded that SAIF's prior acquiescence to the issuance of an order designating a paying agent under ORS 656.307 did not constitute an acceptance of claimant's claim and did not preclude SAIF from subsequently denying compensability of the claim.

Relying on CNA Insurance Companies v. Magnuson, 119 Or App 282 (1993), claimant argues that ORS 656.262(6) is applicable and that SAIF can only rely on evidence regarding claimant's alleged fraudulent conduct which SAIF obtained subsequent to its "acceptance." For the reasons expressed in our prior order, we conclude that SAIF never accepted claimant's injury claim. Since there has been no acceptance of the claim, neither ORS 656.262(6) nor Magnuson is applicable. Consequently, SAIF neither has the burden of proof nor is it limited in the type of evidence it can present in defending against claimant's injury claim.

Accordingly, we withdraw our May 13, 1993 order. On reconsideration, as supplemented herein, we republish our May 13, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES E. CRAWFORD, Claimant
WCB Case Nos. 92-06569 & 92-06087
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Charles Lundeen, Defense Attorney
Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Peterson's order that: (1) set aside its partial denials of claimant's medical services claim for his current low back condition; and (2) upheld the SAIF Corporation's denial of responsibility for claimant's medical services claim for the same condition. In his brief, claimant challenges that portion of the order that declined to assess penalties for Liberty's allegedly unreasonable denials. On review, the issues are compensability, responsibility, and penalties. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We agree with the Referee's ultimate conclusion, but base our decision on the following reasoning.

In reliance upon ORS 656.005(7)(a)(B), Liberty argues that claimant's medical services claim for his current low back condition is not compensable because the major contributing cause of the current need for medical treatment is no longer the accepted lumbar strain, but rather, is attributable to a preexisting degenerative spine condition. The statute provides that:

> "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."

Claimant had mild preexisting degenerative disc disease when he sustained a lumbosacral strain while working for Liberty's insured. We disagree, however, that ORS 656.005(7)(a)(B) applies where, as here, the evidence does not show that claimant's preexisting condition has "combined" with the compensable injury to produce a "resultant condition." See, e.g., Gary Stevens, 44 Van Natta 1179 (1992).

Instead, where a claimant suffers no new injury or condition different from the accepted condition, but rather seeks continued medical treatment for that condition, the treatment is compensable if it bears a material relationship to the compensable condition. See Roseburg Forest Products v. Ferguson, 117 Or App 601, 604 (1993).

We conclude that Ferguson, supra, applies here. Liberty denies that claimant's treatment for his current low back condition is compensable, but it continues to accept claimant's lumbar strain. As in Ferguson, the present claimant is seeking further treatment for his compensable low back strain, rather than benefits for a new injury or condition different from the accepted low back condition. Thus, in order to establish the compensability of his continued medical treatment for his current low back condition, claimant only has to show that his current condition bears a material relationship to his compensable lumbar strain. See Roseburg Forest Products v. Ferguson, supra; Van Blokland v. OHSU, 87 Or App 694 (1987).

We agree with the Referee that claimant has proven the compensability of his current low back condition. The medical evidence supports claimant's assertion that his need for treatment continues to be materially related to his compensable lumbar strain. Although the independent physicians of First NW Health note that claimant's compensable injury while employed by Liberty's insured is no longer the major contributing cause of claimant's current need for treatment, they are unable to rule out the compensable injury as a material contributing cause of his need for treatment. Thus, we find that those reports support the opinion of treating physician Dodge, who has consistently opined that claimant's current back condition is work-related.

Responsibility

We affirm and adopt the Referee's conclusion and reasoning with regard to this issue.

Penalties

We affirm and adopt the Referee's conclusion and reasoning that Liberty's denials were not unreasonable.

Claimant's counsel is entitled to an assessed attorney fee for services on Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, to be paid by Liberty Northwest Insurance 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. Claimant is not entitled to an attorney fee award for that portion of his services on review which concerned the penalty issue.

ORDER

The Referee's order dated August 4, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
SHAUN M. DONOVAN, Claimant
WCB Case No. 91-18350
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Claimant requests reconsideration of our May 7, 1993 order which awarded a $500 attorney fee under ORS 656.386(1) for his counsel's pre-hearing efforts in prompting the SAIF Corporation's acceptance of his lithium treatments and psychological condition (diagnosed as organic mood syndrome). Characterizing the award as "totally inadequate," claimant asks that it be increased.

We previously detailed claimant's counsel's efforts regarding SAIF's eventual acceptance of the aforementioned treatments and psychological condition. Those efforts included the filing of two hearing requests, a February 12, 1992 letter to SAIF, and the submission of a March 18, 1992 "check-the-box" letter from Dr. Maletzky. The latter report was generated approximately one month after SAIF's February 21, 1992 acceptance of the psychological condition.

For the reasons set forth in our prior order, such efforts establish that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. See ORS 656.386(1). In addition, after consideration of those same efforts, as well as the other factors set forth in OAR 438-15-010(4) and detailed in our previous order, we continue to find that a reasonable attorney fee for claimant's counsel's efforts in obtaining the acceptance of both claimant's lithium prescription and his organic mood syndrome condition without a hearing is $500. Finally, we have also taken into account claimant's $250 attorney fee award under ORS 656.382(1) as previously granted by the Referee for SAIF's unreasonable claim processing.

In reaching this conclusion, we wish to further emphasize that we recognize the benefit secured by claimant in obtaining SAIF's acceptance of her prescription and condition. However, the issue before us is not the compensability of such matters nor the propriety of SAIF's conduct (since claimant has already been awarded a penalty-related attorney fee). Rather, our review is confined to a determination of a reasonable attorney fee for claimant's counsel's services in obtaining the pre-hearing acceptances taking into account all of the factors recited in the aforementioned rule.

As a means to assist us in rendering a determination regarding a reasonable attorney fee, a claimant's attorney may file a request for a specific fee which includes a detailed explanation regarding the justification for the fee. See OAR 438-15-029; Sam L. Hoover, 44 Van Natta 718 (1992), aff'd mem Hoover v. SAIF, 117 Or App 268 (1992). Here, claimant's counsel has not availed himself of this opportunity. Instead, counsel has submitted conclusory statements regarding the alleged inadequacy of our prior award, the severity of claimant's condition, counsel's evident assumption that the reconsideration request will be unsuccessful, and an allegation that an attorney with some other firm would have been awarded a larger fee under the same circumstances. Counsel's submission leaves us unpersuaded that the fee awarded does not constitute a reasonable attorney fee for counsel's services.

Accordingly, we withdraw our May 7, 1993 order. On reconsideration, as supplemented herein, we republish our May 7, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY A. FULLER, Claimant
WCB Case Nos. 92-02564 & 92-06252
ORDER ON REVIEW
Leo & Horton, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Schultz' order that: (1) found that claimant's thoracic strain injury claim was prematurely closed; (2) set aside its denials of claimant's aggravation claims as moot; and (3) set aside its denial of claimant's claims for current midback, neck, left shoulder and left arm conditions. With its request for review, the employer moves to reopen the record for admission of further evidence. We treat the employer's request as a motion to remand. On review, the issues are remand, premature closure, compensability and, if the claim was not prematurely closed, aggravation or extent of permanent disability. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence/remand

With its request for review, the employer requests reopening of the record for admission of additional evidence --specifically, the Referee's order, portions of the hearing transcript, two letters from claimant's attorney to Drs. Kaye and Orton and one to the Appellate Unit. Inasmuch as our review is limited to evidence already present in the record, we treat the request as a motion to remand. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). Because the proferred evidence is already present in the record, except for counsel's March 19, 1992 letters to Dr. Orton and the Appellate unit, we consider the motion only for the purpose of admitting the latter documents.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). 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, we find that the March 19, 1992 letters were obtainable with the exercise of due diligence at the time of the June 3, 1992 hearing. In addition, we do not consider the present record, without the letters, to be improperly, incompletely, or insufficiently developed. Moreover, we do not find that admission of these letters would likely affect the outcome of the case. For these reasons, the employer's motion to remand is denied.

Premature closure (aggravation/extent)

We adopt the portion of the Referee's order concerning the premature closure and aggravation issues. In addition, because the claim remains in open status, the extent of disability issue is not ripe and we do not address it.

Compensability of current condition

The Referee set aside the employer's denial of claimant's current condition, based on the opinion of Dr. Orton, treating physician. We agree and adopt the Referee's reasoning on this issue, except for the last three sentences, with the following supplementation.

At the outset, we note that, pursuant to our holding on the premature closure issue, claimant's February 1991 injury claim remains in open status. Thus, the question posed by the insurer's denial is whether the compensable injury remains a material cause of claimant's current disability and/or need for treatment. See ORS 656.005(7)(a).

The employer contends that Orton's opinion does not support compensability, because it suggests only a possible relationship between claimant's current complaints and her injury. See Gormley v. SAIF, 52 Or App 1055 (1981). We disagree.

Dr. Orton, treating physician, opined:

> "Question No. 3 [from claimant's attorney] asks whether [claimant's] complaints of pain in the mid-back area, the base of the neck, and the radiating arm pain, are consistent with, or related to, the prior injuries which I have treated. I must state that this is a possibility in this case, and after again reviewing the chart from this time period, and looking over the Physical Therapist's notes, I did find complaints of pain in this area on both my notes and his notes. I must therefore state that these are probably related, although having not seen this patient for some time I do not know whether these are exacerbated from doing something else. . . ." (Ex. 68-2).

Although Orton initially identified only a "possible" relationship, he concluded, after reviewing his chart notes, as well as those of the physical therapist, that claimant's mid-back, neck and arm pain are "probably" injury-related. (Ex. 68-2). We agree with the Referee that Orton's opinion and the record as a whole supports a finding that claimant's current condition is injury-related. Moreover, considering Orton's personal familiarity with claimant's condition, we find his conclusions are more persuasive than those of Dr. Bald, who examined claimant only once (on December 6, 1991). See Weiland v. SAIF, 64 Or App 810 (1983).[1]

In finding Dr. Orton's opinion persuasive, we note that Orton was aware of claimant's tendency to magnify or exaggerate her symptoms. Orton also posited that intervening activities may very well have contributed to flare-ups of her symptomology. Orton was nonetheless prepared to attribute claimant's current symptoms to the compensable injury, based on the nature and history of claimant's symptoms as reflected in the chartnotes. Our independent review of the record also reveals that claimant had thoracic, neck and left shoulder problems directly associated with the work injury, as well as left arm problems separately identified soon thereafter. (See Ex. 20).

In reaching our conclusion, we acknowledge that claimant did report symptoms and seek treatment following moving and camping incidents. However, based on our review of the record, we find that these events did not disrupt the chain of causation such that the work injury is no longer a material cause of claimant's current condition. As Dr. Orton opined, such events may have caused a flare-up of symptoms attributable to the compensable injury. Therefore, we conclude that claimant's current condition is compensable as it is directly related to her February 17, 1991 injury. See ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991).

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 $2,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services and respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 22, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $2,000, payable by the self-insured employer.

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[1] In reaching this conclusion, we note that our evaluation of the medical opinions is not based on a perception that employer's attorney's March 30, 1992 letter to Dr. Bald is "result-oriented." (See O&O p. 9; Ex. 62A). Rather, it is based on the thoroughness of Dr. Orton's opinion and his familiarity with claimant's history and complaints, as compared with the observations and opinion of Dr. Bald.

In the Matter of the Compensation of
TERESA A. LARA, Claimant
WCB Case No. 92-08044
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Priscilla Taylor, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee McCullough's order that dismissed her request for hearing on the basis that it was not timely filed. On review, the issues are timeliness and good cause.

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

Although we find that claimant failed, without good cause, to timely request a hearing from the insurer's denial and that therefore, the denial must be upheld, the insurer's promise set forth in the denial, to pay the two medical billings, may itself constitute an independent basis for application of the doctrine of estoppel to compel payment of those billings. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992).

ORDER

The Referee's order dated October 2, 1992 is affirmed.

In the Matter of the Compensation of
ROLLIE R. RILATOS, Claimant
WCB Case No. 92-08005
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Lipton.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of claimant's low back injury claim. On review, the issue is compensability.

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

In the alternative, claimant argues that his claim is compensable as an occupational disease. We need not decide the issue, however, because we find that claimant failed to raise this alternative theory of compensability before the Referee. Accordingly, we decline to consider it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

ORDER

The Referee's order dated September 16, 1992 is affirmed.

In the Matter of the Compensation of
JON A. ROGERS, Claimant
WCB Case No. 91-07263
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Lafky & Lafky, Attorneys
Nancy Marque (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 20, 1993, this case has been remanded for consideration of a Claim Disposition Agreement (CDA). On April 1, 1993, we approved a CDA under ORS 656.236 in which claimant released his rights to all past, present, and future compensation (except medical services) resulting from his compensable February 1986 left and right knee injuries. (WCB Case No. C3-00506). The CDA was executed by claimant, his counsel, the SAIF Corporation (as statutory processing agent for the noncomplying employer - West Scio Salvage), SAIF's representatives, and the Department of Insurance & Finance.

The present case pertains to the noncomplying employer's petition for judicial review of our order which affirmed a Referee's decision that set aside a denial of claimant's right knee condition issued by SAIF on behalf of the noncomplying employer. Jon A. Rogers, 44 Van Natta 2313 (1992). The CDA does not address the effect, if any, the disposition has on the noncomplying employer's appeal. Nevertheless, SAIF (as the noncomplying employer's statutory processing agent under ORS 656.054) has entered into an agreement which has disposed of most of claimant's rights to future benefits. Consequently, the extent of benefits flowing from the eventual compensability decision in this case has been profoundly limited as a result of the approved CDA; i.e., the sole benefit which remains viable is claimant's entitlement to medical services. See ORS 656.236(1).

Notwithstanding the aforementioned limitation, the disputed compensability issue regarding claimant's right knee condition (and the past, present, and future medical services resulting from that condition) has not been resolved by the CDA. Thus, we retain authority to decide that issue.

Turning to a reconsideration of that compensability decision, we adhere to the reasoning and conclusions expressed in our prior order. Therefore, we continue to find claimant's right knee condition to be compensable.

Accordingly, on reconsideration of our prior order, we republish our November 18, 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
MARY A. SMITH, Claimant
WCB Case No. C3-01387
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Benjamin Ross, Claimant Attorney

Reviewed by Board Members Neidig and Brazeau.

On May 20, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

ORS 656.236 permits parties, by agreement, to make "such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable," subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9). See also OAR 438-09-001(1). The underscored portion of the rule makes clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement. See Evelyn Christenson, 43 Van Natta 819 (1991).

Here, the proposed agreement refers to an attached "Exhibit A." The exhibit is not attached as referenced in the CDA; however, the agreement recites that, pursuant to Exhibit A, claimant has released all employment rights with Good Samaritan Hospital/Legacy Health Systems. See Pg. 3, sec. 12(a) and (b).

The release of employment rights, because it concerns a matter outside ORS Chapter 656, is not a proper matter for disposition under ORS 656.236 and the rules promulgated thereunder. Karen Vearrier, 42 Van Natta 2071 (1990). Therefore, we have no authority to approve a release of such rights. For those reasons, the proposed disposition is not a "claim disposition agreement" as defined by OAR 438-09-001(1). Furthermore, because the offensive portion of the disposition agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration. See Karen Vearrier, supra. Accordingly, we are without authority to approve any portion of the proposed disposition.

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.

In the Matter of the Compensation of
GREG S. MEIER, Claimant
WCB Case No. 92-08832
ORDER ON RECONSIDERATION
Larry Schucht (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 17, 1993 Order on Review that affirmed a Referee's order which set aside its denial of claimant's left leg injury claim. Specifically, SAIF reiterates its contention that the claim is not supported by medical evidence. In addition, SAIF argues that our conclusion that claimant's injury arose out of the course and scope of his employment will not sustain judicial review.

We shall address SAIF's assertions in reverse order. With supplementation, our prior order expressly adopted the Referee's order. That order contained findings of fact and provided reasoning supporting the conclusion that claimant's injury arose out of the course and scope of his employment. See Mellis v. McEwen, 74 Or App 571 (1985).

We recognize that SAIF disputes the Referee's findings and reasoning. Nevertheless, our failure to expressly address SAIF's argument does not mean that our order will not withstand a "substantial evidence" review. To the contrary, our adoption of the Referee's order signifies our concurrence with the findings, reasoning, and conclusions contained in that order. Moreover, our adoption of the Referee's decision demonstrates our conclusion that, notwithstanding SAIF's challenge, the Referee's order will sustain a "substantial evidence" review.

Finally, we address SAIF's contention that we have found claimant's injury claim to be compensable without requiring him to prove his claim by medical evidence supported by objective findings. See ORS 656.005(7)(a). SAIF mischaracterizes our decision. We did not relieve claimant of his requisite burden of proof. To the contrary, as explained in our prior order, we merely resolved the issue which was disputed at the time of hearing. That issue was identified by SAIF's counsel as follows:

> "SAIF's position is that this was an injury that did not arise out of and in the course and scope of his employment. I think the Mellis factors have to be applied here. I believe we can derive from the claimant's testimony, basically, and I think there's no dispute as to what happened here. [Claimant] was working on a -- I guess a co-employee's personal vehicle of his son, when a tire that they were trying to put on -- I think a 15-inch tire and a 14-inch rim didn't work, and it ended up exploding into his leg and causing an injury to his leg. There's no question about any of those facts. The real question is what the legal analysis is when you apply those facts to the law and whether or not there is a compensable event, and I've got some case law that I think when you analyze this, it may be a closed question but basically we don't think it arose out of and in the course and scope of his employment." (Tr. 4).

As amply demonstrated by SAIF's opening statement, it was undisputed that claimant injured his leg while changing a tire. What was disputed was whether that "tire event" arose out of and in the course of his employment as a volunteer firefighter. Such a posture was also consistent with SAIF's denial.

Considering SAIF's position up to and during the hearing, we continue to find it to be fundamentally unfair to permit SAIF to now challenge the compensability of the claim based on a lack of medical evidence. We consider this conclusion to be particularly appropriate in light of SAIF's counsel's express statement at hearing that there was no question that claimant's leg was injured as a result of the "tire event."

Accordingly, we withdraw our May 17, 1993 order. On reconsideration, as supplemented herein, we republish our May 17, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEANETTE M. ALESHIRE, Claimant
WCB Case No. 92-01255
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Spangler's order that: (1) set aside its denial of claimant's occupational disease claim for a right thumb osteoarthritis condition; (2) set aside its "de facto" denial of claimant's claim for a right thumb synovitis condition; and (3) awarded a fee of $2,500 for claimant's attorney's services at hearing in setting aside both denials. On review, the issues are compensability and attorney fees.

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

The employer argues that the opinions of Drs. Button and Nolan, both of whom are examining physicians, are more persuasive than that of Dr. Layman, treating physician. We agree with the Referee that Dr. Layman's opinion is most persuasive. We agree with the Referee's assessment of Dr. Nolan's opinion and find Dr. Button's opinion to be internally inconsistent. He opines that claimant's osteoarthritis condition is idiopathic and does not relate to her work activities. At the same time, he opines that this "idiopathic" condition is more likely related to "the everyday activities of using the thumb, such as turning on the ignition of a car, writing, twisting the top off of jars, opening doors, etc." (Ex. 18-3). It is inconsistent to opine that a condition is idiopathic, i.e. has an unknown cause, and therefore conclude that it is not related to work activities while, at the same time, opining that the cause is more likely related to everyday activities, thus, in effect, stating that the cause is not idiopathic.

In contrast, Dr. Layman explained that the pinch pressure type of work that claimant has repetitively done over the last several years "significantly increases the load at the first carpometacarpal joint" which accelerates any tendency to the formation of osteoarthritis at that joint. (Ex. 22-2). The employer argues that Dr. Layman's opinions only support an increase in symptoms which is insufficient to establish a compensable occupational disease. We disagree with this assessment of Dr. Layman's opinions. As noted above, Dr. Layman explains that the increase in the underlying pathology makes the condition symptomatic, he does not opine that there was only an increase in symptoms. (Ex. 22).

Regarding the synovitis condition, the employer argues that the condition it accepted, "disabling right wrist tendonitis," is identical to "synovitis." In support of its argument, the employer relies on a definition of "synovitis" in the Dorland Medical Dictionary. It also argues that the Referee erred in not taking administrative notice of the Dorland's definition of "synovitis," and instead citing a definition from another medical dictionary. We need not go outside the record to decide this issue. Dr. Griffin, M.D., initially treated claimant's right thumb condition and explicitly denied that claimant had a diagnosis of "right wrist tendonitis." (Ex. 9-2). Instead, he stated that claimant's diagnoses included "synovitis of the right thumb metacarpal-carpal joint secondary to cumulative trauma [and] degenerative arthritis of the right thumb matacarpal-carpal [sic] joint." Id. Dr. Griffin's opinion is unrebutted. Therefore, we conclude that "right wrist tendonitis" and "synovitis of the right thumb metacarpal-carpal joint" are not synonymous.

Finally, the employer argues that the attorney fee assessed by the Referee was excessive. We disagree. As noted above, we do not find claimant's "synovitis" condition to be the same as the "right wrist tendonitis" condition accepted by the employer. Therefore, we reject the employer's argument that claimant's attorney gained no benefit for claimant in getting the employer's "de facto" denial of the synovitis condition set aside. After applying the factors set forth OAR 438-15-010(4), we agree with the Referee that a reasonable fee for claimant's attorney's services at hearing regarding the compensability issues is $2,500.

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 issues is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

We note that claimant is not entitled to an attorney fee for defending against attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 22, 1992 is affirmed. For services on review concerning the compensability issues, claimant's counsel is awarded $1,000, payable by the self-insured employer.

June 9, 1993 Cite as 45 Van Natta 1017 (1993)

In the Matter of the Compensation of
JOHN L. DESMOND, Claimant
WCB Case Nos. 91-17961 & 92-01632
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Hazelett's order that: (1) set aside the SAIF Corporation's denial of claimant's upper low back injury on behalf of Partooze Construction (SAIF/Partooze); and (2) set aside SAIF's denial of claimant's current low back condition at L5-S1 on behalf of the noncomplying employer (SAIF/NCE). In its respondent's brief, SAIF/Partooze argues that the Referee's assessed attorney fee against it is excessive. In claimant's reply brief, he argues that the Referee's assessed attorney fee against SAIF/Partooze is inadequate. On review, the issues are responsibility and attorney fees.

We affirm and adopt the Referee's order. See ORS 656.308(1); Rodney H. Gabel, 43 Van Natta 2662 (1991) ("same condition," under ORS 656.308(1), means identical condition).

Regarding the attorney fee issue, the Referee applied the factors set forth at OAR 438-15-010 and determined that $1,000 represented a reasonable fee for claimant's attorney's services regarding the compensability issue against SAIF/Partooze. The Referee particularly noted the time and effort devoted to the case and the value of the benefit obtained for claimant. Applying the same factors, we reach the same result and conclude that $1,000 is a reasonable fee for claimant's attorney's services at hearing regarding the SAIF/Partooze compensability issue.

Claimant is not entitled to an attorney fee on review because he did not prevail regarding his argument that SAIF/Partooze should be responsible for claimant's entire low back condition because the separate injuries injured the same general area of the body. See ORS 656.386(1). Also, we note that claimant is not entitled to an attorney fee for defending against the attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated August 14, 1992 is affirmed.

In the Matter of the Compensation of
MELBA P. DOUGHERTY, Claimant
WCB Case No. 92-01263
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

The SAIF Corporation requests review of Referee Michael V. Johnson's order which increased claimant's scheduled permanent disability award for loss of use or function of the left foot (ankle) from 2 percent (2.7 degrees), as awarded by Order on Reconsideration, to 7 percent (9.45 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also adopt the Referee's finding that claimant is a credible witness. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant an additional 5 percent impairment due to a chronic condition based on claimant's testimony and the report of a panel of medical arbiters. We disagree.

Claimant may be entitled to an award for impairment due to a chronic condition "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 . . . ." Former OAR 436-35-010(6) (WCD Admin. Order 2-1991). Any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings. Jill C. Van Horn, 44 Van Natta 1523, 1524 (1992); see also former OAR 436-35-010(1); William K. Nesvold, 43 Van Natta 2767 (1991). When, on reconsideration, a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Former OAR 436-35-007(9).

A panel of medical arbiters was appointed on reconsideration. They found that claimant's waxing and waning of ankle pain was a chronic condition arising out of her work injury. (Ex. 11-3). However, they also found that claimant "is able to use the ankle repeatedly with intermittent pain." Id.

The preponderance of medical opinion, as well as claimant's testimony, establish that claimant is able to repetitively use her left foot and ankle, albeit accompanied by intermittent pain, numbness and tingling. (See Ex. 11, Tr. 3-4). Accordingly, we conclude that claimant is not entitled to an award for permanent impairment due to an inability to repetitively use her left ankle.

ORDER

The Referee's order dated April 20, 1992 is reversed. The Order on Reconsideration dated January 17, 1992 is affirmed.

Board member Hooton dissenting.

The majority decides this case on the basis of the factual determination that claimant has not established that she experiences any limitation of repetitive use. The preponderance of the evidence, and the specific findings of fact made by the Referee and adopted by the majority, are to the contrary. Indeed, the only evidence regarding actual limitation is presented by claimant and is uncontroverted. Consequently, I must conclude that no reasonable trier of fact could reach the conclusion that the majority does reach, and that, therefore, the majority opinion is not supported by substantial evidence in the record as a whole. Moreover, as I will demonstrate, the majority opinion is not supported by any evidence in this record, but rather relies solely upon a bare legal conclusion rendered by a physician which is contrary to the evidence and to the law.

The majority adopts the Referee's findings of fact. To clarify the inadequacies of the present order all one need do is examine those findings. The Referee, and the majority here, find as follows:

> "As of the date of Reconsideration, claimant was unable to walk on the full sole of her left foot, but rather, could only walk on the side of her foot. She had chronic numbness and pain extending from the left foot all the way up into her hip. As a result of the chronic condition, she has had to trade in her manual transmission automobile for an automatic transmission automobile because to flex her foot in operation of the clutch caused intolerable pain. If claimant sits very long she has to elevate her foot, or else the entire left leg goes numb. She also enjoys dancing, and she recently tried to dance with her son, but suffered greatly increased pain in the aftermath of the dance and has decided to never again try to dance. She also tried to climb a ladder, and had to immediately discontinue that because the pressure on her left foot caused intolerable pain." (Opinion and Order p. 2, emphasis added.)

These findings indicate that claimant is unable to perform such repetitive activities as walking (without the adoption of an antalgic gait), clutching, climbing and dancing. These findings are based on claimant's testimony at hearing, which is uncontroverted in the present record. In addition, the majority specifically adopts the Referee's finding that claimant is a credible witness, depriving the majority of the argument that claimant's testimony is unpersuasive.

Each of the limitations expressed by claimant derive from her residual pain. Regarding that pain, and despite a return to regular work, claimant's treating physician stated as follows:

> "...Her symptoms seem to have persisted and have not responded to usual and customary measures for ankle sprain. This does raise the possibility that her ankle discomfort may not be the result of pathology within the ankle itself but could be the result of neural impingement proximal to that point. Up until the time of this accident I know the patient has demonstrated a good work ethic and I believe that she really does have persistent pain although we have been unable to delineate the source of her symptoms." (Ex. 8-1, emphasis added.)

This statement by the treating physician is sufficient to provide the objective medical evidence, required by statute and rule, of a chronic pain syndrome limiting use. Georgia Pacific v. Ferrer, 114 Or App 471 (1992).

The findings of the panel of medical arbiters are consistent with the findings of the treating physician. The panel of medical arbiters found that claimant suffers from a chronic pain condition in the ankle. (Ex. 11-3.) They further found, in particular, that claimant:

> "...has a burning type of pain, which starts on the lateral aspect of the foot, just below and anterior to the lateral malleolus and goes up the lateral aspect of the leg all the way to the upper thigh. This comes on if she uses the left foot for braking or if she goes up and down stairs the wrong way and sometimes even the weight of the covers in bed pulls her foot down. She is now walking on the outside of her foot and states that on occasion, she can work an entire shift without trouble and the next time have considerable discomfort.
>
> "* * *
>
> "Examination of the ankle reveals a slow gait with a limp on the left. . . . Weight bearing is more on the right." (Ex. 11-2).

While it is true that the panel of medical arbiters concluded that claimant "is working, at the present time, so she is able to use the ankle repeatedly with intermittent pain," that finding is based on the inappropriate legal conclusion that a capacity to perform regular work is determinative in the rating of scheduled disability. That legal conclusion is, quite simply, wrong. The only concern in scheduled disability cases is actual loss of use or function. ORS 656.214(1) & (2); Paul E. Denue, 42 Van Natta 44 (1990). That loss may affect regular employment, requiring modification of work activities; it may only affect activities of daily living; or it may have no practical affect on claimant's abilities at all, such as a small loss of range of motion in a single joint in a single digit. Nevertheless, if the loss of use or function is actually present, claimant is entitled to compensation. The panel of medical arbiters, the treating physician and claimant all agree that a loss of use or function due to pain is present. The only dispute is whether it affects her ability to perform her regular work, a factor that is irrelevant to our determination.

Claimant's inability to walk normally, to climb, clutch, brake or dance are all indicative of a loss or limitation in repetitive use. I would, therefore, affirm the order of the Referee in all respects.

In the Matter of the Compensation of
ELIAS S. JONES, Claimant
WCB Case No. 92-05585
And, In the Matter of the Complying Status of
SPITULSKI ENTERPRISES, Noncomplying Employer
WCB Case No. 92-02272
ORDER DENYING MOTION TO DISMISS
Scheminske & Lyons, Claimant Attorneys
O'Connell, et al., Defense Attorneys
Larry D. Schucht (Saif), Defense Attorney

Claimant has moved for an order dismissing a request for Board review filed by Spitulski Enterprises, an alleged noncomplying employer. Claimant contends that Spitulski should have appealed directly to the Court of Appeals. We deny the motion.

FINDINGS OF FACT

On December 6, 1991, the Department issued an order finding Spitulski to be a noncomplying employer. On January 15, 1992, Spitulski issued a "Notice of Claim Denial," advising claimant that it was denying his injury claim because he was not a subject worker.

In February 1992, Spitulski requested a hearing regarding the Department's noncomplying employer order. In April 1992, claimant also filed a hearing request raising the following issues: (1) noncomplying employer; (2) subject employer / subject employee; and (3) penalties and attorney fees. Each hearing request was assigned a WCB Case Number. The cases were consolidated for purposes of hearing.

At the hearing, the Referee further clarified the issues. The Referee acknowledged that Spitulski was contesting the Department's noncomplying employer order. The Referee further noted that the SAIF Corporation had accepted claimant's injury claim on behalf of the alleged noncomplying employer. Nevertheless, noting that Spitulski had issued a denial of claimant's injury claim, the Referee stated that claimant had requested a hearing from that denial. The Referee further clarified that Spitulski was not raising compensability as an issue, but was only contesting whether it was a subject employer for claimant. Finally, claimant's counsel added that claimant was seeking a penalty for an unreasonable denial.

Following the hearing, the Referee issued a February 24, 1993 order which reached the following conclusions. Concluding that claimant was not an independent contractor, the Referee found that claimant was a subject worker and that Spitulski was a noncomplying employer. Consequently, the Department's Order of Noncompliance was affirmed. In addition, the Referee set aside the employer's denial and awarded a $2,200 attorney fee. Reasoning that the employer's denial had a legitimate basis, the Referee declined to assess a penalty.

The Referee's findings and conclusions were contained in one order, which carried both WCB case numbers. Spitulski requested Board review within 30 days of the Referee's February 24, 1993 order.

CONCLUSIONS OF LAW

We lack appellate jurisdiction to review a Referee's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); Ferland v. McMurtry Video Productions, 116 Or App 405 (1992); William K. Kennedy, 45 Van Natta 12 (1993); Spencer House Moving, 44 Van Natta 2522 (1992). However, when an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim 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. ORS 656.704(3).

Here, Spitulski stipulated that it was not contesting the compensability of the claim. Nevertheless, the hearing was not confined to consideration of the Department's noncomplying employer order. Rather, the hearing also included Spitulski's denial of the claim, as well as claimant's request for penalties and attorney fees regarding that denial.

Since Spitulski's denial had the potential of directly affecting claimant's right to receive compensation and the Referee's order addressed that issue (as well as the penalty and attorney fee issues arising from that denial), we conclude that review of the order shall be conducted as provided for a matter concerning a claim. ORS 656.704(3); 656.704(4)(c). Such a procedure necessarily involves Board review of the Referee's order pursuant to ORS 656.289(3) and 656.295. Donna M. Hooper, 41 Van Natta 373 (1989).

Accordingly, the motion is dismiss is denied. As a result of this motion, the briefing schedule shall be revised as follows. Claimant's respondent's brief shall be due 21 days from the date of this order. Spitulski's reply brief shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

June 9, 1993 Cite as 45 Van Natta 1021 (1993)

In the Matter of the Compensation of
CHARLES S. KARAM, Claimant
WCB Case No. 91-03920
ORDER ON REVIEW
Brownstein, Rask, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's right ankle condition 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

In July 1986, claimant compensably sprained his right ankle. After claim closure, an April 1987 Determination Order awarded claimant 10 percent scheduled permanent disability. In November 1990, claimant again sought treatment for right ankle symptoms and was eventually diagnosed with reflex sympathetic dystrophy (RSD). He seeks compensation for this condition.

In finding that claimant had proved compensability, the Referee characterized the claim as one for aggravation. Therefore, the Referee reasoned that claimant must prove that his compensable injury was materially related to his worsened condition. The employer challenges this characterization, asserting that the claim properly should be analyzed under ORS 656.005(7)(a)(A) as a secondary consequential condition. We agree.

In order to prove a compensable aggravation, claimant must show, inter alia, a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be compensable. We determine whether the worker's current condition is compensable, and if it is, whether that condition has worsened. Bertha M. Gray, 44 Van Natta 810 (1992); Marie M. Sax, 44 Van Natta 2152 (1992). Here, the parties agree that claimant has sustained a compensable aggravation if his current condition is compensably related to the industrial injury.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. Albany General Hospital v. Gasperino, 112 Or App 411 (1992). On the other hand, when a condition or need from treatment is caused by the compensable injury, a worker must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

The record contains five opinions regarding claimant's condition. Dr. Ho, an osteopath who treated claimant's ankle symptoms through May 1991, first stated that claimant was "suffering an inflammatory disturbance at his ankle which I believe is related to his industrial injury" and then reported that claimant's work "was directly related to the production of his right ankle discomfort[.]" (Ex. 34A). Dr. Ho's diagnosis was capsulitis and osteitis. (Ex. 34). Dr. Ho supports a conclusion that claimant's ankle symptoms are compensable. However, considering his varying theories regarding the symptom's relationship to claimant's injury and work, we do not find it persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Ho referred claimant to Dr. Heusch, osteopath, who diagnosed claimant's condition as probable reflex sympathetic dystrophy (RSD). (Exs. 36, 37). Dr. Heusch recommended that claimant undergo a sympathetic lumbar block. This procedure was performed and claimant experienced some relief from his right ankle symptoms. Dr. Heusch did not offer an opinion regarding the causation of claimant's condition.

Dr. Gambee, orthopedist, originally treated claimant's ankle sprain and reevaluated him in March 1991. Noting that a bone scan had been abnormal, Dr. Gambee reported that such a result was not related to his ankle sprain. (Ex. 30-2, 35). Dr. Gambee also expressed doubt regarding the diagnosis of RSD. (Ex. 30-2).

Drs. Lohman and Marble, orthopedic surgeons, and Dr. Rich, neurologist, conducted an independent medical examination. The panel found no evidence suggestive of RSD and reported that the "etiology of his ongoing painful complaints are unclear." (Ex. 41-5, 43-1, 44-1). Like Dr. Gambee, the panel concluded that the abnormal bone scan was not related to the industrial accident and that it represented a "new process." (Id).

Finally, Dr. Farris, claimant's current treating physician, examined claimant's ankle on two occasions. He agreed with the diagnosis of RSD and found that it was caused by the 1986 ankle sprain. (Ex. 46-1). Dr. Farris based this opinion on claimant's history of chronic pain since the industrial accident, (Ex. 47-21), the abnormal bone scan, and the failure to relieve claimant's symptoms with a lumbar block, (id. at 29).

Claimant alleges that he suffers from RSD. The medical evidence establishes that claimant's current condition of RSD is separate from his original compensable strain. (Ex. 46-1). In addition, the medical evidence supporting compensability indicates that the accepted ankle sprain and subsequent low-grade pain and not the July 1986 industrial accident itself, was the cause of the RSD. (Exs. 46-1, 47-15). Therefore, claimant must prove that the compensable ankle sprain is the major contributing cause of his RSD in order to prove compensability. Albany General Hospital v. Gasperino, supra.

When there is a dispute among medical experts, we give more weight to those opinions that are well-reasoned and based on complete information. See Somers v. SAIF, supra. Under this test, we find that Dr. Farris' opinion is the most reliable. As provided above, he gives a well-reasoned explanation for his opinion, in contrast to the opposing medical experts who provide no reasons for their rejection of the diagnosis of RSD in the face of claimant's continuing symptoms and abnormal bone scan.

In relying on Dr. Farris, we acknowledge that he does not expressly state that the compensable ankle sprain is the major contributing cause of claimant's RSD. Nevertheless, medical evidence is not required to consist of a specific incantation or mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, 77 Or App 412, 417 (1986). We find that Dr. Farris' opinion supports a direct relationship between claimant's compensable ankle sprain and his RSD condition. Therefore, we conclude that claimant proved that the 1986 industrial accident was the major contributing cause of his ankle condition.

Finally, because the employer requested review and the Board did not disallow or reduce the compensation awarded to claimant, claimant's counsel is entitled to an assessed fee. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 6, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
MARY S. LEON, Claimant
WCB Case No. 91-10413
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by the Board en banc.

The insurer requests review of Referee Leahy's order that: (1) found that the Hearings Division has jurisdiction to review the Director's order denying approval of palliative care; and (2) set aside its de facto denial of claimant's palliative care. On review, the issue is jurisdiction. We vacate.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

ORS 656.245(1)(b) provides that if a worker's attending physician believes that palliative care which is not otherwise compensable under the statute is appropriate to enable the worker to continue current employment, the attending physician must request approval from the insurer for such treatment. If the approval is not granted, the attending physician may request the Director's approval for such treatment. Id.

After reviewing the palliative care request, the Director issues a final order approving or disapproving the treatment. OAR 436-10-041(10). Administrative review of the Director's order is expressly subject to OAR 436-10-008(6). OAR 436-10-041(11). OAR 436-10-008(6) provides, in relevant part, that "[o]nly the insurer or attending physician aggrieved by an order approving or disapproving palliative care to enable an injured worker to continue current employment may request review by the director."

On March 28, 1991, Dr. Mitchell, claimant's attending physician, submitted to the insurer a request for palliative treatment to enable claimant to continue employment. The request was denied. Thereafter, Dr. Mitchell requested Director approval of the treatment. On May 17, 1991, the Director's Medical Advisor, Dr. Craig, issued a Palliative Care Order that disapproved the treatment on the grounds that it is not related to the compensable injury and is not necessary to enable claimant to continue current employment. (Ex. 33). On May 26, 1991, Dr. Mitchell made a second request for palliative treatment to enable claimant to continue employment. That request was also denied by the insurer. Dr. Mitchell requested Director approval, which was denied by Dr. Craig's Palliative Care Order dated July 24, 1991. (Ex. 36).

On August 5, 1991, claimant's counsel filed a request for administrative review of the May 17, 1991 Palliative Care Order. (Ex. 36A). The request was not accompanied by any report from Dr. Mitchell. On August 7, 1991, the Workers' Compensation Division responded that only the attending physician may request Director review of the order. (Ex. 37). Dr. Mitchell did not request administrative review. Instead, claimant's counsel filed a request for hearing on the May 1991 Palliative Care Order with the Hearings Division. At hearing, the insurer moved for dismissal of claimant's hearing request for lack of jurisdiction.

The Referee found that the Director's administrative review procedures do not allow claimant to seek review of the Director's decision disapproving palliative treatment, but concluded that those procedures violate the intent of ORS Chapter 656. The Referee denied the insurer's motion to dismiss and set aside what he characterized as the insurer's de facto denial of palliative care.

Subsequent to the Referee's order, we held in Rexi L. Nicholson, 44 Van Natta 1546 (1992), that the Board and Hearings Division lack jurisdiction to review a Director's order issued in response to an attending physician's request for approval of palliative care, because review of such matters rests exclusively with the Director. We based this conclusion on the statutory scheme provided in ORS 656.245(1)(b) and 656.327(3), as well as legislative history concerning medical services in general and palliative care in particular. Based on Nicholson, therefore, we conclude that the Referee lacked jurisdiction of claimant's request for hearing concerning the Palliative Care Order.[1]

Given our conclusion that we lack jurisdiction of this matter, we do not have the authority to address claimant's argument that ORS 656.245(1)(b) and OAR 436-10-008(6) violate her constitutional rights to equal protection and due process.[2] Accordingly, we vacate the Referee's order and dismiss claimant's hearing request.[3]

ORDER

The Referee's order dated December 17, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

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[1] In Nicholson, we recommended construing ORS 656.245(1)(b) to allow the injured worker to request Director review of proposed palliative care, subject to the requirement that the request be supported by an explanatory report from the worker's attending physician. 44 Van Natta at 1548. While we continue to recommend that statutory construction, we also recognize that administration of palliative care review is a matter solely within the Director's jurisdiction; it is not a matter for the Board to decide.

[2] Member Gunn notes that his dissent in Nicholson avoided the constitutional question by concluding that claimants have a remedy under ORS 656.327(2). However, the Nicholson holding and the doctrine of stare decisis bind him to join in the majority's conclusion that the Board lacks jurisdiction of the Director's Palliative Care Order. Lacking jurisdiction to review this palliative care dispute, he likewise must join in the majority's conclusion that the Board lacks authority to reach the constitutional issue in this matter.

[3] In her brief on review, claimant also argues that the insurer de facto denied the requested palliative care on the ground that it is not related to the compensable injury. Regardless of whether the disputed palliative care is related to the compensable injury, jurisdiction of this dispute did not vest with the Hearings Division, because the dispute arose from the Director's Palliative Care Order issued pursuant to ORS 656.245(1)(b). By disapproving the palliative care, the Director effectively determined that the care is not compensable. While we acknowledge that the Director's Palliative Care Order was based, in part, on the conclusion that the requested palliative care is not related to the compensable injury, the order was also based on the conclusion that the palliative care does not enable claimant to continue current employment. Given the fact that we lack jurisdiction to review the order, the Director's consideration of the causal relationship, even if error, does not grant us jurisdiction, where none exists, to review his order. Further, even if we were to find that the causal relationship issue is properly before us, our resolution of that issue would not entitle claimant to palliative care in light of the Director's disapproval order.

Board Members Hooton and Kinsley dissenting.

We find that the appeal procedure provided in the second and third sentences of ORS 656.245(1)(b), as well as the corresponding rules at OAR 436-10-008(6), 436-10-041(2) through (5), (8), (9) and (11) (WCD Admin. Order 32-1990) are invalid because they violate "due process" and "equal protection" rights found in the Oregon and the United States Constitutions. These protections require state statutes to: (1) provide to each person the due process of law when state action deprives a person of life, liberty or property; and (2) ensure that each person shall have equal protection of the law. Because the procedure is invalid, it is a nullity and, as a result, there is no procedure "otherwise provided" to the parties as that term is used in ORS 656.704(3). Therefore, the Workers' Compensation Board, including the Hearings Division, retains jurisdiction to provide a forum for resolution of this case pursuant to ORS 656.283.

We further find that, apart from the issue of whether ORS 656.245(1)(b) and relevant administrative rules are invalid, the "compensability" or causal relationship of the requested medical treatment to the compensable injury is an issue over which the Workers Compensation Board, including the Hearings Division, has retained jurisdiction. Michael A. Jaquay, 44 Van Natta 173 (1992). We find that this issue was properly raised by claimant in this case and should be decided.

Therefore, we agree with the Referee that the Board has jurisdiction to decide all the issues presented in this case.

CONSTITUTIONAL ISSUES

ORS 656.245(1)(b) states:

> "Notwithstanding paragraph (a) of this subsection, after the worker has become medically stationary, palliative care is not compensable, except when provided to a worker who has been determined to have permanent total disability, when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition or to monitor the status of a prosthetic device. If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment." (Emphasis added.)

In this case, claimant was requesting palliative medical services to enable her to continue her current employment. By the express terms of the statute, claimant is excluded from requesting this palliative care from the insurer or participating in the appeal of an adverse decision to the Director. Similarly, the above-cited administrative rules exclude claimant from any participation in the process, but only allow an attending physician to request approval for the treatment and to make an appeal of an adverse decision by the insurer to the Director of the Department of Insurance and Finance.

Claimant argues that the procedure in ORS 656.245(1)(b) and these rules is unconstitutional because these laws violate her right to procedural and administrative due process and equal protection of the law.

DUE PROCESS

We agree with claimant that both the statute and the rules, by the clear meaning of the terms therein, violate claimant's right to due process.

We have previously discussed our reasons in the dissenting opinion in Rexi L. Nicholson, 44 Van Natta 1546 (1992). There, we found that when a procedure excludes the party seeking relief, that party has no procedure available other than the traditional right to a full hearing before the Board. ORS 656.704(3). The constitutional provisions which provide for "due process" and "due course of law" prohibit state action which deprives a person of life, liberty or property without due process of law. US Const Amend XIV, §1; Or Const Art 1, §10. "Property" includes not only tangible property interests, but also those created by statute in the way of entitlement to certain interests in benefits. The Oregon Court of Appeals recognized that temporary disability benefits are a property interest entitled to due process protections. Carr v. SAIF Corporation, 65 Or App 110 (1983).

The test to determine whether a due process right is created is to determine whether "the recipients' claims of entitlement to the benefits are grounded in the statutes defining eligibility for them." Carr, supra, 65 Or App at 117. We recognize that recent legislative changes limit a claimant's entitlement to palliative medical care. However, a claimant remains entitled to such palliative care under ORS 656.245(1)(b):

(1) when he or she is permanently and totally disabled;

(2) when necessary to monitor prescription medication required to keep the worker medically stationary;

(3) when necessary to monitor the status of a prosthetic device; and

(4) when the palliative care is appropriate to enable the worker to continue current employment.

Here, as in Rexi L. Nicholson, supra, claimant seeks to establish that she is specifically entitled to palliative care by the terms of subsection (4). There is no doubt in this case that claimant's attending physician believes that palliative care is appropriate to enable her to continue current employment. We, therefore, conclude that, because the entitlement to benefits is grounded in ORS 656.245(1)(b) which defines eligibility, claimant is entitled to due process as a matter of constitutional law.

The minimal process that is due includes notice of the contemplated state action, a meaningful opportunity to be heard and an impartial decision maker. However, given the importance to a claimant of receiving medical care necessary to maintain current employment so that claimant can provide for herself, in our view, the process that is due is a hearing before the Board which allows full participation by all parties. The summary procedures before the Director completely exclude claimant from participation. See OAR 436-10-008(6) and 436-10-041.[1]

While it is a useful fiction to say that the attending physicians are representative of the interests of claimants and, therefore, can adequately address these issues, the conflict in individual interests is sufficiently severe that serious questions remain. As the Referee in this case noted, "[c]laimant's doctor's job is to heal, not to battle adversarial bureaucracy." (Opinion and Order at 4). It is clear in this case that the attending physician became quite frustrated with the months of battling the "adversarial bureaucracy." An attending physician may neither have the legal and administrative expertise, the same incentives nor the necessary time to pursue approval for treatment on behalf of a claimant. Clearly, an attending physician does not stand in the same shoes as a claimant and, therefore, the claimant does not obtain due process of the law because the attending physician is included in the process.

It is clear that the administrative rules are applying ORS 656.245(1)(b) in a manner that excludes claimant from the process in this palliative care matter. Because claimant is not entitled to notice or an opportunity to meaningfully participate in the proceeding, but must rely, instead, upon the benevolence of the attending physician, who clearly does not have interests identical to claimant, to fully pursue the matter, the proceeding established in ORS 656.245(1)(b) and the corresponding administrative rules are not sufficient to withstand constitutional scrutiny and are invalid.

While the majority opinion does not directly respond to the constitutional arguments presented in this case, its reliance on Nicholson appears to be an affirmation of its brief commentary on the constitutional arguments presented there. Otherwise, it has failed to address the constitutional issues specifically raised in the present case by claimant which, if successful, would give the Board jurisdiction to decide the matter. Since the majority has concluded that the Board does not have jurisdiction, it must also have concluded that ORS 656.245(1)(b) is not violative of due process rights as it has construed the statute. In Nicholson, the majority stated its position as follows:

> "[A]ssuming, as the dissent contends, that the new procedure is unconstitutional (because the injured worker's physician, but not the injured worker, may request Director review), it would not be necessary or appropriate for the Board to declare the statute invalid and assert jurisdiction. Rather, our first duty would be to interpret the statute in such a way as to avoid the unconstitutionality without obstructing the legislature's central purpose. This could be done by construing the statute to allow the injured worker to request Director review subject to the requirement that the request be supported by an explanatory report from the worker's treating physician. Since there is a less drastic alternative available which would be consistent with the legislative intent, the appropriate action for the Board would not be to declare the statute invalid in toto and assert jurisdiction as though the statute did not exist." Nicholson, supra, 44 Van Natta at 1548 (emphasis added).

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[1] We also note that the rules do not allow the insurer to directly provide any information to the Director prior to the issuance of its order in the initial review procedure. See OAR 436-10-041. Also, neither the insurer nor the attending physician have a guaranteed right to provide information during the second review procedure by the Director:

> "In the course of said review the person conducting the review may require or allow such input or information from the parties or others as he or she deems to be helpful." OAR 436-10-008(6)(c) (Emphasis added.)

We agree that our first duty is to construe the statute in a manner that avoids constitutional questions whenever possible, given the legislature's intent and purpose. However, that duty does not include rewriting the statute to include a party that, by its terms, was specifically excluded by the legislature. Although we understand the majority's desire to render the statute constitutional by including the claimant, the majority has cited no legislative history which supports its version of ORS 656.245(1)(b). Only the legislative branch of our government has the power to write statutes. As tempting as it is to rewrite the statute ourselves, we should leave that task to those good women and men who were elected by the people to perform that task.

EQUAL PROTECTION

Claimant raises as an additional issue the question whether ORS 656.245(1)(b) violates the principles of equal protection and is, therefore, unconstitutional.

On its face, by the specific exclusion of claimants, ORS 656.245(1)(b) is violative of Article I, section 20, of the Oregon Constitution and the Fourteenth Amendment, Section 1, of the United States Constitution which prohibit laws granting privileges or immunities to any class of citizens which are not available to all citizens upon the same terms. Further, however, the majority's reinterpretation of that statute to permit claimant's access on the condition that claimant first provide a supporting physician's report is, likewise, violative of equal protection principles.

Although that reinterpretation would permit a claimant access to the forum, it also establishes a barrier to access, or precondition, which is not borne by the attending physician or the insurer. The right to equal protection of the law prohibits laws granting privileges or immunities to any class of citizens which are not available to all citizens upon the same terms.

Claimants are individuals who have sustained an injury or disease arising out of an employment exposure. They, as well as attending physicians and insurers, are a group of individuals that is identified by virtue of antecedent personal or social characteristics wholly apart from the statute in question. State ex rel Borisoff v. Workers' Compensation Board, 104 Or App 603 (1990). Each of these groups may have an interest in the outcome of the proceeding before the insurer and the Director. That proceeding certainly affects the physician's right to receive payment or to render treatment he or she deems appropriate and necessary. The insurer, who has to pay the claim on behalf of the employer, also has an interest. The claimant, whose entitlement to treatment is tied to her ability to continue employment, certainly has an interest. Nevertheless, the statute fails to treat each of these groups equally, but provides a remedy for attending physicians and insurers which is not also available to claimants.

Just as providing claimant's attending physician access to the forum does not provide due process rights to claimant, neither does it provide the claimant with equal protection of the law. Clearly, an attending physician does not have interests identical to the claimant and cannot be expected to be her legal representative before the law.

We recognize that equal protection rights will not be applied to invalidate a procedure when a member of the excluded group can bring itself within the protected group. Peacock v. Veneer Services, 113 Or App 732 (1992). However, that consideration has no significance here. Claimants can become neither their attending physicians nor the insurers.

Therefore, we conclude that ORS 656.245(1)(b) is invalid because it violates claimant's equal protection rights. Further, the solution posed by the majority in Nicholson and apparently adopted by the majority here, adds to that violation by creating an additional requirement for claimant not borne by the other parties. The best solution in this case is to declare the procedure in ORS 656.245(1)(b) and the corresponding rules to be invalid. In this way, the claimant and the insurer would be entitled to a full hearing at the Board to resolve their disputes, until and unless the legislature devises another procedure before the Director that meets the due process and equal protection requirements.

APPLICABILITY OF ORS 656.327(2)

In response to the concurrence in footnote 2 of the majority opinion which states that application of ORS 656.327(2) avoids the constitutional questions discussed above, we disagree. Even if it were possible for the parties to invoke the appeal procedure set out there, that procedure is also unconstitutional.

The parties' rights of participation in the review process under ORS 656.327(2) have been established in Iola W. Payne-Carr, 44 Van Natta 2306, on recon 45 Van Natta 335 (1993). That appeal process begins when the Director creates a "record" in which the parties are not guaranteed any opportunity to participate in the gathering, presentation or admission of the evidence that is contained in the "record." Further, the parties are not permitted to present any evidence either supporting, opposing or supplemental to the Director's "record" in the subsequent "hearing" conducted by the referee. Finally, the referee may only disturb the Director's order if it is not supported by substantial evidence in the "record" which was prepared by the Director. Although the parties are given notice of the Director's review and the subsequent Board hearing, there is no meaningful ability to participate in the procedure due to the lack of a means to provide evidence to the Director for the "record" and the inability to introduce any evidence at "hearing."

For these reasons and for the other reasons set out in that dissenting opinion, we find that the review process envisioned by the decision in Payne-Carr is violative of the due process rights of all the parties. Payne-Carr, supra, 45 Van Natta at 337.

EX POST FACTO

We are not persuaded by the claimant that ORS 656.245(1)(b) is a prohibited ex post facto law. The analysis of the Supreme Court in Hall v. Northwest Outward Bound School, 280 Or 655 (1977) is both persuasive and binding precedent on that question. Claimant argues that all that must be established to show a prohibited ex post facto law is a showing that the law is retrospectively applied, and that it disadvantages the parties affected by it. Those principles are applicable with regard to penal laws, but Article I, section 21 of the Oregon Constitution has not been applied where civil laws are at issue. Further, although Article I, section 10 of the United States Constitution may apply to some vested proprietary interests, claimant cites no authority, nor have we discovered any authority, that would apply those principles to the statutory rights created in ORS Chapter 656. Generally, where a remedy is created by statute, it may also be amended or removed by legislation action. The legislature is not restricted in its ability to amend a legislatively created remedy in a retrospective manner. Id. at 662. Further, the court will not apply a statute retrospectively absent a clear expression of legislative intent that it do so. Barrett v. Union Oil Distributors, 60 Or App 483, 486 (1982). This relates only to the question of fairness as to the parties affected, but does not reach the question of the constitutionality of retrospective application.

We recognize the essential unfairness that can result from a retrospective application of statute. In Ida M. Walker, we declined to apply the provisions of ORS 656.245(1)(b) to a palliative care dispute. In that case, the application of the statute would have required the claimant to comply with an administrative requirement of preauthorization of medical care which did not exist at the time the services were rendered. That is not the case here. Claimant has not shown that any services in dispute were rendered prior to July 1, 1990, or that it was impossible for her to comply with the requirements of the statute in the manner set forth. In fact, our discussion above recognizes that there were no procedures in the statute which the claimant could follow.

BOARD JURISDICTION ON THE ISSUE OF COMPENSABILITY

In her request for hearing, claimant specifically raised the issue of de facto denial of medical services. (August 5, 1991 Request for Hearing.) The issue of de facto denial of medical care was raised again at the hearing. (Tr. 2.) Both the May 17, 1991 and the July 24, 1991 orders were put in issue on this point. (Tr. 2, 12.) The issue was acknowledged by the insurer. (Tr. 4.) It is clear to us that the causal relationship issue was raised, is properly before us and should be decided on the merits.

In her brief on review, claimant contends that the Referee correctly decided the issue of de facto denial of medical services. She argues as follows:

> "Dr. Schwan reviewed the records, but did not examine claimant (Ex. 31-1). He concluded that claimant was not entitled to palliative care because the current request was not related to the compensable injury (Ex. 31-2). Dr. Craig, Medical Director, issued an order denying palliative care because the requested treatment was unrelated to the compensable injury (Ex. 33-2). Thus, Dr. Schwan and Dr. Craig raised compensability as an issue. Claimant was denied treatment because the requested treatment was not related to her injury." (Respondent's Brief at p. 5, emphasis added).

The claimant's argument is well taken. The May 17, 1991 Palliative Care Order by the Director results from a request to the Director by the attending physician to review the insurer's disapproval of the palliative care. The Director then arranged for a file review of the matter by Dr. Schwan. There is no evidence of what questions the Director asked of Dr. Schwan, whether Dr. Schwan had knowledge that the insurer had not placed the issue of causal relationship of the requested treatment before the Director, or whether Dr. Schwan understood the scope of his review. In his report, Dr. Schwan concluded:

> "The information presented is not persuasive that the current request for continued palliative chiropractic care is related to the compensable injury of February 13, 1984, a muscle strain occurring over six years ago." (Ex. 31-2 emphasis added).

The resulting order from the Director finds the requested palliative care not compensable and relies specifically on the findings of Dr. Schwan that the services are unrelated to the compensable injury:

> "I conclude that the requested palliative care is not appropriately related to the worker's 1984 injury and that it has not been shown to be necessary to enable the worker to continue current employment." (Ex. 33-2, emphasis added).

The Director gives no reason, other than that the palliative care was not causally related to the accepted injury, for denying claimant the palliative care. However, that reason is not an issue which is within the scope of the Director's authority to address pursuant to ORS 656.245(1)(b). The statute states, in relevant part:

> "If the worker's attending physician . . . believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer . . . . If approval is not granted, the attending physician may request approval from the director . . . ."

On the basis of this language, it is clear that the Director's duty under this statute is to determine whether the requested treatment is necessary to enable the worker to continue current employment. Neither this statute, nor any other statute, gives the Director the duty to decide causal relationship issues. Only the insurer has the duty to deny claims on that basis. In turn, if the denial is disputed, by statute those disputes are resolved by the Board where the parties have a right to a full hearing pursuant to ORS 656.283. Besides the absence of express statutory authority giving the Director that duty, we find no legislative history which would support such a grant of jurisdiction.

We have addressed this issue in Michael A. Jaquay, 44 Van Natta 173 (1992). There, we noted that by the specific terms of section (1) of ORS 656.245, that statute addresses the provision of medical services for compensable injuries. Here, in the absence of a denial of compensability of the medical services by the insurer, the Director must assume that an adequate causal relationship exists as between the medical services and the compensable injury and, accordingly, so limit the scope of their physician reviewer's report. The Director does not have the authority to initially deny the compensability of claims nor to resolve such disputes even if the insurer had made such a denial. Rather, compensability or causal relationship issues are "matters concerning a claim" over which the Board has original jurisdiction. ORS 656.704(3) and 656.283. In Jaquay, we held that there was no suggestion in the legislative history that it was the intent of the legislature to remove causal relationship questions from the litigation process. Accordingly, we concluded that we properly had jurisdiction of the medical treatment dispute regarding causal relationship.

The Director's order of July 24, 1991 was based on a subsequent request for palliative care by the attending physician that was again denied by the insurer. Again, the Director obtained a medical review. The physician reviewer's report is missing from this record and neither the physician's identity, qualifications, extent of the review, findings or any other basis for the reviewer's conclusion is mentioned in the Director's resulting order. However, the Director's order recited that the physician reviewer concluded that "the cervical thoracic strain has subsided and chiropractic treatment is unnecessary." (Ex. 36-1, emphasis added). This is the only expressed reason given for approval of the denial. The order denied the palliative care based on the following language:

> "I conclude that the requested palliative care is not needed to enable the worker to continue current employment. I base my conclusion on my review of the records and my concurrence with the physician reviewer's findings." (Ex. 36-2).

Based on the only expressed basis for the order's conclusion, one could interpret the Director's order as indicating that, whatever has caused the attending physician to request palliative care for this claimant, it is not related to the compensable injury because that condition has resolved. While this second order does not so clearly use the causal relationship language seen in the earlier order, we believe that the Director was again basing the determination on a compensability analysis, rather than assuming the compensability and merely addressing whether the related treatment would enable the worker to continue current employment. Again, the Director reached a compensability dispute, the resolution of which is not within the Director's jurisdiction.

We recognize that, up to the point that the Director issued the above orders, the insurer had never separately denied the palliative care on the basis that it was not related to the compensable injury. If the insurer did not intend for the denial to be grounded on that basis, it could have requested reconsideration of the orders by the Director to clarify its position and point out that it was error for the Director to reach the compensability issue. However, the insurer made no such request. Rather, the insurer now seeks to rely upon the above Director orders which prevent the claimant from receiving the requested care, (Tr. 20), and asks that they be allowed to become final. (Employer/EBI's reply brief at p. 4). We find that the insurer's position shows that they are relying upon and are in agreement with the Director's orders, thereby placing the de facto denial of the compensability of palliative care at issue.

Further, unlike the majority, we find that the Board should reach and decide the compensability issue. If claimant is unable to prove at hearing that the palliative care is related, then the case before the Director becomes a moot point. However, if the claimant is able to prove a causal relationship, a Board order so finding should have a significant impact on any further proceeding before the Director since the basis for the Director's review and conclusions would have an entirely different focus.

It is unfortunate that the Board does not have the apparent authority to invalidate the Director's orders on this jurisdictional issue and remand the matter to the Director for correction. To some, it may seem inefficient to break up these issues into different forums with differing appeal routes. Prior to the passage of Senate Bill 1197 in 1990, the Board was able to resolve these issues all at one time. However, since passage, the law requires that the issues in a case be carefully analyzed so that the proper forum, either the Board or the Director, addresses the appropriate issues. This portion of the dissent merely recognizes that fact. Therefore, we conclude that the Board has de novo authority to address the issue of de facto denial by the insurer of the compensability of the requested palliative care.

CONCLUSION

On the basis of all the above considerations, we would find that the procedure in ORS 656.245(1)(b) is unconstitutional. Therefore, we would find the parties are entitled to a hearing pursuant to ORS 656.283 on all the issues raised in this case. Further, regardless of whether the procedure in ORS 656.245(1)(b) is constitutional, the parties are entitled to a decision on the merits in this forum on the issue of the de facto denial of the causal relationship of the requested palliative care to the compensable injury. We, therefore, dissent.

In the Matter of the Compensation of
TINA R. FLANSBERG, Claimant
WCB Case Nos. 90-22505, 90-17315 & 90-15708
ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Kevin Mannix, PC, Defense Attorneys
Garrett, et al., Defense Attorneys
Beers, et al., Defense Attorneys

On December 15, 1992, we withdrew our November 30, 1992 Order on Review which had found Connecticut Indemnity, Safeco Insurance Company, and Liberty Northwest Insurance Corporation jointly responsible for claimant's bilateral carpal tunnel syndrome condition. We took this action to consider Connecticut's motion for reconsideration. Having received the remaining parties' respective positions regarding Connecticut's motion, we proceed with our reconsideration.

In reaching our prior conclusion regarding joint responsibility, we declined to apply the last injurious exposure rule because we found claimant's employment for Taco Bell (insured by Connecticut and Safeco) to be concurrent with her employment for Bason Janitorial (insured by Liberty). We relied on the reasoning expressed by the court in Colwell v. Trotman, 47 Or App 855 (1980), which stated that the rationale behind the last injurious exposure rule did not support the rule's application to concurrent, as opposed to successive, employment exposures. See also Mary J. Joseph-Duby, 44 Van Natta 2272 (1992).

We also found that this case presented a "dual employment" situation and that claimant's activities in both employments combined to cause her condition. We concluded, therefore, that Taco Bell and Bason Janitorial were jointly responsible for claimant's condition and any resulting disability and need for treatment.

After considering the parties' arguments on reconsideration, we conclude that Colwell is distinguishable from the present case on at least two significant grounds. In Colwell, the claimant had been concurrently employed by two different employers as a dental hygienist for eight years when she developed an elbow condition. As a result of this condition, she simultaneously quit working for both of her employers and filed occupational disease claims against both. In holding both employers to be jointly responsible, the Colwell court reasoned:

> "[t]he [last injurious exposure] rule makes complete sense in the context of successive employments which contribute to an occupational disease; it makes little sense in the present context, where the worker was exposed to conditions which contributed to her occupational disease in two separate but simultaneous employments." Colwell v. Trotman, supra, at page 860. (Emphasis added).

Here, claimant worked part-time for Taco Bell as a restaurant worker from January 1990 to September 1990. She also worked part-time for Bason Janitorial as a housekeeper between February 1990 and July 1990. Thus, rather than the extensive eight-year period of concurrent employment present in Colwell, the present claimant was employed by two employers concurrently for approximately five months of a nine-month period. Moreover, unlike the claimant in Colwell, the present claimant did not simultaneously cease her employment with both of her employers. Rather, she continued working for Taco Bell for two months after she stopped working for Bason Janitorial. Finally, when claimant filed her claim for benefits and became disabled, she was working for only one employer (Taco Bell).

In light of such circumstances, we now conclude that claimant's employments were not "simultaneous." Therefore, we conclude that the concurrent employment rationale expressed in Colwell is inapplicable in this case.[1] Rather, on reconsideration, we conclude that claimant's claim is properly characterized as one for an occupational disease arising from successive, rather than concurrent, employments. We, therefore, apply the last injurious exposure rule in order to assign liability among the three potentially liable employers/insurers.

Under the last injurious exposure rule, if a worker establishes that an occupational disease was caused by work conditions in existence when more than one insurer is on the risk, the insurer on the risk during the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984).

The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The "onset of disability" is the date on which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date 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).

Claimant's last day of work for Bason Janitorial was July 11, 1990.[2] She continued to perform her work activities for Taco Bell. Claimant first became disabled on July 16, 1990, when Dr. McHolick issued a "Work Status Report" which restricted claimant from performing heavy lifting. (Ex 3-1). Safeco was on the risk at that time. Similar restrictions occurred on July 24, 1990, when Dr. McHolick released claimant to modified duty; i.e., limiting the frequency of her lifting and repetitive arm use. (Ex. 3-2). Finally, on July 31, 1990, Dr. McHolick limited claimant's lifting activities to 15 pounds and her repetitive cash register duties to one hour. (Ex 6).

Because Safeco was the insurer on the risk at the onset of claimant's disability, that insurer is assigned initial responsibility for the claimant's claim. Safeco can avoid responsibility by establishing that a prior employment exposure was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while Safeco was on the risk to have caused her disability. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Dr. Button could not state that either of claimant's work exposures alone was the major contributing cause of her carpal tunnel syndrome. He did conclude, however, that claimant's carpal tunnel syndrome was caused, in major part, by the combination of her work exposures at Taco Bell and Bason Janitorial. Button's opinion does not establish that claimant's employment exposure for Bason

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[1] Although not determinative of our ultimate conclusion, we note that application of the "concurrent employment" analysis to this type of situation will virtually assure further litigation of the present claim regarding the ongoing claim processing obligations for each carrier. Such a result would be inconsistent with the goals of the workers' compensation system, as well as with the rationale expressed in Colwell.

It is well-settled that the "last injurious exposure" rule was developed as a means of arbitrarily assigning responsibility to one carrier for a condition to which possibly multiple carriers may have contributed. See UAC v. Hacke, 101 Or App 598 (1990). In reaching its decision, the court in Colwell, supra, specifically recognized the value of such a rule in the context of successive employments, i.e., placing responsibility with an identifiable employer rather than requiring the worker to prove which of two or more equally likely possibilities is true. Colwell, supra at 860. Nevertheless, the court reasoned that such logic was not applicable when dealing with two separate but simultaneous employments.

The Colwell court further recognized, however, the difficulty inherent in drawing a distinction between "successive" and "concurrent" employments. Colwell v. Trotman, supra, at 861, n. 1. Nonetheless, the court declined to address that distinction because the claimant had concluded her work schedules for both employers essentially at the same time.

Application of the "concurrent employment" rationale to this case would disregard the Colwell court's warning regarding the "blurriness" between "simultaneous" and "concurrent employment." Such an analysis would profoundly expand the term "simultaneous employments" to include overlapping employments where one job continues several months after the other has ended. (This continued activity would also coincide with claimant's disability date.) This result would not be consistent with the more restrictive approach suggested by Colwell.

A "concurrent employment" determination would also have significant practical effect with regard to the future processing of the claim. While her temporary disability can be pro-rated among the carriers, OAR 436-60-020(7), each carrier would be responsible for the future processing of its respective claim, i.e., each claim would require closure. See ORS 656.268. Moreover, if permanent disability is granted, it is likely that issues concerning the proportionate share of permanent disability attributable to each carrier would arise. Likewise, responsibility disputes regarding future medical services and aggravation claims would likely occur. In short, the stage would be set for countless future responsibility disputes. Inevitably, those disputes would lead to further litigation.

In conclusion, a primary goal of the workers' compensation system is to reduce litigation and to eliminate the adversial nature of compensation proceedings. See ORS 656.012(2)(b). Expansion of the "concurrent employment" doctrine to this claim would not only be inconsistent with the stated goal of the workers' compensation system, but it would substantially detract from it.

[2] Some confusion exists regarding the termination of claimant's employment with Bason Janitorial and the exact date that her affiliation with that employer ceased. In light of such unclarity and considering the sporadic and variable nature of her work activities for this employer, we consider the undisputed last day that claimant worked for Bason Janitorial to be the appropriate date for determining the termination date for her employment.

Janitorial was the sole cause of her disability. Neither does it establish, however, that it was "impossible" for her work activities at Taco Bell to have been the cause of her disease. Consequently, we conclude that Safeco cannot avoid liability for claimant's claim. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bracke v. Baza'r, 293 Or 239, 248 (1982); Meyer v. SAIF, supra,; Progress Quarries v. Vaandering, supra; SAIF v. Carey, supra.

Accordingly, on reconsideration, we reverse that portion of the Referee's order that found Safeco and Liberty to be jointly responsible for claimant's bilateral carpal tunnel syndrome claim. In lieu of the Referee's order and our Order on Review, we conclude that Safeco is solely responsible for claimant's carpal tunnel condition. Therefore, the denials of Liberty Northwest Insurance Corporation and Connecticut are reinstated and upheld. Claimant's claim is remanded to Safeco for processing according to law. Safeco is responsible for the Referee's $3,000 attorney fee award, as well as our assessed attorney fee award on Board review.

Finally, claimant's attorney is also entitled to an assessed attorney fee for services rendered on 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 fee for claimant's attorney's services on reconsideration is $750, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's responses to the request for reconsideration), the complexity of the issues, and the value of the interest involved.

As modified and supplemented herein, we republish our November 30, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board members Hooton, Kinsley and Lipton dissenting.

The majority correctly states the substance of the Order on Review withdrawn for reconsideration. We agree that the Order requires modification, but disagree that a strict application of the last injurious exposure rule is the correct resolution of this dispute regarding responsibility.

In its discussion of the last injurious exposure rule in Bracke v. Baza'r, 293 Or 239, 247 (1982) the Supreme Court specifically discussed the importance of the onset of disability in determining liability for an occupational disease claim. It stated that:

> "...In the search for an identifiable instant in time which can perform such necessary functions as to start claim periods running, establish claimant's right to benefits, determine which year's statute applies, and fix the employer and insurer liable for compensation, the date of disability has been found most satisfactory." (Emphasis added).

While Bracke v. Baza'r, supra, is often considered the definitive last injurious exposure rule case, that perception is incorrect. In Bracke, the issue was whether the last injurious exposure rule could be used defensively to overcome claimant's proof of actual causation by a particular employer. The extensive discussion of the last injurious exposure rule in that case is limited to developing an understanding of the purpose of the rule, and the reasons for finding it inappropriate to apply the rule when claimant, or any other party, has demonstrated the actual causation of the condition at issue. Consequently, the onset of disability as the date fixing the liability of the employers/insurers involved in the claim is applicable to proof by actual causation and concurrent employment, as well as the artificial determination of responsibility under the last injurious exposure rule.

The majority correctly notes that two possible dates are used to fix liability of employers/insurers in the Oregon occupational disease law, the date of disability and the date of first medical treatment. Progress Quarries v. Vaandering, 80 Or App 160, 163 (1986). Here, those dates are identical. On July 16, 1990, claimant first sought medical treatment from William J. McHolick, M. D. At that time, claimant was diagnosed with mild synovitis and early carpal tunnel syndrome. She was also advised to avoid heavy lifting in her work. (Ex. 3-1.) On July 23, 1990, claimant was formally placed on light

duty, consistent with a modified work release specifically limiting frequency of lifting and repetitive arm use. (Ex. 3-2). Given the totality of the evidence, it is clear that claimant was disabled at the time that she first sought medical treatment on July 16, 1990. Under the reasoning provided in Bracke v. Bazá'r, supra, that date is the date upon which the potential liability of her employers/insurers became "fixed," and the determination whether claimant's employment is successive or concurrent must be made as of that date.

Claimant began work for Taco Bell on January 23, 1990. (Ex. A-1.) She actually provided work for Taco Bell for a total of four days, and only 17 total hours, before she began work for Bason Janitorial on January 30, 1990. (Ex. B-1.) Claimant last performed work for Bason Janitorial on July 11, 1990, a mere five days before her first medical treatment and the onset of disability. (Ex. B-9.) However, it is inappropriate to conclude that claimant terminated her employment with Bason on July 11, 1990.

At the time of her first medical treatment, claimant advised her doctors that she had two employments. (Ex. 3-1.) She also testified that she neither quit, nor was she fired by Bason Janitorial at any time prior to August 1, 1990, but rather, that she was unable to work as a result of the restrictions imposed by her doctor. (Tr. 14-16.) The record indicates that claimant's work with Bason was irregular and occasionally involved periods of inactivity longer than one week. (Ex. B.)

With the exception of the period between January 23, 1990 to January 30, 1990, therefore, claimant was employed concurrently by Taco Bell and Bason Janitorial from January 30 through July 11, 1990. The one week period in January of 1990 is not sufficiently significant to support the application of the last injurious exposure rule, rather than the concurrent employment rule developed in Colwell v. Trotman, 47 Or App 855 (1980). See Mary J. Joseph-Duby, 44 Van Natta 2272 (1992).

The majority provides no authority for its conclusion that it is appropriate to consider the ongoing exposure with Taco Bell after July 16, 1990, in fixing the liability of the parties. Indeed, the case law will not support that consideration. The determination of initial liability is based on the employers/insurers on the risk on the date of disability. If subsequent exposure is considered, it must be for the purpose of shifting liability from the insurer to whom that liability was initially assigned. To accomplish that result the employer/insurer to whom initial liability was assigned must demonstrate an actual contribution to a pathological worsening of the condition during the subsequent exposure. Progress Quarries v. Vaandering, supra at 166; ORS 656.308(1).

In addition, there is virtually no justification for considering the period of employment with Taco Bell after August 1, 1990. After that date, claimant was working for reduced hours and in a capacity that eliminated all repetitive use of the hands, sustained gripping or heavy lifting. (Ex. 7b.) These are the potentially causal factors discussed by Dr. Button. No opinion in the record indicates that claimant's work as a hostess after August 1, 1990 could have, in any way, contributed to the causation of her condition.

At the time of first medical treatment, and the onset of disability, claimant was concurrently employed by Taco Bell and Bason Janitorial. That is a sufficient basis for the application of the concurrent employment doctrine outlined in Colwell. However, this case presents an even stronger argument for application of that doctrine.

The medical record indicates that neither Dr. McHolick nor Dr. Carter, claimant's subsequent treating physician, rendered an opinion regarding causation. In his November 2, 1990 report of an independent medical evaluation Dr. Morris Button also declined to distinguish between causal factors. (Ex. 15.) However, in his deposition of August 26, 1991, Dr. Button did discuss the causal contributions of claimant's on and off-work activities and predisposing factors, and thus provides the only medical opinion on causation in the claim.

When questioned regarding the various individual activities characteristic of claimant's employment with Taco Bell, Dr. Button indicated that none of those activities were of a kind which, in and of themselves, would cause the development of a carpal tunnel syndrome. (Ex. 22-13 & 14.) When questioned about the activities characteristic of claimant's employment with Bason Janitorial, Dr. Button explained that those activities were more consistent with the development of a carpal tunnel syndrome, except for the relatively few hours per week that claimant spent involved in those activities. (Ex. 22-21 & 22.) However, when specifically questioned regarding the contribution of these employment exposures in combination Dr. Button indicated that he would presume that they were the major contributing cause of her carpal tunnel and tenosynovitis conditions. (Ex. 22-19.) Consequently, this case presents a situation in which neither of two potentially liable employment exposures can be

demonstrated to be a likely cause of the resultant disability and need for treatment, but the same two exposures, in combination, in fact, did. We would, therefore, conclude that the concurrent employment rule, and not the last injurious exposure rule, is the appropriate rule for allocation of responsibility in this claim.

That, unfortunately is not the end of the analysis. During the period of its exposure, Taco Bell was successively insured by EBI Insurance Companies and Safeco Insurance Companies. However, Safeco was the carrier on the risk at the time of first medical treatment and the onset of disability. We would, therefore, assign full liability for Taco Bell's proportionate share of claimant's disability and treatment to Safeco, unless Safeco has demonstrated that the prior insurer, EBI, was the sole cause of claimant's disability. FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). On this record, it did not, and could not, do so.

In the Matter of the Compensation of
ROBERT L. PARRISH, Claimant
WCB Case No. 92-05310
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of that portion of Referee Brown's order that concluded that it must pay claimant temporary partial disability, as awarded by an Order on Reconsideration, at the full temporary total disability rate. Claimant cross-requests review of that portion of the order that declined to award penalties or attorney fees for the insurer's allegedly unreasonable refusal to pay those benefits. On review, the issues are rate of temporary disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, with the exception of his ultimate finding of fact number 2.

CONCLUSIONS OF LAW AND OPINION

Rate of TPD

If an injured worker returns to work earning the same or higher wages than before the injury, but is subsequently terminated for reasons not related to the injury, the worker is not entitled to temporary disability benefits after the termination date. Stone v. Whittier Wood Products, 116 Or App 427, 429 (1992); Henry L. Studer, 45 Van Natta 214 (1993). Consequently, if a Determination Order or Order on Reconsideration awards temporary partial disability benefits for periods after the claimant is terminated for reasons not related to the injury, the rate of those benefits is properly calculated as zero. Jason L. Bail, 42 Van Natta 553, 554 (1990).

Claimant sustained a compensable disabling injury on October 31, 1990. He returned to modified work at his pre-injury wage, but was discharged on November 14, 1990. An Order on Reconsideration awarded claimant temporary partial disability benefits for periods including November 14, 1990 through April 9, 1991, and from June 25, 1991 through September 10, 1991. The Referee concluded that the insurer was required to pay those temporary partial benefits at the temporary total benefits rate, because the employer discharged claimant for reasons related to the compensable injury. We disagree.

Claimant testified that his supervisor told him that he was being terminated because there was insufficient modified work for him to do. (Tr 22). If that were true, we would conclude that claimant was terminated because of his injury. Faustino Martinez, 44 Van Natta 2585 (1992). However, the Referee concluded, and we agree, that claimant is not a reliable historian. Moreover, on the day he was terminated, claimant stated that disagreements with his supervisor, rather than his injury, led to his termination. (Ex. 27). Consequently, we do not rely on claimant's testimony.

Claimant's supervisor testified that claimant was terminated after he refused to sign a disciplinary warning relating to a violation of the employer's work policies. (Tr. 33). Although that termination occurred shortly after claimant returned to work, the record reflects that claimant had a long history of disciplinary problems with the employer. During the eight months prior to his termination, claimant received six written warnings and evaluations concerning his poor work performance and attitude. (Ex. 27). During that same period, he also received numerous verbal warnings concerning his deficiencies in those areas. (Tr 40). Nothing in the record suggests that the issue of claimant's attitude resolved prior to his November 14, 1990 termination.

That history reflects that claimant's attitude was an ongoing concern of the employer. In light of such circumstances, we are not persuaded that claimant was terminated from his employment for a reason related to his compensable injury. Since claimant was receiving his pre-injury wage at the time of his termination, the insurer properly calculated claimant's temporary partial disability rate as zero. Stone v. Whittier Wood Products, supra. Consequently, claimant was not entitled to additional temporary disability benefits as a result of the Order on Reconsideration. Jason L. Bail, supra.

Penalties and Attorney Fees

On cross-review, claimant requests penalties and attorney fees for the insurer's failure to pay the temporary partial disability benefits awarded by the Order on Reconsideration. Because we have concluded that there is no compensation due, no penalty is available under ORS 656.262(10). Moreover, the insurer could not have unreasonably resisted the payment of compensation, so no attorney fee is available under ORS 656.382(1).

ORDER

The Referee's order dated September 24, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that determined that the rate of temporary partial disability benefits due for the periods November 14, 1990 through April 9, 1991, and June 25, 1991 and September 10, 1991 is the rate for temporary total disability, and awarded an "out-of-compensation" attorney fee payable from the increased compensation, is reversed. The rate of temporary partial disability for those periods is zero. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MARK A. PENDELL, Claimant
WCB Case No. 91-13051
ORDER ON RECONSIDERATION (REMANDING)
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On April 15, 1993, we abated our March 16, 1993 Order on Review which had affirmed a Referee's order that held that an Order on Reconsideration, which had issued without appointment of a medical arbiter, was invalid. After further consideration of the matter, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

On August 7, 1989, claimant sustained a compensable back injury. The claim was accepted by the insurer as a mid back contusion and strain. Claimant's treating physician for his injury was Dr. Lee.

Claimant's claim was closed by a December 19, 1990 Determination Order. Claimant was found medically stationary as of November 9, 1990 and was awarded 6 percent unscheduled permanent disability. The Determination Order was based on Dr. Lee's November 9, 1990 chart note which indicated that claimant's back condition was medically stable with some lost range of motion.

On April 21, 1991, claimant requested reconsideration of the Determination Order. His request for reconsideration was made on the form provided by the Department of Insurance and Finance. On the form, claimant checked the box indicating that he disagreed with the impairment findings made by his attending physician at the time of claim closure. With his request for reconsideration, claimant submitted a supplemental report from his attending physician. In the supplemental report, Dr. Lee responded to questions from claimant's counsel with regard to the extent of claimant's permanent

disability under the relevant Director's rules. Dr. Lee indicated that claimant was medically stationary on December 1, 1990, but did not indicate the date of the examination on which his findings were based.

On August 29, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all aspects. The order acknowledged that claimant was entitled to a medical arbiter as there was a dispute over the impairment findings. However, the order explained that the Director was required by a circuit court judge's injunction to issue a reconsideration order "regardless of whether the reconsideration process had been completed."

By a letter dated October 28, 1991, the Appellate Unit of WCD informed claimant that in accordance with his counsel's request, a medical arbiter had been selected to review the impairment findings used in rating his disability. In a letter dated November 6, 1991, claimant's counsel informed the Appellate Unit that claimant would not be attending the medical arbiter examination due to the amount of time which elapsed between claimant's request for reconsideration and the scheduling of the arbiter's examination.

At hearing, claimant's counsel acknowledged that claimant had checked the box indicating that he disagreed with the impairment findings made by the attending physician at the time of closure. (Tr. 15). Counsel indicated that claimant did not disagree with the impairment findings of the attending physician. (Tr. 16). Rather, claimant wanted the findings supplemented by Dr. Lee's April 19, 1990 report. (Tr. 16). However, claimant was not willing to withdraw his disagreement with the impairment findings used to close his claim unless the supplemental report was considered. (Tr. 15, 16).

CONCLUSIONS OF LAW AND OPINION

The Referee found that the Order on Reconsideration was not valid. Therefore, he set aside the Order on Reconsideration and dismissed claimant's request for hearing. We disagree.

At the outset, we note that the insurer moved to dismiss claimant's hearing request on the ground that the Order on Reconsideration was invalid because no medical arbiter had been appointed. (Tr. 4-5). Subsequent to the Referee's order, we held that only the party objecting to the Determination Order or Notice of Closure has the right to enforce the statutory requirement for appointment of a medical arbiter. Randy M. Mitchell, 44 Van Natta 2304 (1992). In other words, the party who did not object to the Determination Order or Notice of Closure may not use the statute defensively to have an Order on Reconsideration declared invalid for failure to appoint a medical arbiter. Id. Since the insurer did not object to the Determination Order in this case, it may not move to dismiss claimant's request for review on the basis that the Order on Reconsideration is invalid because no medical arbiter was appointed.

We proceed to a determination concerning whether the attending physician's supplemental report may be considered and whether claimant withdrew his objection to the impairment findings of his attending physician at the time of claim closure.

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).

Generally, whether a party objects to the attending physician's impairment findings, so that appointment of a medical arbiter is required, is a question of fact. Dale A. Pritchett, 44 Van Natta 2134 (1992). However, the present issue is whether a supplemental report submitted pursuant to ORS 656.268(5) constitutes a disagreement with the impairment requiring a medical arbiter to be appointed under ORS 656.268(7).

In 1990, the legislature amended ORS 656.268 to establish a mandatory reconsideration process that must be completed prior to requesting a hearing on extent of permanent disability. ORS 656.268(4)(e); 656.268(5); 656.268(6)(b); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991). To implement the reconsideration process, the legislature also amended several other statutes governing how the extent of permanent disability is to be evaluated and what type of evidence may be used to establish extent of permanent disability.

The question presently before the Board turns on the meaning and appropriate application of ORS 656.268(5) and how it relates to ORS 656.268(7). The particular language at issue is underscored below:

> "(5) Within 10 working days after the department receives the medical and vocational reports relating to an accepted disabling injury, the claim shall be examined and further compensation, including permanent disability, award, if any, determined under the director's supervision. If necessary the department may require additional medical or other information with respect to the claim, and may postpone the determination or reconsideration for not more than 60 additional days. If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration. 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." (Emphasis supplied).

ORS 656.268(5) expressly requires the Appellate Unit to consider, during the reconsideration proceeding, reports submitted by the claimant or the carrier which correct erroneous information and 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). In relevant part, the statute also authorizes the Director to require additional medical or other evidence concerning claimant's condition and to abate the reconsideration process for 60 days for that purpose.

Here, the medical report was submitted by claimant at the reconsideration proceeding. Setting aside the question about whether the report constitutes a disagreement with impairment findings, the report may be medical evidence that "should have been but was not submitted by *** the attending physician at the time of claim closure". ORS 656.268(5). After conducting our review of the record in light of the statute and applicable legislative history, We conclude that it is a medical report that can be considered pursuant to ORS 656.268(5).

The legislative history concerning the reconsideration process in general, and ORS 656.268(5) in particular, demonstrates a legislative purpose to reduce litigation by providing an administrative process prior to hearing that corrects mistakes by the insurer or the Workers' Compensation Division made in their initial rating of the extent of the worker's permanent impairment. In this regard, Cecil Tibbets, co-chair of the Governor's Worker's Compensation Labor-Management Advisory Committee, said the following at the May 3, 1990 meeting of the Interim Special Committee on Worker's Compensation:

> "Mr. TIBBETTS: Beginning on the bottom of page 29, we have instituted a new administrative requirement. And our purpose here is to cut down the number of appeals, the number of hearings that have to take place. So what we're now instituting is that a worker who is unsatisfied with a determination order will have an obligation to request reconsideration of that order by the Department of Insurance and Finance. That reconsideration will be handled in a separate section of the department that will virtually specialize in this. And their job will be to catch any mistakes that were made. In checking what causes some of the appeals, we find a number of appeals occur because the initial determination order had mistakes in it and therefore the worker did not receive the full benefits that ought to be allowed. We feel by providing this mandatory reconsideration, we can cut down the number of appeals that have to go to referees. * * * Last year there were 26,000 appeals. So we're talking about a lot of appeals that are going to full hearing. The thing that concerns us about that is that because of the large numbers of appeals, we're getting out now five months that a worker is having to wait from the time they get a determination order until the time they get a hearing on their appeal. So this process is intended to help some workers get a settlement quicker within a couple of weeks possibly, as opposed to having to wait five months." (Emphasis Supplied) Tape Recording, Interim special Committee on Workers' Compensation, May 3, 1990, Tape 2, Side B at 42.

In addition, during the Senate Floor debates, Senator Shoemaker explained that as the result of the amendments, a Referee at hearing may consider only that medical evidence developed at the time of claim closure and during the reconsideration process. He stated:

> "So this process that I've just described allows a worker's particular disability to be adequately addressed within the 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, he then may appeal and go up to the referee, Workers' compensation Board and into the courts just as they do now. One change, the medical evidence that can be brought before those bodies will be evidence developed at the administrative level. In other words, you can't go out and get yet another medical examination. You come to the referee and the Board with the medical examinations that have already been conducted. However, you can of course argue different conclusions from those medical examination." (Emphasis Supplied). Senate Floor Debates on SB 1197, May 7, 1990.

In our view, ORS 656.268(5) is not primarily a limitation on the authority of the Appellate Unit to consider relevant and material evidence from the attending physician. Rather, we believe that to advance its purpose, it is properly to be construed as a grant of authority, indeed a direction, to receive evidence submitted from the attending physician establishing the full extent of the worker's impairment at claim closure.

This interpretation is clearly illustrated by the instant case. The Determination Order was based on a chartnote from Dr. Lee. (Ex. 11). The chartnote is very limited and does not address all inquiries relevant to the determination of claimant's permanent impairment. By contrast, Exhibit 12A, the supplemental report from Dr. Lee, contains findings regarding claimant's permanent impairment that take into account the standards adopted by the Director for evaluating the extent of an injured worker's impairment. Thus, Exhibit 12A provides a complete and well informed assessment of the extent of claimant's permanent disability. We conclude therefore, that Exhibit 12A is a supplemental report within the meaning of ORS 656.268(5).

Inasmuch as Exhibit 12A is a supplemental report that could have been considered by the Appellate Unit pursuant to ORS 656.268(5) the issue becomes whether claimant waived his request for a medical arbiter. We conclude that he has.

On the form provided by the Department of Insurance and Finance, claimant checked the box indicating that he disagreed with the impairment findings made by his treating physician at the time of claim closure. Standing alone, this would be sufficient to invoke the mandatory appointment of a medical arbiter pursuant to ORS 656.268(7). Olga A. Soto, supra. However, next to the box indicating his disagreement, claimant listed "Dr. Lee Questionnaire." With the Department's form, claimant submitted Exhibit 12A which is the supplemental report from Dr. Lee.

At hearing, claimant's counsel acknowledged that claimant had checked the box indicating that he disagreed with the impairment findings made by the attending physician at the time of closure. However, counsel indicated that claimant did not disagree with the impairment findings of the attending physician. Rather, claimant wanted the findings supplemented by Exhibit 12A, Dr. Lee's supplemental report.

Inasmuch as Exhibit 12A is medical evidence that could be considered pursuant to ORS 656.268(5) and in light of claimant's representation that he agreed with the findings of his attending physician as supplemented, we conclude that to the extent claimant initially objected to the impairment findings, he subsequently waived such objection. In view of claimant's waiver, we find the Order on Reconsideration valid. See Brenton R. Kusch, 44 Van Natta 2222 (1992).

Since 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. Under these circumstances, we find that the record is incompletely developed with regard to the issue of extent of permanent disability. See Charles R. Butler, 44 Van Natta 994 (1992).

We, therefore, find it appropriate to remand this matter to the Referee for further proceeding 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 May 14, 1992 is vacated. The matter is remanded to Referee Hazelett for further proceedings consistent with this order.

Chair Neidig, specially concurring:

I agree with the majority that Dr. Lee's supplemental report is evidence that can be considered pursuant to ORS 656.268(5). I write only to note that the record establishes that the supplemental report was based on an examination which occurred prior to claim closure. Thus, the supplemental report is not based on a post-closure examination. Whether a medical report submitted pursuant to ORS 656.268(5), that is based on a post-closure examination, can be considered must wait for another case for resolution.

June 10, 1993 Cite as 45 Van Natta 1040 (1993)

In the Matter of the Compensation of
THOMAS S. RAMIREZ, Claimant
WCB Case No. 91-12087
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Michael Johnson's order that: (1) set aside an Order on Reconsideration as invalidly issued; and (2) dismissed claimant's hearing request. On review, the issue is jurisdiction.

We affirm and adopt the Referee's order with the following comments and correction. The Referee's reference to Exhibit 28A in the last paragraph on page 1 is corrected to "21A."

In dismissing claimant's hearing request, the Referee reasoned that the Order on Reconsideration was not valid and, therefore, not reviewable by the Hearings Division. The Referee found that despite claimant's disagreement with the medical findings concerning his impairment, the reconsideration order issued without the appointment of a medical arbiter or the Appellate Unit's consideration of a medical arbiter report. The Referee relied on Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992). On review, claimant argues that by failing to appoint a medical arbiter, the Department of Insurance and Finance has deprived him of his right to a hearing.

It is the parties' responsibility to seek from the Department the issuance of a valid Order on Reconsideration. If claimant objects to the Department's alleged failure "to do its statutory duty," claimant's remedy lies with the Department or the courts. See Carl R. Alatalo, 44 Van Natta 2097, on recon 44 Van Natta 2285 (1992). Moreover, because claimant has not specifically waived his right to a medical arbiter, see Brenton R. Kusch, 44 Van Natta 2222 (1992), we agree with the Referee that the Order on Reconsideration is invalid. Olga I. Soto, supra.

Claimant also contends that failure to appoint a medical arbiter has no effect on the issues of premature claim closure and temporary disability benefits. Therefore, he argues, the Referee had jurisdiction to resolve these issues. We disagree.

We have previously held that a valid reconsideration order is a condition precedent to the Referee's consideration of issues raised by the request for reconsideration. Consequently, in the absence of a valid reconsideration order, jurisdiction to consider any and all issues arising from the Determination Order remains with the Department. Robert G. Edwards, 44 Van Natta 2368 (1992). The Referee, therefore, was without jurisdiction to address the issues of premature closure, see Robert G. Edwards, supra, or temporary disability benefits, see Jose M. Camargo, 44 Van Natta 2480 (1992); Galvin C. Yoakum, 44 Van Natta 2403 (1992); Ralph E. Fritz, 44 Van Natta 1168 (1992).

ORDER

The Referee's order dated October 7, 1992 is affirmed.

In the Matter of the Compensation of
DENNIS P. NORTHROP, Claimant
WCB Case No. 92-04965
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Eileen G. Simpson, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Holtan's order that upheld the insurer's denial of claimant's injury claim for low back and knee conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer issued an acceptance for sprains of the low back and right knee based on a May 1991 accidental injury. However, it limited benefits to a period of six weeks following the accident on the basis that claimant's preexisting conditions were the major contributing cause of his need for medical services or disability. The insurer also denied compensation for claimant's preexisting arthritis and obesity.

The medical record shows that claimant's compensable injury combined with his preexisting conditions. (Exs. 10-6, 14, 20-2, 21, 23-6). Therefore, we agree with the Referee's application of ORS 656.005(7)(a)(B) to analyze compensability. Under this statute, when a compensable injury combines with a preexisting disease or condition, the resultant condition is compensable only if the work-related injury is the major contributing cause of claimant's disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409, 412-13 (1992).

With regard to causation, the record contains opinions from the Orthopaedic Consultants, Dr. Burr, orthopedic surgeon and claimant's treating physician, the Western Medical Consultants, and Dr. Lewis, orthopedic surgeon. Drs. Farris and Geist, both orthopedic surgeons, were members of the panel for the Orthopaedic Consultants that conducted an independent medical examination. They found that claimant's accidental injury "caused a temporary worsening of the preexisting lumbosacral strain and degenerative disc disease, as well as a temporary worsening of the degenerative arthritis of both knees." (Ex. 10-6). The panel further found that the underlying conditions were not materially worsened by the accident and that claimant could be expected to return to his preinjury condition six to eight weeks from the date of their examination. (Id. at 6-7).

Dr. Burr concurred with the report. (Ex. 11). Dr. Burr later agreed with the insurer's attorney that claimant's preexisting conditions were not factors during the first two to three weeks of his need for treatment following the accident but that after that time the major contributing cause of his need for treatment was the preexisting conditions. (Ex. 14).

Dr. Lewis examined claimant once at claimant's attorney's request. He concluded that claimant's injury "severely aggravated" claimant's degenerative arthritis of the knees and lumbosacral spine. (Ex. 20-3). In subsequent reports, Dr. Lewis reiterated his opinion that the injury had materially worsened the preexisting conditions, (Exs. 21, 27, 28), and added that there were "significant pre-existing changes which would have been further altered by the injury and thus, one could not make an accurate assessment of how long it should take for this to resolve if at all," (Ex. 28). Dr. Burr concurred with all of Dr. Lewis' reports. (Exs. 24, 29).

Finally, Dr. Thomas, orthopedist, who conducted an independent examination for the Western Medical Consultants, reported that it was "appropriate for the employer to cover [claimant's] initial need for medical services following his injury of May 9, 1992, but the acute condition which would have resulted primarily due to the injury should have resolved within a short time and six weeks is a reasonable estimate by the insurance carrier." (Ex. 23-6). Dr. Thomas also found that the "major contributing cause of the continuation of his complaints and need for treatment after the period immediately following the injury is his preexisting and unrelated arthritis which is complicated by the increasing stress on his knee from his morbid obesity." (Id).

We agree with the Referee that claimant failed to carry his burden of proving that the compensable injury was the major contributing cause of his need for treatment and disability. The panels from the Orthopaedic Consultants and Western Medical Consultants and Dr. Burr all found that, shortly after the injury, the compensable injury was not the major contributing cause. Furthermore, we interpret Dr. Lewis as supporting the inference that, although claimant continued to have symptoms, the cause of his complaints were the preexisting conditions. Therefore, we do not find that Dr. Burr's concurrence with Dr. Lewis' reports contradicted his prior agreement with the opinion that the compensable injury was not the major contributing cause of claimant's need for treatment two to three weeks after the injury.

Consequently, we conclude that claimant did not prove that the compensable injury was the major contributing cause beyond the six-week period accepted by the insurer. Therefore, the claim beyond this period is not compensable. See ORS 656.005(7)(a)(B).

ORDER

The Referee's order dated September 29, 1992 is affirmed.

In the Matter of the Compensation of
ROBERT DERDERIAN, Claimant
WCB Case No. C3-01482
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Martin J. McKeown, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

On May 28, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A CDA must contain the terms, conditions and information prescribed in OAR 436-60-145(3) and (4). An agreement that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5), 438-09-020(2).

Here, the proposed agreement recites that:

> "Additionally, temporary or permanent disability paid by SAIF Corporation to claimant on or after 5/6/93 shall be considered advance payments of the $35,000 settlement amount and shall be credited toward the $29,913 otherwise payable to claimant."

Temporary disability compensation must continue up until the date of submission to the Board. See ORS 656.236; OAR 438-09-025(2); George T. Taylor, 43 Van Natta 676 (1991). Furthermore, it is not the function of a CDA to accomplish claim processing functions such as establishing a medically stationary date or serving to close a claim. See Debbie K. Ziebert, 44 Van Natta 51 (1992).

The current CDA does not provide a statutory justification for converting the apparently due and payable temporary or permanent disability benefits to a CDA "advancement" on a date which precedes the CDA's "submission" to the Board. Without statutory authority, we consider this selection of an arbitrary date upon which to stop temporary or permanent disability payments to be contrary to law.

Because the improper portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we conclude that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CATHERINE E. EVANS, Claimant
WCB Case No. C3-01036
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Richard F. McGinty, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewed by Board Members Neidig and Brazeau.

On April 14, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The CDA contains the signatures of the insurer's claims examiner and claimant's attorney, but does not include claimant's signature. On the line provided for claimant's signature, her counsel signed "for" claimant.

On April 22, 1993, by letter, the Board requested claimant's original signature. See OAR 438-09-025(1). On May 24, 1993, the Board received an "addendum" to the CDA from claimant's attorney. The addendum provides that, on February 12, 1993, claimant informed her attorney that she was moving to California. The addendum further provides that, upon receiving the CDA for claimant's signature, claimant's attorney forwarded it to her new address, but the CDA was returned. The addendum provides that all attempts to contact claimant have been unsuccessful. Finally, the addendum includes a copy of a September 8, 1992 retainer agreement purportedly between claimant and her counsel which contains a provision that authorizes claimant's attorney to "sign any settlements on his or her behalf."

We will not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of the existing statues or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any and all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and condition prescribed by the Director. In accordance with this statutory mandate, the Director's rules permit such dispositions subject to the terms and conditions of OAR 436-60-145 and Division 09 of the Board's rules. OAR 436-60-145(1).

The Board's rules define a "claim disposition agreement" as a written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. OAR 438-09-001(1). In other words, the Board rules require a CDA to be executed by all parties. See OAR 438-09-001(1); Edgar C. Sixberry, 43 Van Natta 335 (1991).

Accordingly, because the original CDA does not contain claimant's original signature and her signature has not been provided by addendum, it is not in compliance with Director and Board rules. See OAR 436-00-145(1); OAR 438-09-001(1). Consequently, we disapprove the agreement as unreasonable as a matter of law. See ORS 656.236(1)(a). We recognize that the retainer agreement purports to authorize claimant's counsel to sign for claimant. Nevertheless, such an authorization cannot relieve a party from compliance with the express statutory and regulatory requirements. We consider this approach to be particularly appropriate, where, as here, the record is devoid of a signature from claimant evidencing her understanding regarding the finality and significance of a CDA.

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.

June 14, 1993 Cite as 45 Van Natta 1044 (1993)

In the Matter of the Compensation of
DEBRA L. LAINE, Claimant
WCB Case No. 91-17229
ORDER ON REVIEW (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of Referee Brown's order which: (1) found that a cervical condition was due to claimant's compensable injury; and (2) affirmed an order on reconsideration which awarded 9 percent (28.8 degrees) unscheduled permanent partial disability. On review, the issues are compensability and extent of unscheduled permanent disability. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured when she fell backwards and struck her head. An emergency room physician diagnosed a scalp laceration and mild neck and upper shoulder strain. The insurer accepted the claim for laceration of the head and shoulder and arm contusion.

Approximately one month after the injury, claimant began to notice a vibration when she flexed her neck. Dr. Sullivan, claimant's treating neurologist, reported that cervical spine films revealed mild disc space narrowing at C4-5 and C5-6. Diagnosing a cervical lesion of uncertain cause, Sullivan ordered tests to rule out multiple sclerosis. A myelogram and CT scan found mild cervical spondylosis with no significant cord compression. Noting that the "multiple sclerosis test results were pending, Dr. Sullivan reported that, if the results were negative, claimant may have had a cord contusion at the time of her injury. When the tests revealed no evidence of multiple sclerosis and no cord compression, Dr. Sullivan concluded that claimant's symptoms were secondary to a cervical cord contusion (which may or may not resolve).

The insurer scheduled an independent medical examination to determine whether claimant had a cervical condition and, if so, whether the condition was causally related to her compensable injury. Claimant did not attend that examination, nor a second scheduled examination.

As a result of claimant's failure to attend these examinations, the insurer sought and obtained an order from the Department of Insurance and Finance which suspended claimant's rights to compensation. The order further authorized the insurer to seek claim closure if claimant did not seek to have his compensation reinstated within 60 days.

Claimant did not file a request for reconsideration or hearing from the suspension order within 60 days. When claimant did not timely comply with the suspension order, the insurer sought claim closure. A Determination Order issued, awarding temporary disability through the date of the suspension order. No permanent disability was granted. Claimant requested reconsideration, objecting to her attending physician's impairment findings.

Dr. Kho was appointed as a medical arbiter and performed an examination. (Ex 36-4). The following conditions were diagnosed: mild cerebral concussion; chronic cervical sprain; a history of mild cervical spondylosis (non-aggravated); non-related bilateral carpal tunnel syndrome; and mild exogenous obesity. Despite noting reduced active ranges of motion in the cervical area, Dr. Kho concluded that claimant did not have a chronic and permanent medical condition which would limit repetitive use of her cervical spine. Finding no permanent spinal nerve injury, Dr. Kho opined that claimant had a "medium work" physical capacity which would not limit her ability to perform her duties as a cook.

Thereafter, an Order on Reconsideration issued. Based on Dr. Kho's "range of motion" findings, claimant was awarded 9 percent unscheduled permanent disability.

Both parties requested a hearing. Claimant's request was filed within 180 days of the DO (excluding the reconsideration proceeding). The insurer's request was not timely filed.

At hearing, claimant sought an increased permanent disability award. In response, the insurer contended that claimant's cervical condition was not due to her compensable injury. Furthermore, in light of the suspension order, the insurer argued that claimant was not entitled to the permanent disability award granted by the reconsideration order.

The Referee concluded that the suspension order did not terminate claimant's right to receive a subsequently granted permanent disability award. Moreover, since the insurer had not appealed the reconsideration order within 180 days of the date of the Determination Order, the Referee reasoned that the Hearings Division lacked jurisdiction to reduce the permanent disability award. Consequently, the Referee affirmed the reconsideration order.

The dispute in this matter arose as a result of claimant's failure to attend two independent medical examinations. The insurer scheduled these examinations to obtain a medical opinion on whether claimant's cervical condition was causally related to her fall at work. The insurer's requests were prompted by reports from claimant's treating physician suggesting such a relationship.

In light of such circumstances, we consider the treating physician's reports regarding the cervical condition to constitute a claim. See ORS 656.005(8); Safeway Stores, Inc. v. Smith, 117 Or App 224 (1993). Moreover, since more than 90 days had elapsed after the insurer's receipt of those reports, we construe the insurer's position at hearing as raising a "de facto" denial of compensability for the cervical condition.

Having concluded that the compensability issue was properly before the Referee, we next determine whether the record is sufficiently developed to resolve that issue. We may remand to the Referee if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, the evidence concerning the compensability of claimant's cervical condition is, at best, sparse. Dr. Sullivan's initial impression was a cervical lesion of uncertain cause. A myelogram revealed mild cervical spondylosis. When multiple sclerosis and a cervical cord compression were ruled out, Dr. Sullivan concluded that claimant's symptoms were secondary to a cervical cord contusion (which may or may not resolve). Finally, Dr. Kho, medical arbiter, recorded some decreased cervical range of motion. Diagnosing a chronic cervical sprain and mild cervical spondylosis (unaggravated), Kho did not expressly attribute these findings to claimant's fall at work.

Under such circumstances, we consider the record to be incompletely and insufficiently developed for us to resolve the compensability of claimant's cervical condition. See ORS 656.295(5). While the treating physician's reports generally support compensability, none of the medical opinions squarely address or discuss the relationship, if any, between claimant's cervical condition (whether that condition is a sprain or spondylosis) and her fall at work. Furthermore, in light of the procedural history of this case (claimant's failure to attend independent medical examinations followed by an Order on Reconsideration awarding permanent disability which was apparently based on a condition which the insurer had not accepted, but was attempting to investigate), we find a compelling reason to remand this matter to the Referee for further evidence concerning this compensability issue.

Accordingly, the Referee's order dated May 27, 1992 is vacated. This matter is remanded to Referee Brown with instructions to admit additional evidence from both parties pertaining to the compensability issue concerning claimant's cervical condition. Such evidence may be presented in any manner that the Referee determines achieves substantial justice. Following the presentation of the evidence and the closure of the record, the Referee shall issue a final, appealable order.

Considering our conclusion regarding the compensability issue, we need not address the remaining issues raised in this case. However, those remaining issues shall be reconsidered by the Referee in light of his conclusions concerning the compensability issue.

IT IS SO ORDERED.

Board Member Kinsley dissenting in part.

The issues in this case include whether any or all of claimant's diagnosed cervical conditions are related to her work injury and, if related, whether these conditions cause permanent disability.

Pursuant to ORS 656.325(1)(a), when a worker refuses to submit to an independent medical examination, or obstructs the same, the right of the worker to compensation is suspended until the examination takes place and no compensation is payable during or for account of such period. Here, claimant has refused to submit to the very examinations that would provide evidence on these issues. I am unwilling to allow a claimant to profit from her refusal to provide evidence on the very issues for which she seeks compensation. To do so sets this system down the path of rewarding parties for their failure to provide discovery of evidence bearing on the issues before us. In my view, that is not a proper goal to encourage. For that reason, I would affirm the insurer's de facto denials of the cervical conditions and allow no benefits on account of those conditions.

Even if the Board should allow this claimant to prove her case on a manipulated record, remand is not appropriate and necessary in this case. Claimant has the burden to prove that her cervical conditions are compensable and that the conditions resulted in permanent impairment. Unlike the insurer, claimant has had no barriers to obtaining a medical opinion from her attending physician, Dr. Sullivan, or from any other physician that would support her case. However, she has failed to produce such evidence.

Claimant's best evidence on compensability of any cervical condition is one report from Dr. Sullivan that claimant's symptoms of numbness and tingling relate to a cord contusion that she "may" have sustained at the time of her work injury. Exs. 10-1 and 10-2. This opinion is too speculative and indefinite to meet claimant's burden of proof, especially in the context of a record where the insurer was prevented from fully developing the medical opinion. However, even if we were to find a "cord contusion" condition compensable based on this evidence, the record is devoid of any medical opinion that Dr. Sullivan or any other doctor finds permanent impairment based on these symptoms.

The award for permanent disability that was made in the Department's Order on Reconsideration was based on the examination of cervical range of motion made by Dr. Kho, medical arbiter. Ex. 36-3. However, there is no opinion from Dr. Kho, or any other doctor, that these findings were related to the injury at work or that these findings represented permanent impairment. Further, there is no medical opinion from Dr. Kho or any other doctor that claimant has permanent impairment due to any condition accepted by the insurer or due to any denied cervical condition.

On this record -- a record where claimant had no barriers to producing any evidence that she wished -- claimant has failed to meet her burden of proving that any cervical condition is related to her work injury or that she suffers from any permanent disability as a result of a compensable cervical condition. Most of claimant's cervical symptoms came on months after the original injury. Also, her diagnoses include degenerative conditions. Claimant provides no medical opinion that sorts out all these conditions and determines what is related and what is not. This case is complex and requires such medical opinion to resolve the compensability issue. To allow claimant another opportunity on remand to develop her record at hearing is to reward her for failing to provide evidence to the insurer and failing to develop her record at the first hearing.

The only party that was not able to develop the record was the insurer. Claimant thwarted the legal process when she refused to provide the insurer with evidence through an independent medical examination. However, there is no need to remand the case for the insurer to have another opportunity to obtain evidence regarding the cervical conditions because it is the claimant who had the burden to prove her case, not the insurer. Since the claimant has failed to meet that burden of proof, there is no reason to remand for further evidence submitted by the insurer.

However, since the majority has allowed remand, the only fair and just instructions regarding the admission of additional evidence would be to require claimant to submit to an independent medical examination arranged by the insurer, admit the subsequent medical report and only allow claimant to submit additional evidence insofar as it is rebuttal evidence to the independent medical report. The insurer should be allowed to develop its case and submit any evidence that it would have obtained and submitted but for claimant's obstruction of evidence. If the claimant fails to attend the independent medical examination, the insurer's de facto denial of her cervical conditions should be affirmed and the award in the Order on Reconsideration should be reduced to reflect no award for any cervical conditions.

Finally, I agree with the majority's holding that the compensability of claimant's cervical condition is proper for adjudication before the Referee. The insurer has not "waived" its right to deny and litigate the compensability of claimant's cervical conditions because it did not raise that issue before the Department. The Workers' Compensation Board Hearings Division has original jurisdiction over compensability issues. Therefore, there is no "raise or waive" problem in this case that would prevent either party from raising that issue for the first time at the Board.

However, if, in conjunction with disproving compensability of a condition as a result of a hearing on compensability at the Board, a party wants a remedy from an order on reconsideration, that reconsideration order must be kept "alive" and jurisdiction conferred on the Board so that a remedy can be given. In this case, the reconsideration order was kept alive through claimant's timely request for hearing. Once jurisdiction was obtained over the determination order, the insurer was able to ride on the coat tails of the jurisdiction established by claimant and seek its remedy from the determination order. Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983); Gleason W. Rippey, 36 Van Natta 778 (1984). Therefore, even though the insurer's request for hearing on the reconsideration order was untimely, the Board has jurisdiction to decrease the award.

June 14, 1993 Cite as 45 Van Natta 1047 (1993)

In the Matter of the Compensation of
DEMETRIOS C. MELETIS, Claimant
WCB Case No. 91-07919
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Hoguet's order which: (1) upheld the insurer's denial of his occupational disease claim for chronic toxic encephalopathy (CTE); (2) found that claimant was not entitled to interim compensation; and (3) declined to award penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, interim compensation and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation. We do not adopt the first sentence of the last paragraph on page 6 of the Opinion and Order.

On page 3 of the Opinion and Order, the second sentence of the first full paragraph should read: "The EG automatically spreads glue in a band, approximately five inches wide, on to 8-10 foot pieces of veneer."

Air monitoring tests do not take into account the percutaneous absorption of solvent directly through the skin. (Tr. 34).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's occupational disease claim for CTE is not compensable. We disagree.

Claimant's symptoms from the CTE were not sudden in onset, but arose gradually over a period of time. Therefore, this claim is properly analyzed as an occupational disease, rather than an injury. O'Neal v. Sisters of Providence, 22 Or App 9, 16, (1975). Accordingly, claimant must prove, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his CTE. ORS 656.802(2). The "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 Referee relied on the the opinion of the independent medical examiner, Dr. Montanaro, allergist and clinical immunologist. Dr. Montanaro agreed that depression and mood abnormalities are symptoms of organic brain damage (Tr. 340), and that a diagnosis of CTE is possible. However, he opined that claimant's cognitive complaints and deficits on testing were due to a severe mood and personality disorder and that claimant was suffering from severe depression, rather than CTE. (Tr. 328, 340; Ex. 20-6)). Asserting that an isolated single neurologic evaluation frequently yields confusing information, Dr. Montanaro would not base a diagnosis of CTE on only one evaluation. (Tr. 300-301).

Dr. Morton, claimant's treating physician, is a specialist in occupational medicine. (Tr. 16, 17). He is the Director of the Occupational Health Clinic at Oregon Health Sciences University. The purpose of the clinic is to diagnose toxic conditions that arise from the workplace. (Tr. 17). Over the ten-year period that the clinic has been in operation, approximately 140 individuals have been diagnosed with work-related, solvent-induced encephalopathy. (Tr. 234). Further, Dr. Morton has particular experience with toxic exposure in the plywood production industry, which is the industry in which claimant was employed. (Tr. 32; Ex. 32).

In order to verify his preliminary diagnosis of CTE, Dr. Morton referred claimant to Dr. Colby, psychologist. Dr. Colby's work consists primarily of neuropsychological screening and assessment. (Tr. 46). He is qualified to make diagnoses on Axes I and II of the DSM-III-R. Examples of those diagnoses are depression, psychosis, anxiety and organic mental disorder on Axis I, and personality disorders, mental retardation and learning disabilities on Axis II. (Tr. 58).

After extensive testing over a period of two full days (Tr. 51, 68-87; Ex. 15), Dr. Colby diagnosed organic mental disorder NOS, organic delusional disorder, and organic personality disorder (Provisional). (Ex. 15-9). After reviewing the results of Dr. Colby's evaluation, Dr. Morton made a final diagnosis of CTE. Dr. Morton based his diagnosis on the results of Dr. Colby's evaluation, his own examination of claimant, and the history and information that he had obtained from claimant. (Tr. 128). Finding no other explanation for claimant's condition (Tr. 196), Dr. Morton concluded that claimant's work exposure was the major contributing cause of claimant's CTE. (Ex. 154, 196).

In reaching his decision to rely on Dr. Montanaro, the Referee concluded that Dr. Feldstein, occupational medicine, and a former colleague of Dr. Morton, did not agree with Dr. Morton's diagnosis. The Referee also concluded that Dr. Feldstein was not willing to accept Dr. Colby's findings as the basis for a diagnosis of CTE. We disagree with the Referee's reasoning concerning Dr. Feldstein's opinion.

Although Dr. Feldstein's diagnoses of claimant's condition varied between "cognitive impairment secondary to solvent exposure" and "cognitive impairment of unknown etiology" (Exs. 22A-4, 6, 9, 14), we do not find any indication that Dr. Feldstein did not agree with Dr. Morton or that she was unwilling to accept Dr. Colby's neuropsychological evaluation. Dr. Feldstein did not request further neuropsychological testing, even though she knows that testing is necessary for a diagnosis of CTE. (See Ex. 32-2, 4). Rather, after receiving a report from Dr. Barton, neurologist, who had diagnosed a psychiatric condition, Dr. Feldstein requested a further psychiatric consultation in order to clarify whether claimant's condition is psychiatric versus organic. (Ex. 22A-14). The record contains no further opinion from Dr. Feldstein. Consequently, rather than concluding, as the Referee did, that Dr. Feldstein did not agree with Dr. Morton and did not accept Dr. Colby's findings, we conclude that Dr. Feldstein's reports are inconclusive.

Dr. Barton, neurologist, saw claimant one time, on referral from Dr. Feldstein. (Ex. 22A-11). After cursory psychological testing, Dr. Barton diagnosed a psychiatric disorder. His opinion, as a whole, is conclusory, and we do not afford it great weight. See Somers v. SAIF, 77 Or App 259 (1986).

On the other hand, claimant's treating physician, Dr. Morton, occupational medicine specialist, diagnosed CTE only after extensive testing by a neuropsychologist and other physical examinations. Dr. Montanaro knew about Dr. Morton's testing but, for the reasons previously discussed, did not agree with his diagnosis. (Tr. 302, 306).

We generally defer to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Morton's opinion is well-reasoned and thorough, and based on extensive neuropsychological testing and examination. We find no reasons not to defer to Dr. Morton and, thus, find his analysis persuasive.

The insurer argues that claimant's work cannot be the cause of CTE because he was not exposed to chemicals at a toxic level. It bases that argument on tests of ambient air levels conducted near the edge gluer where claimant often worked that showed that the chemical content of the air was far below that of a toxic level. We disagree. In reaching our conclusion, we rely on claimant's credible testimony concerning his work exposure to chemicals and on Dr. Morton's opinion.

Claimant credibly testified that he was frequently sprayed with glue from the waist to the knees while working at the edge gluer. In his 27 years working for the employer, claimant worked 40 to 50 percent of his time on the edge gluer. His clothes were often soaked with glue. (Tr. 528). The solvents in the glue include methylene chloride and 1,1,1-trichloroethane. (Tr. 740). The Material Safety Data Sheet for solvent based adhesive states that skin should be protected by use of rubber gloves and protective clothing. (Ex. P1-3). Claimant sometimes wore rubber gloves with the fingers cut out and holes cut in the back of the hand. (Tr. 526-27). In order to clean the glue from his hands and arms, claimant washed his hands with diesel fuel three times a day. (Tr. 554).

Dr. Morton was aware of the air-quality testing performed at the mill. He did not believe that negative air-quality testing conclusively proved that there had been no exposure to chemicals. His reasoning arose from the facts that the tests were done considerably after the period his symptoms began, and the tests did not represent any skin contact that occurred. (Tr. 132; see Tr. 34-36). Dr. Morton obtained a history from claimant of the extent and type of chemical exposures. He considered skin exposure as important as fume exposure. (Tr. 216). Based on the sum total of all exposures throughout the years of working for the employer, Dr. Morton made his diagnosis of CTE. (Tr. 238-39).

After considering the entire record in this case, we are persuaded by the opinion of Dr. Morton that claimant suffers from CTE, and it is more likely than not that his work is the major contributing cause of the condition. Consequently, we conclude that claimant's occupational disease claim is compensable.

Interim Compensation

"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 (9182). 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).

Although a claimant is entitled to interim compensation whether or not the claim 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, 569 (1986).

Concluding that claimant did not leave work because of his work-related condition, the Referee declined to award interim compensation. We disagree.

After claimant saw Dr. Brookhart on January 3, 1991, he returned to work in the position of edge-gluer for approximately two weeks. (Tr. 536). When the doctor recommended that claimant should avoid the area of toxic chemicals (Ex. 3), claimant was transferred to a position at the "green end." (Tr. 537). He worked there until January 25, 1991, when the foreman told claimant that he could no longer work in that position. Id. On that day, one of the Board of Directors filled out a Request for Leave of Absence form, which claimant signed. (Ex. 6AA). The stated purpose of the leave of absence was, "Can't work position inside plant due to medical condition." (Ex. 6AA). Claimant was given no option other than to take a six-month leave of absence. (Tr. 538). We conclude, from the evidence, that claimant left work for reasons related to his compensable condition. See Faustino Martinez, 44 Van Natta 2585 (1992). Accordingly, he is entitled to interim compensation beginning January 26, 1991.

The insurer contends that the April 26, 1991 denial denied claimant's CTE condition. Claimant argues that the denial did not specifically deny CTE and, therefore, there was a "de facto" denial. We agree with the insurer's contention. Accordingly, interim compensation was payable until the date of the denial. Bono v. SAIF, supra, 298 Or at 407 n. 1 (1984)

Claimant signed an 801 form on January 24, 1991. (Ex. 6). He referred to lab tests conducted on January 3, 1991, and to Dr. Brookhart's chart note. (Exs. 1, 2, 3). Dr. Brookhart's chart note stated that certain levels in the blood were elevated, consistent with overexposure to chemicals, and that claimant should be removed from his job until the levels returned to normal. (Ex. 3). On April 26, 1991, the insurer denied "conditions diagnosed as A.L.T. carboxyhemoglobin and thalassemia" and "subsequent symptoms." (Ex. 12). At the time of the denial, the insurer had in its possession Dr. Morton's initial medical report that stated that claimant's symptoms were suggestive of CTE. (Ex. 8-3). Accordingly, we are persuaded that the April 26, 1991 denial represents a formal denial of CTE. Thus, claimant is entitled to interim compensation between January 26, 1991, the date he left work due to the work-related condition, and April 26, 1991, the date of the insurer's denial.

Penalties and Attorney Fees

The Referee did not assess penalties or attorney fees because he found that claimant was not entitled to interim compensation and that the CTE condition was not compensable. In light of our earlier conclusions, we proceed to analyze the penalty and attorney fee issues.

Claimant seeks penalties and attorney fees based on the insurer's failure to timely accept or deny his occupational disease claim, its failure to pay interim compensation pursuant to that claim, its unreasonable denial of blood tests as "conditions," and its unreasonable denial of CTE.

Considering our conclusion that claimant left work due to his compensable condition, we find that the insurer's refusal to pay interim compensation between January 26, 1991 and April 26, 1991 was unreasonable. As discussed above, all the evidence available to the insurer indicated that claimant left work because of a medical condition. Accordingly, we find that the insurer is liable for a penalty of 25 percent of the amounts due between January 26, 1991 and April 26, 1991.

Furthermore, we conclude that the insurer's denial of claimant's claim was two days late. Claimant signed an 801 form on January 24, 1991, after Dr. Brookhart's examination and diagnosis of overexposure to toxic chemicals. (Exs. 3, 6). The 801 form was signed by the employer's safety director on the same day. (Ex. 6). The insurer issued its denial, which we found to have been a denial of CTE, on April 26, 1991, 92 days after the employer had notice of the claim. Because the insurer did not accept or deny the claim within 90 days, we conclude that its conduct was unreasonable and that a penalty may be assessed under ORS 656.262(10), based on the amounts then due on the date of the untimely denial. Michael L. Dodson, 45 Van Natta 198, 199 (1993); Jeffrey D. Dennis, 43 Van Natta 857 (1991).

As discussed above, the insurer failed to pay interim compensation. Thus, there were amounts then due at the time of the insurer's untimely denial. No additional penalty, however, is allowed because the maximum 25 percent penalty has already been assessed on the only compensation due. Nevertheless, by failing to respond to the claim, the insurer unreasonably resisted the payment of compensation. See ORS 656.382(1). Thus, claimant is entitled to an attorney fee for the insurer's untimely denial. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). After consideration of the factors set forth in OAR 438-15-010(4), we conclude that a reasonable assessed attorney fee is $750.

Claimant contends that the insurer's denial was unreasonable. We disagree.

Pursuant to ORS 656.262(10), claimant is entitled to a penalty 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 standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time of the denial, the insurer had in its possession medical reports relating claimant's symptoms to overexposure to toxic chemicals at work. However, before the denial, no physician had diagnosed CTE. Dr. Morton acknowledged that further testing was required. Furthermore, the insurer had in its possession two reports of air quality testing at the mill, performed at the employer's request by an industrial hygienist employed by the insurer, after claimant filed his claim. (Ex. 9A, 10A). Those reports indicated that air contaminant levels were well below the levels to which most workers may be exposed without adverse health effects. Accordingly, we conclude that evidence available at the time of its denial was sufficient to raise a legitimate doubt, on the part of the insurer, of the existence of a work-related condition. Therefore, its denial was not unreasonable.

The insurer's denial also denied "conditions diagnosed as A.L.T. carboxyhemoglobin and thalassemia." (Ex 12). Claimant also contends that that portion of the denial was unreasonable. We disagree.

The insurer had four reports in its possession at the time it denied claimant's claim. Lab results and Dr. Brookhart's chart note diagnosed "elevated carboxyhemoglobin and elevated ALT due to occupational exposure." (Ex. 5). Notwithstanding the insurer's mistaken belief that A.L.T. and carboxyhemoglobin are "conditions," we conclude that it was reasonable, based on Dr. Brookhart's report, that A.L.T. and carboxyhemoglobin were conditions related to toxic exposure at work. In light of our conclusion that the CTE denial was not unreasonable, we further conclude that the insurer's denial of "A.L.T. and carboxyhemoglobin" was not unreasonable.

Finally, 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 $15,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record, claimant's appellant's brief and reply brief, and claimant's counsel's statements of services and the insurer's response), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 26, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $15,000 to be paid by the insurer. Claimant is awarded interim compensation for the period from January 26, 1991 through April 26, 1991. Claimant's attorney is awarded an attorney fee of 25 percent of this interim compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. For the insurer's unreasonable refusal to pay interim compensation, claimant is awarded a penalty in an amount equal to 25 percent of interim compensation, with one-half to be paid to claimant's attorney. Claimant's counsel is awarded an insurer-paid attorney fee of $750 for services concerning the insurer's failure to timely accept or deny claimant's claim.

In the Matter of the Compensation of
EILEEN WIENKE, Claimant
WCB Case No. 92-05474
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

The self-insured employer requests review of Referee Herman's order that set aside its partial denial of claimant's low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant sustained two low back injuries prior to the compensable injury in April 1977. On November 20, 1965, claimant injured her back while lifting and was treated in April and May of 1966. On November 27, 1967, claimant again injured her back while lifting; the diagnosis was acute recurrent lumbar strain.

In December 1976, five months before the compensable injury, claimant experienced gradually progressive discomfort in the right leg following a back strain. Lumbar x-rays revealed mild scoliosis to the right, marked asymmetric narrowing of the L4-5 disc space on the left with prominent spurring, and slight narrowing of the L2-3 disc space with prominent spurring.

On April 25, 1977, claimant compensably injured her low back while lifting a heavy box at work. She experienced severe low back pain radiating into the right leg. The diagnosis was "[a]cute exacerbation of her chronic back strain." At some point, claimant developed radiating symptoms in the left leg. On May 17, 1977, three weeks after the compensable injury, x-rays revealed moderate disc space narrowing of L3-4 and L4-5, early degenerative spondylolysis of L4-5 and disc degeneration of L3-4. Additionally, the facet joints at L5-S1 were considered essentially obliterated on oblique films by overgrowth osteophyte bone.

After conservative treatment measures were unsuccessful, claimant underwent surgery on August 4, 1977, for total laminectomy at L4-5 with foraminotomies at L5 and S1 roots bilaterally. The claim was closed by Determination Order on August 23, 1978, with an award of 20 percent unscheduled permanent disability benefits. Claimant has not returned to work since the compensable injury.

On March 24, 1992, the employer issued a letter denying the compensability of current low back treatment as not related to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current low back condition is compensable, finding that the compensable 1977 back injury is the major contributing cause of the current back condition. The employer contends that the Referee's finding is not supported by a preponderance of the evidence in the record. We agree.

It is undisputed that claimant has degenerative disc disease which preexisted the compensable injury. It is also undisputed that the preexisting disease combined with the compensable injury to cause disability and need for treatment. Therefore, in order to prove the compensability of her current condition, claimant has the burden of proving by a preponderance of the evidence that the compensable injury is the major contributing cause of her current condition. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We conclude that claimant has not sustained her burden of proof.

Claimant's history of prior back injuries and degenerative disc disease, combined with the substantial period of time that has elapsed since the compensable injury (15 years), make the causation issue in this case a medically complex question. Therefore, resolution of this issue turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The medical evidence is divided. Dr. Iverson, the attending physician, checked "yes" in response to a questionnaire prepared by claimant's counsel which asked: "Is the industrial injury and/or the treatment made necessary as a result of the industrial injury likely the major contributing cause of the treatment which is required at the present time?" (Ex. 41-2). Dr. Iverson provided no explanation for his response.

Drs. Dinneen and Snodgrass, who examined claimant at the employer's request, opined:

> "In our opinion, [claimant's] slowly progressing condition over the past 15 years cannot reasonably be attributed to her industrial injury. It is our opinion, instead, that the major contributing cause of her problems in the past 13-14 years have been continued natural degeneration from a process which was already fairly advanced when her injury occurred." (Ex. 42-5).

Unlike the Referee, we are not persuaded by Dr. Iverson's opinion. Although we ordinarily defer to the treating physician's opinion, we find persuasive reasons not to do so in this case. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Treating physicians are generally afforded deference because of their opportunity to observe and evaluate a condition over a substantial period of time. That is not true in this case, however, as Dr. Iverson treated claimant only since March 1992, almost 15 years after the compensable injury.

Further, given the complexity of the "combination" issue and the length of time between the injury and current condition, we find that the resolution of the causation issue in this case requires expert analysis, rather than expert external observation. See Hammons v. Perini Corp., 43 Or App 299 (1979). Therefore, Dr. Iverson has no greater advantage in evaluating the causal factors contributing to claimant's condition.

Finally, the persuasiveness of Dr. Iverson's opinion itself is reduced, because it is conclusory and possibly based on inaccurate history. At hearing, claimant testified that she reported to Dr. Iverson that she had no low back problems or treatment for several years prior to the compensable injury. (Tr. 15-17, 21). That history is contradicted by Dr. Drips' June 21, 1977 report, which states that during a visit on December 7, 1976, just five months before the compensable injury, claimant complained of "gradually progressive discomfort in the right leg following a back strain." (Ex. 5). Further, although there is no previous report of similar complaints, Dr. Drips' description strongly suggests that claimant's leg discomfort had been developing for some unspecified period of time prior to December 7, 1976. To the extent that claimant's history is inconsistent with the medical record, we find that history to be unreliable.

Claimant argues that Dr. Iverson was provided with Dr. Drips' report along with other exhibits and should, therefore, be presumed to have considered it in his opinion. We disagree. The conclusory nature of Dr. Iverson's opinion provides us no guidance for determining whether or not he, indeed, considered Dr. Drips' report or was aware of claimant's symptoms in December 1976.

Finally, the Referee found that Dr. Iverson's opinion is supported by the continuity of claimant's symptoms, treatment and disability since the compensable injury. We are not so persuaded, because claimant had a degenerative condition before the compensable injury which continued to worsen naturally following the injury, unaffected by the injury or subsequent surgery (See Ex. 42-5); she already had symptoms shortly before the compensable injury; and 15 years had elapsed since the compensable injury.

For these reasons, we discount Dr. Iverson's opinion. Based on the better reasoned opinion of Drs. Dinneen and Snodgrass, we conclude that claimant has failed to prove the compensability of her current condition.

ORDER

The Referee's order dated October 22, 1992 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
LARRY R. RUECKER, Claimant
Own Motion No. 92-0492M
OWN MOTION ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 19, 1993 Own Motion Order in which we declined to reopen claimant's claim for temporary disability compensation on the ground that he had not established that he remained in the work force at the time of his disability. With his request, claimant submits additional information regarding the work force issue.

In order to consider claimant's motion, we withdraw our May 19, 1993 order. The SAIF Corporation is granted an opportunity to respond by submitting a response within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE A. AYERS, JR., Claimant
WCB Case No. 92-07476
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of that portion of Referee Hoguet's order which declined to award an assessed fee under ORS 656.382(1) for the insurer's allegedly unreasonable resistance to providing vocational assistance. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

The insurer accepted a lumbar strain with consequential L4-5 disc. (Ex. 11). On January 29, 1992, back surgery was performed. (Ex. 19A-1). In March and April 1992, claimant participated in a work-hardening program. (Id).

The parties stipulated at hearing that claimant requested vocational services on March 6, 1992. On March 24, 1992, the insurer informed claimant by letter that eligibility evaluation could not be completed until it received physical capacity recommendations from claimant's attending physician and information regarding the availability of suitable employment with the employer. (Ex. 15). The letter also stated that, until the information was received, it appeared that claimant was not likely eligible for vocational assistance. (Id).

On April 9, 1992, Dr. Corrigan examined claimant and identified permanent work restrictions. (Ex. 19A). However, Dr. Corrigan also indicated that claimant had not yet completed a work-hardening program and was not medically stationary and, therefore, would see him again after the program was completed. (Id). The insurer received this information on May 8, 1992. (Id).

On April 30, 1992, Dr. Corrigan again examined claimant. In his chart note, Dr. Corrigan indicated that claimant had completed the work-hardening program and again provided permanent work restrictions. (Ex. 19D). The insurer received this information on May 19, 1992. (Id).

On May 12, 1992, claimant was referred to a vocational consultant for evaluation. (Ex. 28-1). On June 12, 1992, the consultant found claimant eligible for vocational services. (Ex. 28). On June 18, 1992, the insurer informed claimant's attorney's office of this eligibility. (Ex. 31). On July 24, 1992, the insurer sent claimant a notice of eligibility for vocational assistance. (Ex. 33).

CONCLUSIONS OF LAW AND OPINION

ORS 656.340(1)(a) requires carriers to provide vocational services to eligible workers. The carrier must contact the worker for evaluation of vocational assistance within five days of "[h]aving knowledge of the worker's likely eligibility for vocational assistance, from a medical or investigation report, notification from the worker, or otherwise[.]" ORS 656.340(1)(b)(A); OAR 436-120-035(4). For likely eligibility to exist, along with other kinds of material, there must be a Form 801 or "medical report which indicates the severity of the injury" "sufficient to indicate the worker will probably meet the eligibility criteria under OAR 436-120-040[.]" OAR 436-120-035(2)(a). If this information is not available, the insurer must obtain it within 30 days of receiving a request for vocational services. OAR 436-120-035(3).

Not more than 30 days after the worker is found likely eligible, the carrier must "cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance." ORS 656.340(4); OAR 436-120-035(6). The carrier also must notify the worker of the decision regarding his or her eligibility for vocational assistance. Id.

Claimant asserts that as of March 6, 1992, the insurer knew that he was likely eligible for vocational assistance. He further contends that, because the insurer did not determine that claimant was eligible for vocational services until June 12, 1992, and he was not informed of this determination until July 24, 1992, the insurer did not comply with ORS 656.340(4). Claimant maintains, therefore, that the insurer unreasonably resisted the payment of compensation and he is entitled to an assessed fee of $20,000 based on ORS 656.382(1).

Claimant requested vocational services on March 6, 1992. We disagree, however, that this request provided the insurer with the knowledge that claimant was likely eligible for vocational assistance. In particular, there is no proof that medical evidence regarding the severity of claimant's injury or indicating that claimant would likely have permanent disability was available to the insurer on that date. See OAR 436-120-035(2)(a), 436-120-040(2). Therefore, we find that the insurer lacked sufficient information on March 6, 1992 to determine whether claimant was likely eligible.

The insurer's first notice that claimant may have permanent work restrictions occurred on May 8, 1992, when it received Dr. Corrigan's April 9, 1992 report. However, in that same report, Dr. Corrigan qualified this opinion by noting that claimant had not completed a work-hardening program. Following completion of the program, Dr. Corrigan issued an April 30, 1992 chart note, which continued to set forth permanent work restrictions. In light of Dr. Corrigan's prior qualifications, we find that this later chart note triggered the insurer's responsibility to begin vocational services.

The insurer received Dr. Corrigan's April 30, 1992 chart note on May 19, 1992. By that date, the insurer had already referred the claim to a vocational consultant. The vocational consultant's report (which supported claimant's eligibility for vocational assistance) issued on June 12, 1992. On June 22, 1992, 10 days later, claimant's attorney confirmed his understanding that claimant was eligible for vocational assistance. Formal notification of this eligibility, as well as the implementation of procedures for initiating the vocational services, occurred on July 24, 1992.

In light of such circumstances, we are not persuaded that the insurer's conduct in evaluating claimant's vocational assistance claim and in providing services was unreasonable. Inasmuch as we find that the insurer did not unreasonably resist the payment of compensation, we conclude that an attorney fee is not warranted. See ORS 656.382(1).

ORDER

The Referee's order dated October 7, 1992 is affirmed.

In the Matter of the Compensation of
PAUL BILECKI, Claimant
WCB Case No. 92-07571
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Peterson's order that: (1) declined to assess a penalty for the insurer's allegedly untimely acceptance of his neck strain claim; and (2) declined to assess attorney fees for his attorney's efforts in obtaining the insurer's acceptance of the neck strain claim. On review, the issues are penalties and attorney fees.

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

The Referee found, and we agree, that the insurer accepted the neck strain claim within 90 days after after it received notice or knowledge of the claim, which occurred with claimant's attorney's representative's February 18, 1992 letter. ORS 656.262(6). A claim is not denied "de facto" until after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132 (1987): Doris J. Hornbeck, 43 Van Natta 2397 (1991). The insurer accepted the cervical strain on February 26, 1992, well within the 90 day requirement. Therefore, there was no "de facto" denial of the cervical strain claim.

Claimant argues that a claim was made for the cervical strain by an October 16, 1991 chart note from Dr. Camp, claimant's treating physician. However, claimant offers no evidence as to when the insurer received this chart note. Furthermore, Dr. Camp's 827 form, which was received by the insurer on October 18, 1991, describes claimant's complaints as "low back pain" and diagnoses only "low back strain." (Ex. 2). Although this form mentions "slight neck pain," it makes no reference to any treatment regarding the neck. On this record, we are unable to determine that the insurer had notice or knowledge of the neck strain claim prior to its receipt of the February 18, 1992 letter. Rachelle E. Volz, 43 Van Natta 903 (1991).

Because claimant failed to establish an untimely acceptance or a "de facto" denial of the neck stain, there is no basis for a penalty pursuant to ORS 656.262(10). In addition, without a written or a "de facto" denial, there is no basis for an assessed attorney fee pursuant to ORS 656.386(1). ORS 656.386(1) provides that, if an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, a reasonable attorney fee shall be allowed. In Michael A. Dipolito, 44 Van Natta 981, 982 (1992), we held that ORS 656.386(1) has "no application when the hearing request did not pertain to a denial (written or 'de facto') and, thus, there was no denial to withdraw after the hearing request and before the hearing." See also Simpson v. Skyline Corp., 108 Or App 721 (1991) (ORS 656.386(1) is not applicable where the issue of causation is not in dispute); Gloria J. Shelton, 44 Van Natta 2232 (1992) (ORS 656.386(1) is only applicable to a denied claim).

Claimant relies on Robert J. Egyedi, 44 Van Natta 1194 (1992), in support of his argument that he is entitled to an assessed attorney fee. However, there, the claimant established that the insurer had "de facto" denied several conditions even though it paid for the medical services required by those conditions. Here, claimant did not establish that the insurer "de facto" denied his neck strain condition.

ORDER

The Referee's order dated September 11, 1992, as reconsidered October 9, 1992, is affirmed.

In the Matter of the Compensation of
MICHAEL T. CROUNSE, Claimant
WCB Case No. 92-09719
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its denial of claimant's claim for his current asthma condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In early 1982 claimant sought treatment for shortness of breath. At that time, claimant was working as a green grader and trimmer in a sawmill where he was exposed to pine dust. He was diagnosed with obstructive pulmonary disease, and it was recommended that he change jobs to avoid pine dust exposure. In October 1985 claimant filed an occupational disease claim for breathing difficulties involving his "lungs." The employer accepted the claim.

Claimant changed jobs to green chain puller, working outside the sawmill. His condition improved initially, but then grew worse. Dr. Adler, allergist, opined that claimant most likely had preexisting, asymptomatic reactive airways disease, which was symptomatically worsened by pine dust exposure and non-occupational factors. The claim was closed by Determination Order on November 3, 1987, with an award of 10 percent unscheduled permanent disability. By stipulation dated February 9, 1988, the award was increased to 20 percent unscheduled permanent disability for "chronic asthma and reactive airway disease."

In late 1988 the employer denied claims for medical services relating to claimant's asthma. By Opinion and Order dated January 6, 1989, a prior referee set aside those denials, finding that the employer had accepted claimant's underlying asthma condition and that the asthma condition was a material cause of the need for medical services. That order was not appealed and became final.

On July 7, 1992, the employer denied claimant's current asthma condition on the basis that work exposure is not the major contributing cause of the condition and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the employer's July 7, 1992 denial, reasoning that claimant's current condition is the same underlying asthma which the prior referee found to be compensable. We agree.

The "issue preclusion" doctrine of res judicata 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).

In the prior proceeding, the parties actually litigated the compensability of claimant's asthma condition in 1988. The referee determined that the employer had, as a matter of law, accepted the compensability of claimant's underlying asthma condition. (See Ex. 10-3). That determination was essential to the referee's decision that claimant's condition and need for treatment in 1988 were compensable. Inasmuch as that decision was not appealed and is now final, the employer is precluded from relitigating the compensability of claimant's underlying asthma condition. See id.

Even if we were to conclude that the employer is not so precluded, on the merits, we would still find that the employer accepted the underlying asthma condition. The employer accepted claimant's claim on the same claim form which he filed for breathing difficulties involving his "lungs." (See Ex. 3). By specifically accepting the claim for breathing difficulties, which was a symptom of claimant's underlying asthma, the employer accepted the underlying asthma as well. See Georgia-Pacific v. Piwowar, 305 Or 494, 500-501 (1988); Rouse v. FMC Corp. Marine-Rail, 118 Or App 25, 29 (1993).

Insofar as the employer's denial is an attempt to back-up deny the underlying asthma, it is invalid because it issued more than two years after claim acceptance and there is no allegation that the acceptance was induced by fraud, misrepresentation or other illegality. See ORS 656.262(6); Anthony G. Ford, 44 Van Natta 240 (1992).

On review, the employer argues that the current condition is not compensable because there is insufficient evidence to prove that work exposure was the major contributing cause of the condition. The employer apparently assumes that ORS 656.005(7)(a)(b) applies because claimant had preexisting asthma which combined with work exposure to produce his current condition.

However, we have previously held that an accepted condition is not deemed a "preexisting disease or condition" for purposes of ORS 656.005(7)(a)(B). See Lizbeth Meeker, 44 Van Natta 2069, 2071 (1992); Richard R. Zippi, 44 Van Natta 1278 (1992). Therefore, because the employer has accepted the underlying asthma, it is not a "preexisting condition," and ORS 656.005(7)(a)(B) does not apply. Rather, we apply the material contributing cause standard of compensability. See ORS 656.005(7)(a).

The medical evidence establishes that claimant's current condition and need for treatment are materially related to the underlying asthma which the employer has accepted. Accordingly, claimant's current condition is compensable.

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 $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.

ORDER

The Referee's order dated October 27, 1992 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the self-insured employer.

June 17, 1993 Cite as 45 Van Natta 1058 (1993)

In the Matter of the Compensation of
ARMAND J. DEROSSET, Claimant
WCB Case No. 90-11927
ORDER ON REMAND
Bennett & Durham, Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). The court has reversed our prior order which set aside the self-insured employer's denial of claimant's left knee replacement surgery. Concluding that claimant had suffered a "new injury" to the same condition previously injured in 1977, we determined that the employer was responsible for all further compensable medical services and disability involving claimant's left knee condition under ORS 656.308. Reasoning that we had not determined whether claimant's knee replacement surgery involves the "same condition" as was held to be compensable in either 1977 or 1984, the court has remanded for that determination.

We first determine whether claimant's total left knee replacement surgery in 1988 involved the same condition as either his 1977 left lateral meniscectomy or his 1984 sprain injury.

In 1977, claimant compensably injured his left knee. The injury was a twisted left knee with a cartilage tear. (Ex. 3). Dr. Coletti, M.D., orthopedic surgeon, performed a left lateral meniscectomy. (Ex. 6). He noted significant preexisting arthritis at the time of the surgery (Ex. 6, 61-5), and indicated that, after the 1977 surgery, claimant would have ensuing degenerative changes. (Ex. 25). The claim was closed on September 15, 1978 with an award of 10 percent scheduled permanent disability for loss of use or function of the left leg. (Ex. 10).

In 1984, claimant compensably sprained his left knee as he attempted to move away from escaping hot liquid and steam. (Ex. 16). X-rays of the left knee at that time showed moderately severe degenerative changes. Id. No effusion was evident. (Ex. 15). Claimant's treating physician for this injury was Dr. Abbott, M.D, who diagnosed knee sprain and noted moderately severe degenerative changes at the left knee. (Ex. 15). This claim was closed on February 19, 1986 with no additional award for permanent disability.

On November 12, 1987, claimant returned to Dr. Coletti for continuing left knee symptoms. Dr. Coletti attributed claimant's complaints to degenerative changes from the 1977 surgery. (Ex. 25). In March 1988, Dr. Coletti recommended either unicompartmental or total joint replacement. Id.

Claimant's 1977 injury claim was with EBI, who accepted responsibility for the knee replacement surgery. Inasmuch as claimant's aggravation rights under that claim had expired, EBI submitted claimant's "reopening" claim to the Board pursuant to ORS 656.278. (Ex. 35). Thereafter, the Board reopened the 1977 claim.

Claimant requested a hearing, contending that his surgery was causally related to his 1984 left knee sprain claim, rather than his 1977 meniscectomy. Concluding that claimant had suffered a "new injury" to the same condition as the 1977 injury, we reasoned that, pursuant to ORS 656.308, the employer was responsible for all further compensable medical services and disability involving claimant's left knee condition. The court reversed and remanded for a determination of whether the 1988 surgery involved the same condition as either the 1977 or 1984 injury claims.

Dr. Isaacson, claimant's orthopedic surgeon, recommended total knee replacement because of claimant's arthritic knee condition. (Ex. 60-12). In her opinion, the 1988 knee replacement surgery and the 1984 injury involved the same condition as the 1977 injury insofar as they all concerned the left knee. (Ex. 60-25, 26). We agree that all of claimant's injuries involve the same body part, but the preponderance of the medical evidence does not establish that the injuries involve the same "condition." Specifically, as diagnosed by Dr. Isaacson and Dr. Coletti, claimant's 1988 surgery resulted from degenerative arthritis, which is not the same condition as his 1984 knee sprain or the 1977 cartilage tear and meniscectomy. Moreover, Dr. Butler, orthopedic surgeon, based his decision to replace claimant's knee on a diagnosis of degenerative joint disease, as opposed to the sprain. (Ex. 61-21). Accordingly, because we conclude that the degenerative arthritis of claimant's knee which resulted in his need for total knee replacement surgery did not involve the same condition as his 1977 or 1984 injuries, ORS 656.308(1) is not applicable. See Beverly R. Tillery, 43 Van Natta 2470, 2472 (1991).

Because we have concluded that claimant's knee surgery did not involve the same condition as his 1984 left knee sprain, and that ORS 656.308(1) is not applicable, we now address the relationship of claimant's left knee replacement surgery to his 1984 accepted sprain injury.

To prove compensability of his left knee replacement surgery, as it relates to his 1984 left knee sprain, claimant must establish that his current condition arose as a consequence of his 1984 compensable left knee injury. ORS 656.005(7)(a)(A). Thus, he must prove that his 1984 left knee sprain is the major contributing cause of his left knee replacement surgery. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Dr. Isaacson diagnosed moderately severe arthritis of the left knee and, based on that diagnosis, recommended a total knee replacement. (Ex. 60-12). Dr. Isaacson stated that the degeneration of claimant's left knee was a natural progression from his original injury in October 1977 and the resulting surgery. (Ex 45). Dr. Isaacson further stated that the September 1984 injury was not a material contributing cause of claimant's left knee condition and degeneration. (Ex. 60-21).

Dr. Abbott, M.D., claimant's treating physician for his 1984 burn injury and knee sprain, reported, at the time of the injury, that x-rays showed moderately severe degenerative changes in claimant's left knee. (Ex. 16). In January 1986, after claimant's knee was medically stationary, Dr. Abbott stated that "[t]he condition of the knee is not much worse now than it was prior to this most recent accident * * * . (Ex. 20).

Dr. Duff, orthopedic surgeon, examined claimant in an independent medical examination on July 27, 1988. (Ex. 30). He noted that claimant's degenerative arthritis was present prior to his 1977 injury, but that the 1977 injury and subsequent removal of cartilage, accelerated and materially worsened the process of osteoarthritis. (Ex. 30-3).

Claimant saw Dr. Butler on August 22, 1988. (Ex. 31). After reviewing claimant's radiographic reports, Butler opined that, at the time of the 1977 injury, the degenerative process in claimant's left knee was far advanced, and the "fact that he then got 13 more years [use of the knee] is pretty darn good." (Ex. 61-18). Dr. Butler also stated that the degeneration in claimant's knee was a natural progression of the original injury in 1977 and resultant surgery. (Ex. 61-12).

The record indicates that every physician who examined claimant either related his knee replacement surgery to his 1977 injury and surgery, or reported that the 1984 sprain injury contributed only slightly to claimant's current condition. Thus, we conclude that claimant has failed to prove that his 1984 injury was the major contributing cause of his knee replacement surgery. ORS 656.005(7)(a)(A). Accordingly, claimant's knee replacement surgery is not compensable under the employer's 1984 left knee sprain injury claim.

On reconsideration, we reverse the Referee's May 29, 1991 order. The employer's "de facto" partial denial of claimant's left knee replacement surgery claim is reinstated and upheld. The Referee's attorney fee award is reversed.

IT IS SO ORDERED.

June 17, 1993 Cite as 45 Van Natta 1060 (1993)

In the Matter of the Compensation of
DOUGLAS FREDINBURG, Claimant
WCB Case Nos. 92-05032 & 92-05033
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The Department of Insurance and Finance (Department) requests review of that portion of Referee Garaventa's order that set aside its order declaring claimant to be a non-subject worker of Dan Morris (Morris). See OAR 436-80-060(3); OAR 438-06-038. In his respondent's brief, claimant argues that the Referee erred by declining to address compensability. On review, the issue is subjectivity. We reverse in part and affirm in part.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant injured his right knee while working for Morris, a non-subject employer. Claimant's work for Morris was "casual employment" in the course of Morris' trade as painter.

CONCLUSIONS OF LAW AND OPINION

The Referee found that Morris was claimant's employer and that claimant was injured while working for Morris. We agree and adopt her reasoning in this regard.

The Referee also found that Morris was a subject employer under ORS 656.023 and claimant was a subject employee, not excepted from coverage by ORS 656.027(3). We disagree.

ORS 656.023 defines an employer subject to ORS Chapter 656 as an "...employer employing one or more subject workers in the state...." ORS 656.027 includes as subject workers all workers except the following, in pertinent part:

"(3)(a) A worker whose employment is casual and either:

"(A) The employment is not in the course of the trade, business or profession of the employer; or

"(B) The employment is in the course of the trade, business or profession of a non-subject employer."

"Casual" employment "refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200." ORS 656.027(2)(b).

Although the Referee found that Morris paid claimant less than $200, she also found the evidence insufficient to establish how much Morris had agreed to pay claimant and one other employee. Thus, she concluded that claimant's employment was not casual.

The Department argues that, because claimant is the moving party challenging its determination that claimant was not a subject worker when injured, claimant bears the burden of proving subject worker status. We agree. See Konell v. Konell, 48 Or App 551, 557 (1980), rev den 290 Or 449 (1981) ("Claimant had to establish that the employers' labor costs would exceed the statutory amount of $200[.]); see also Acc Prev. Div. v. Sunrise Seed, 26 Or App 361, 363, withdrawn on other grounds, 26 Or App 879, 881 (1976) (One who initiates a proceeding has the burden of proving his contentions). In addition, because there is no evidence of labor costs equal to or greater than $200, the Department argues that claimant has not carried his burden. Again, we agree. Accordingly, on this evidence, we conclude that Morris' employment of claimant and one other person was "casual" within the meaning of ORS 656.027(2)(b).

As a casual worker, claimant is not a subject worker if his work for Morris is outside the course of Morris' trade, business or profession or, if Morris is a nonsubject employer, if the work is in Morris' trade, business or profession. ORS 656.027(3)(a)(A)&(B). Here, Morris' trade is painting. It follows that claimant's painting work for Morris is within the course of Morris' trade. In addition, in the absence of evidence that Morris employed one or more subject workers, Morris was a non-subject employer of claimant. Thus, because claimant's work for Morris was casual and in the course of Morris' painting trade, claimant was a non-subject worker when injured. See Bisbey v. Thedford, 68 Or App 200, 202-03 (1984) (Even if a claimant meets the statutory definition of "worker" and was engaged in the employer's profession, he was exempt from coverage as a casual worker where his pay did not exceed $200 and the employer otherwise hired no subject employees); Ray McDonald, 42 Van Natta 2753 (1990). Accordingly, we reinstate the Department's order concerning claimant's nonsubject status.

On the question of compensability, because of our holding on subjectivity, there is no subject employer against whom claimant can claim. See Lasiter v. SAIF, 109 Or App 464 (1991). Thus, there can be no compensable claim under ORS Chapter 656 and the compensability issue is moot.

ORDER

The Referee's order dated June 10, 1992, as corrected June 19, 1992, is reversed in part and affirmed in part. That portion of the order that set aside the order declaring claimant to be a non-subject worker and referring the claim to the Department is reversed. The Department's order is reinstated and affirmed. The remainder of the order is affirmed.

In the Matter of the Compensation of
WILLIE M. HOLLING, Claimant
WCB Case No. 92-05050
ORDER ON REVIEW
Mark G. Reinecke, Claimant Attorney
Phillip Nyburg, Defense Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The noncomplying employer requests review of Referee Spangler's order which set aside the SAIF Corporation's denial, on its behalf, of claimant's left arm injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, except the Referee's Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the factors set forth in Jordan v. Western Electric, 1 Or App 441 (1970), in determining whether claimant's injury arose out of and in the course of employment. He concluded that claimant had satisfied four of the seven factors, and had met her burden of establishing compensability. We disagree.

Claimant need not satisfy all seven Jordan factors in order to establish compensability. No single factor, nor the sum of the factors, is dispositive. Preston v. SAIF, 88 Or App 327 (1987); Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985); Jennifer J. Kahn, 43 Van Natta 2760 (1991). There is no precise formula for determining whether the particular circumstances under which an employee has been injured have occurred in the course and scope of employment. Rogers v. SAIF, 289 Or 633, 643 (1980); Hansen v. SAIF, 28 Or App 263 (1977). Rather, to establish compensability, claimant must ultimately prove that "the relationship between the injury and the employment is sufficient that the injury should be compensable." Rogers, 289 Or at 642.

In this case, the employer hired claimant to work as an apartment manager in Bend. At the time of hiring, claimant lived in Lebanon. While moving her personal belongings into the apartment, which would also serve as the manager's office, claimant fell from her pick-up truck onto the street, injuring her left arm.

To determine whether the injury is work-related, we are guided by the factors outlined by the court in Jordan, supra:

1. Whether the activity was for the benefit of the employer.

The Referee concluded that the employer received an indirect benefit from the activity during which claimant was injured, i.e., claimant's eventual occupancy of the manager's apartment.

The employer contends on review that claimant's moving into the apartment was, at most, of incidental benefit because it was no different than the benefit an employer receives when a worker commutes to work. Claimant, on the other hand, contends that the employer received direct benefit because claimant was preparing her apartment for use as the manager's office at the time she was injured.

After reviewing the record, we conclude that claimant was not simply commuting or "going to" work at the time of her injury. She was moving from Lebanon to Bend in preparation for the start of a new job. We do not find that activity to be the kind of "preparatory act" leading to a finding of compensability, however.

In Jackie J. Freeny, 43 Van Natta 1363 (1991), we held that an injury occurring as a result of the claimant's act of preparing for work within a reasonable interval before working hours began was compensable. In so holding, we noted that what constitutes a "reasonable interval" depends on the length of the interval, the circumstances occasioning it, and the nature of the worker's activity during the interval in which the injury occurs. Id. (Citing 1A Larson, Workmen's Compensation Law, 21.60, 5-42).

Even when a "reasonable interval" exists, however, a personal deviation from preparatory work activity can break the link with employment. 1A Larson, Workmen's Compensation Law, 21.60, 5-48. For example, if the present claimant had injured herself while moving into an apartment simply to be closer to work, the injury would likely not have been compensable, for the fact that a worker's employment brings him/her to the situs of the accident is, in and of itself, insufficient to establish the requisite work relationship. Wallace v. Green Thumb, Inc., 296 Or 79, 83 (1983).

In the present case, we find that the activity that resulted in claimant's injury, although of indirect benefit to the employer, was primarily for claimant's personal benefit. She was unloading and moving her personal belongings into what would be her personal living space, an activity she was not hired to perform. Further, she had not yet begun her apartment manager job at the time of her injury.

2. Whether the activity was contemplated by the employer and employee.

The Referee found that although the employer did not contemplate that claimant would personally move her belongings at the time he hired her, he later did so by permitting her to move her belongings prior to commencing employment. We agree and adopt the Referee's findings and conclusions with regard to this factor.

3. Whether the risk was an ordinary risk of, and incidental to, the employment.

Claimant contends that the employer virtually required her to unload her vehicle by not providing a moving service. However, claimant testified that she had not considered using a moving service. Moreover, as the Referee found, personally moving her belongings was not part of claimant's employment duties and was, therefore, not a risk inherent in her employment.

4. Whether the employee was paid for the activity.

The Referee found that the employer did not pay claimant's moving expenses nor did claimant expect to be reimbursed for those expenses. He further found that it was not dispositive that the employer paid claimant's wages for the entire month, because claimant was not performing work activity in the course of employment during her move. We agree.

Claimant contends that she was being paid at the time of her injury because the injury occurred within her fixed-duty hours. We conclude, however, that even if claimant's injury occurred during her work hours, the injury did not occur in the course of her employment.

5. Whether the activity was on the employer's premises.

The Referee found that claimant fell into a public street and may have hit her arm on a public sidewalk. He, therefore, concluded that claimant was not on the employer's premises at the time of her injury. We agree. In addition, we find that the employer exercised no control over the street or sidewalk where the injury occurred. See Cope v. West American Ins. Co., 309 Or 232, 239 (1990).

6. Whether the activity was directed by or acquiesced in by the employer.

The Referee found that the employer did not direct claimant's move, but that he did acquiesce to her unloading and moving her belongings. We agree and adopt the Referee's findings and conclusions with regard to this factor.

7. Whether the employee was on a personal mission of her own.

The Referee found that claimant was not on a distinctly personal mission because the activity indirectly benefitted the employer. We disagree.

Claimant was in the process of moving into her residence prior to beginning her employment with the employer. Although claimant had been hired on August 28, 1992 to start work on September 5, 1992, her work duties did not commence until after she had settled into her apartment. As discussed supra, claimant was not in the course of employment at the time of the injury.

Conclusion

Having considered all of the Jordan factors, we conclude that claimant's injury did not arise out of and in the course of her employment. The activity which resulted in claimant's injury was primarily for her personal benefit. The activity for which claimant was not paid and occurred prior to the commencement of her job, was not a risk inherent in her employment as an apartment manager. Finally, the injury did not occur on her employer's premises or in an area over which the employer exercised control. Claimant has, therefore, failed to prove a compensable relationship between the injury and her employment.

In addition, although not directly applicable, a discussion of the "bunkhouse" rule is instructive. In Maria L. Hernandez, 44 Van Natta 1029 (1992), we adopted the rule, which provides that an injury to an employee required to live on the employer's premises is generally compensable if the worker was continuously on call, or the source of the injury was a risk distinctly associated with the conditions under which the claimant was required to live. Id. at 1031.

We find, based on the employer's testimony, that the present claimant was not required to be continuously on call, nor was she on call at the time of the injury.

Furthermore, the source of claimant's injury was not a risk associated with the employer's premises. Claimant fell off her personal vehicle while moving her personal belongings. She fell onto a public street over which the employer exercised no control. She was not being paid to move her belongings. She had not yet begun her duties as apartment manager. Therefore, under the "bunkhouse" rule, the risk of injury associated with claimant's employment was no greater than the risk of injury associated with her moving to an apartment for a new job.

In sum, we find that under the Jordan factors and the "bunkhouse" rule, the relationship between claimant's injury and her employment was not sufficient to establish compensability. We, therefore, reverse the Referee's order. Because we have reversed the Referee's compensability finding, claimant is not entitled to an attorney fee for services at hearing.

ORDER

The Referee's order dated August 12, 1992 is reversed. The SAIF Corporation's March 30, 1992 denial, on behalf of the noncomplying employer, is reinstated and upheld. The Referee's attorney fee is also reversed.

June 17, 1993 Cite as 45 Van Natta 1064 (1993)

In the Matter of the Compensation of
BRIAN McKINNEY, Claimant
WCB Case No. TP-93001
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to SAIF's entitlement to recover immediate reimbursement for $4,768.36 in medical bills which it received following its approval of claimant's third party settlement. We hold that it would not be "just and proper" to permit SAIF to immediately recover reimbursement for the aforementioned medical bills.

FINDINGS OF FACT

In January 1989, while performing work for a construction company, claimant suffered a compensable "crush" injury to his face, chest, and back. As a result of his injuries, he was rendered a paraplegic. SAIF, the insurer for claimant's employer, accepted the claim and has provided benefits.

Claimant retained counsel to initiate a lawsuit against a third party. A lawsuit was subsequently filed. Prior to trial, a settlement conference was scheduled for June 23, 1992.

On June 19, 1992, Mr. Smith, a third party claims adjuster for SAIF, forwarded to claimant's counsel a letter describing SAIF's lien. The lien totalled $669,064.08 and consisted of the following itemized costs: (1) paid costs to date ($254,444.08); (2) estimated future medical bills ($297,298); (3) estimated vocational benefits ($22,207); and (4) estimated permanent disability award ($117,100). Smith stated that the lien was "valid for the scheduled settlement conference on June 23, 1992 and for the July trial."

Mr. Smith's June 19, 1992 letter also provided an explanation of SAIF'S future medical cost estimate. Based on its experience with the particular needs concerning a paraplegia claim, Smith projected annual medical costs from $11,600 to $12,150. Smith further estimated claimant's life expectancy at 50+ years.

On June 19, 1992, claimant and the third party reached a settlement totalling $1.525 million. The settlement received SAIF's approval. Part of the settlement was to be paid in monthly installments, with SAIF receiving $1,000 of each monthly payment.

On July 22, 1992, Mr. Smith sent claimant's attorney a Claim Disposition Agreement (CDA). Smith reported that "[w]e have agreed to continue payments until the Board approves the CDA. These payments and costs will be added to paid costs of the claim and recovered from the third party settlement."

On July 28, 1992, the Board received the parties' executed CDA. Pursuant to the disposition, in return for $60,000, claimant agreed to release his rights to workers' compensation benefits (except medical services) for his compensable injury. The CDA did not refer to the third party settlement or SAIF's lien.

Prior to its approval of the CDA, the Board received the parties' addendum. The parties reported that a third party settlement had been reached. The addendum further provided that: (1) the CDA proceeds were not being paid pursuant to a structured settlement; and (2) "[n]o part of the SAIF third party lien is being reduced or waived to pay the money due to the attorney and worker under the Claims Disposition Agreement." On August 28, 1992, the Board approved the CDA, as amended.

On August 31, 1992, Mr. Smith sought recovery of SAIF's third party lien. Specifically, SAIF requested a "lump sum cash payment" of $262,043.98 for its paid costs. In making the request, Smith noted that since the June 1992 third party settlement negotiations, SAIF had paid an additional $7,599.90. (A payment ledger for medical bills and time loss payments was enclosed.) Smith further requested that claimant's counsel withhold another $2,500 until "some final pre-August 1, 1992 medical bills are processed." Finally, Smith reported that SAIF anticipated receiving "the first $1,000 monthly payment on the structured settlement on September 1, 1992."

When claimant did not fully comply with its request, SAIF petitioned the Board for resolution of this dispute regarding a "just and proper" distribution of proceeds from the third party settlement. Specifically, SAIF seeks $8,974.64. This figure represents temporary disability from June 17, 1992 to August 12, 1992 ($4,206.28), which was paid during the CDA proceedings and unreimbursed medical bills paid after June 19, 1992 for pre-August 1, 1992 services ($4,768.36). Claimant agrees that the temporary disability payments are reimbursable. However, he contests SAIF'S entitlement to immediate reimbursement for the $4,768.36 in medical bills.

In response to SAIF'S petition, claimant's attorney has filed an affidavit containing the following statements. On June 19, 1992, a third party settlement was reached, as well as a resolution of claimant's workers' compensation rights under a CDA. Inasmuch as claimant's temporary disability was his primary source of income, SAIF agreed to continued paying the temporary disability while the CDA was pending Board approval. In return, claimant's counsel agreed that the temporary disability payments would be added to SAIF's lien for immediate reimbursement from the third party settlement.

Concerning the medical bills, claimant's attorney stated that "at no time during the negotiations leading to the settlement agreement of June 19, 1992," was he advised by SAIF that: (1) there were unpaid medical bills; (2) SAIF expected reimbursement for the payment of medical bills being paid pursuant to ORS 656.245; or (3) any unpaid medical bills would be added to SAIF's reimbursement claim for the third party settlement. Claimant's counsel recalled a June 19, 1992 telephone conversation when SAIF specifically wanted to add "post-June 19" expenses. However, counsel rejected the proposition because SAIF would be receiving $1,000 monthly payments from the third party structured settlement to offset its medical costs.

Claimant's attorney's affidavit concludes as follows. In negotiating the settlement, claimant's attorney relied on the actual paid figures represented by SAIF. It was not until late August-early September 1992, that claimant's attorney learned of SAIF's reimbursement claim for additional medical expenses.

Mr. Smith, SAIF's third party claim adjuster, has also submitted an affidavit which contains the following statements. During the settlement negotiation, SAIF agreed to continue to pay claimant's temporary disability, as well as incurred medical expenses. Claimant's attorney did not request that any of those payments be exempted from SAIF's lien. It was Mr. Smith's understanding that all medical payments and temporary disability benefits paid up to and including August 1, 1992 would be immediately recovered from the third party settlement.

CONCLUSIONS OF LAW

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

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Finally, any remaining balance from the third party recovery shall be paid to the worker. ORS 656.593(1)(d).

When either a worker or an agency, in the course of negotiating a third party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation. Estate of Troy Vance v. Williams, supra, 84 Or App at p. 620.

Here, prior to the settlement of claimant's third party action, SAIF submitted a June 19, 1992 notice of its third party lien to claimant's counsel. SAIF's lien was described as "paid costs to date" and "estimated" future medical bills, vocational expenses, and permanent disability awards. SAIF's notice further provided that "[t]his lien is valid for the scheduled settlement conference on June 23, 1992 and for the July trial."

Notwithstanding this lien notice, SAIF asserts that claimant was aware that there were unpaid medical bills existing at the time it approved claimant's third party settlement on June 19, 1992. SAIF contends that claimant likewise knew that additional medical bills would subsequently arise through August 1, 1992. In support of these assertions, SAIF relies on its June 19, 1992 lien notice, which included nearly $300,000 in estimated future medical bills.

SAIF's assertions beg the question. Claimant was certainly aware that SAIF would incur additional medical expenses which were not listed on its June 19, 1992 lien notice. Moreover, claimant recognized that SAIF would receive reimbursement for those claim costs from third party settlement. Nevertheless, the issue before us is whether the parties agreed that SAIF would receive immediate reimbursement from the third party settlement proceeds for medical bills paid subsequent to June 19, 1992 and before August 1, 1992. Our review of the record convinces us that the answer to that question is no.

It is undisputed that the parties agreed that claimant would continue to receive his temporary disability benefits pending Board approval of the CDA. Such an agreement would be necessary because, unless the CDA provided otherwise, such payments would not be required. ORS 656.236(3). Since the payment of such temporary disability benefits during the "pending CDA" period exceeded SAIF's ordinary statutory obligations, it is understandable that SAIF would expect something in return; i.e., immediate reimbursement from the forthcoming third party settlement for such "extra" benefits.

On the other hand, SAIF was not authorized to terminate payment of claimant's medical expenses pending Board approval of the CDA. ORS 656.236(3). Thus, its payment of such expenses was entirely consistent with its statutory claim processing duties. Since the processing of medical bills during the "pending CDA" period was not beyond SAIF's ordinary statutory duties, there would appear to be no basis for SAIF's expectation of immediate reimbursement for the "post-June 19, 1992" medical bills.

Additional support for this conclusion is drawn from the parties' agreement that SAIF would also receive $1,000 from claimant's monthly third party settlement installments. Such an arrangement, when viewed in conjunction with SAIF's "lien notice" representations regarding the validity of its claim costs, further confirms claimant's counsel's understanding that only the "pending CDA" temporary disability benefits would receive immediate reimbursement from the third party settlement proceeds. In other words, the record supports a determination that SAIF would eventually receive reimbursement for its "post-June 19, 1992" medical bills; it just would not receive immediate reimbursement as it would for its "pending CDA" temporary disability payments.

In light of such circumstances, we decline to grant SAIF's request to receive immediate reimbursement from the third party settlement for medical bills it paid between June 19, 1992 and August 1, 1992. We do not consider such a proposed distribution to be "just and proper." ORS 656.593(3). Rather, we find that the following allocation of third party settlement proceeds represents a "just and proper" distribution. Id.

Accordingly, claimant's attorney is directed to forward $4,206.28 to the SAIF Corporation as immediate reimbursement for temporary disability benefits paid while the parties' CDA was pending Board approval. Reimbursement of SAIF's remaining claim costs will be gradually recovered as SAIF receives $1,000 of claimant's monthly installments from the third party settlement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL J. McNEIL, Claimant
WCB Case No. 92-08746
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Myers' order that: (1) increased claimant's unscheduled permanent disability award from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.40 degrees) for a left shoulder condition; and (2) awarded an approved attorney fee equal to 25 percent of the increased compensation resulting from that increased compensation. On review, the issues are extent of unscheduled permanent disability 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

Extent

We affirm and adopt the Referee's conclusions and analysis concerning the extent of claimant's unscheduled permanent disability.

Attorney Fees

A Determination Order awarded 15 percent unscheduled permanent disability. An Order on Reconsideration reduced that award to 5 percent. Prior to hearing, SAIF acknowledged that claimant was entitled to at least the 15 percent award granted by the Determination Order (which claimant had already received).

The Referee awarded claimant a total of 17 percent unscheduled permanent disability. The Referee awarded claimant an approved attorney fee equal to 25 percent of the increased compensation created by his 12 percent (38.4 degree) "increase" of claimant's unscheduled permanent disability award. SAIF contends that, due to its pre-hearing stipulation that claimant was entitled to at least the 15 percent (48 degrees) unscheduled permanent disability granted by the Determination Order, the Referee increased claimant's award by only 2 percent (6.40 degrees), rather than by 12 percent. We agree.

In Ralph D. Stinson, 44 Van Natta 1274 (1992), the claimant requested review of an Order on Reconsideration that had awarded him 3 percent unscheduled permanent disability. Prior to the hearing, the insurer stipulated that claimant was entitled to at least the 8 percent awarded by the Determination Order, which it had already paid. The referee increased the claimant's award to 15 percent and awarded claimant an attorney fee based on the 12 percent difference between that award and the 3 percent awarded by the Order on Reconsideration.

On review in Stinson, the insurer argued that, due to its pre-hearing stipulation that the claimant was entitled to an award of 8 percent, the Referee's order only increased the claimant's award by 7 percent. We agreed concluding that, under those circumstances, "no overpayment existed to be offset against the 'increased compensation' created by the Referee's order." 44 Van Natta at 1275.

Here, as in Stinson, the insurer stipulated that claimant was entitled to a larger unscheduled permanent disability award than that provided by the Order on Reconsideration (i.e., the Determination Order award of 15 percent), and had paid that stipulated award. Thus, following the Stinson rationale, the Referee's order increased claimant's award only by the difference between his award and the stipulated amount. That difference is 2 percent (17 - 15). Consequently, claimant's attorney is entitled to 25 percent of that increase, not to exceed $2,800. See OAR 438-15-040(1).

Claimant is entitled to an assessed attorney fee for services on review concerning the extent of permanent 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 claimant's unscheduled permanent disability is $500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In determining an appropriate fee, we note that inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for counsel's services on review concerning that issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 21, 1992, as reconsidered on November 18, 1992, is affirmed in part and modified in part. That portion of the Referee's order that awarded an approved attorney fee of 25 percent of the 12 percent "increase" in claimant's unscheduled permanent disability award is modified. Claimant is awarded an approved attorney fee of 25 percent of the 2 percent (6.4 degrees) increase in claimant's unscheduled permanent disability award. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DAVID E. SAKRISSON, Claimant
WCB Case No. 89-09271
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Neal's order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issues are jurisdiction and, if jurisdiction exists, 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

Claimant compensably injured his low back in October 1985. In 1987, he developed right knee pain while in physical therapy for his compensable back injury. Claimant underwent knee surgery in May 1987. Claimant's claim was closed by an April 18, 1989 Determination Order which awarded 13 percent unscheduled disability for the low back injury and 9 percent scheduled disability for the right knee condition. Claimant appealed the award seeking an increased scheduled and unscheduled permanent disability award. In July 1989, claimant filed a second request for hearing. Among the issues raised was the extent of scheduled and unscheduled permanent disability. Before a hearing was held, the insurer reopened claimant's claim for vocational training. Claimant's requests for hearing were deferred on October 23, 1989 pending completion of an authorized training program.

After completing his vocational training, claimant's claim was re-closed by a June 6, 1991 Determination Order. The Determination Order awarded additional time loss but awarded no additional permanent disability, stating: "On redetermination, the Department finds no change in your previous award for permanent disability. The Department orders you entitled to no additional compensation for permanent disability." The June 6, 1991 Determination Order was amended on July 15, 1991 to correct the medically stationary date. Claimant never appealed the June 6, 1991 Determination Order and it has become final.

The Referee held that although claimant's request for hearing on the 1989 Determination Order was deferred, claimant was still required to re-request a hearing within the time limitations contained in ORS 656.319. The Referee concluded that since claimant did not re-request a hearing within the limits of ORS 656.319, she lacked jurisdiction over the extent issues. The Referee also held that since claimant did not timely appeal the June 1991 Determination Order, she likewise did not have jurisdiction over the extent of permanent disability issues on the basis of an appeal of the June 1991 Determination Order. Based on this reasoning, the Referee dismissed claimant's request for hearing.

On review, claimant contends that since his hearing request on the April 18, 1989 Determination Order was in deferred status, he was not required to re-request a hearing in order to preserve his rights to proceed on the issues of extent of permanent disability. We agree.

OAR 438-06-105(1) provides that a hearing may be deferred if the primary issue is unscheduled permanent disability and the claimant is entitled to temporary disability compensation under an authorized training program (ATP). Here, the claim was reopened for an ATP and claimant's hearing request was deferred by a referee's Order Deferring Hearing on October 23, 1989. The order of deferral indicates that a hearing date would be assigned when the claim was closed. We conclude that the deferral order preserved claimant's hearing requests on the April 18, 1989 Determination Order.

We have previously held that attempts to informally "reserve" issues raised by a request for hearing amounts to a dismissal of those issues without prejudice. Claudia I. Hamilton, 42 Van Natta 600 (1990). Those deferred issues may be reraised at any time within the time limits set

out by ORS 656.319. Id. In Hamilton, the parties "reserved" the issues of extent of permanent and temporary disability and premature closure after having raised those issues by a request for hearing. The WCB case number assigned to the reserved issues was not placed in inactive status. Rather, the referee in that case went on to litigate and finally resolve the other "nonreserved" issues raised by that request for hearing. In Hamilton, no request for hearing was made before the Determination Order became final as a matter of law. There, we held that the appeal of the Determination Order was untimely. See also Ralph B. DePaul, 44 Van Natta 92 (1992); Jerome S. Andre, 42 Van Natta 861 (1990); David L. Mallette, 38 Van Natta 843 (1986).

In Ralph B. DePaul, supra, a referee attempted to "preserve" the extent of permanent disability issue for later litigation, but the case was not placed in inactive status. In both Hamilton and DePaul, we held that the attempts to "preserve" the issues amounted to a dismissal of those issues without prejudice. We further held that those issues could be reraised at any time within the time limits set out by ORS 656.319.

The cases cited above are distinguishable from the present case. In the cases cited above, the parties and referees attempted to preserve issues for later litigation. However, in doing so, the referees dismissed the claimant's hearing requests. Here, by contrast, claimant's hearing request on the 1989 Determination Order was not dismissed. To the contrary, claimant's hearing request was expressly deferred by a referee's order pursuant to OAR 438-06-105(1). The referee's deferral order further stated that a hearing would be rescheduled when the claim was closed. Thus, here, claimant's request for hearing on the 1989 Determination Order was never dismissed and, in fact, was expressly deferred for future resolution. Consequently, we hold that the April 1989 Determination Order is properly before us.

The insurer next contends that the unappealed June 1991 Determination Order superseded the April 1989 Determination Order, since the June 1991 Determination Order redetermined the extent of claimant's permanent disability after he completed a vocational training program. ORS 656.268(8) deals with reconsideration of a worker's permanent disability after the completion of a vocational training program. It provides that if the worker becomes enrolled and actively engaged in vocational training, any permanent disability payment due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. The statute further provides that when the worker ceases to be enrolled and actively engaged in the training, "the Department of Insurance and Finance shall reconsider the claim pursuant to this section unless the worker's condition is not medically stationary."

In Minor v. Delta Truck Lines, 43 Or App 29 (1979), rev den 288 Or 253 (1980), the court held that the Board is precluded from denying a hearing regarding the adequacy of a Determination Order award of permanent disability pending completion of a rehabilitation program. The court came to this conclusion despite its recognition that delaying a decision on the extent issue was administratively economical and convenient because such a determination again would be made by the Evaluation Section upon the completion or abandonment of the training program. See also Marty L. Hornback, 44 Van Natta 975 (1992), aff'd mem 118 Or App 748 (1993). The Minor court based its decision that the claimant had a right to challenge the Determination Order which issued prior to the claimant's participation in an ATP on the fact that the claimant was entitled to an expeditious hearing. Minor also lends support to our conclusion here that a claimant has a right to a hearing on both the Determination Order which issues prior to the training program, as well as the Determination Order which redetermines the extent of permanent disability after vocational training is completed.

Here, we find no support for a conclusion that claimant's failure to appeal the June 1991 Determination Order, which issued after claimant completed the training program, affects his right to a hearing on the April 1989 Determination Order. Although claimant's hearing was deferred during the vocational training program, he preserved an appeal from the April 1989 Determination Order and has a right to a hearing on that Determination Order. Thus, because we conclude that the record is fully developed on the issue of extent of permanent disability, we address the extent of scheduled and unscheduled permanent disability issues arising from claimant's appeal of the April 1989 Determination Order.

Because claimant's condition became medically stationary on December 23, 1988, and his claim was closed by Determination Order on April 18, 1989 we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. (WCD Admin. Order 7-1988).

Unscheduled Permanent Disability

The April 18, 1989 Determination Order awarded 13 percent (41.6 degrees) unscheduled permanent partial disability.

Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

The parties stipulated to the following values: age (0), education (0), skills (1), training (0), and adaptability (3).

Claimant contends that he is entitled to a value of 5 percent for decreased range of motion in the lumbar spine. In the lumbar spine, claimant retains 65 degrees flexion, 27 degrees of extension, 22 degrees right flexion, 30 degrees left flexion, and 45 degrees right and left rotation. Claimant is entitled to 4 percent for lost range of motion in the lumbar spine. Former OAR 436-35-360(6)-(9).

Claimant also contends that he is entitled to 5 percent impairment for lost range of motion in the cervical spine. The insurer argues that claimant has not established that the cervical impairment is due to the compensable injury. We agree with the insurer. There is no evidence in the record which relates the cervical condition to the compensable injury. Accordingly, claimant is not entitled to an award for a cervical condition.

Claimant next argues that he should receive a 5 percent award for a chronic condition limiting repetitive use of the lumbar spine pursuant to former OAR 436-35-320(4). However, the applicable standards define "impairment" as a decrease in the function of a body part or system, as measured by a physician. Former OAR 436-35-005(1) (Emphasis added). Since the record contains no medical evidence documenting a loss of repetitive use of the lumbar spine, claimant is not entitled to an award for a chronic condition limiting repetitive use of the lumbar spine. See William K. Nesvold, 43 Van Natta 2767 (1991).

Finally, claimant contends that he is entitled to an award for disc bulges at L4-5 and L5-S1. The insurer agrees that the disc bulges are due to the compensable injury and that an award for the disc bulges is appropriate. Accordingly, claimant is entitled to an award of 4 percent for each disc bulge. Former OAR 436-35-350(2).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. The parties have stipulated that the age and education value multiplied by the adaptability value is 3. When that value is added to claimant's impairment value 12, the result is 15 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 15 percent.

Scheduled Permanent Disability

The April 18, 1989 Determination Order awarded claimant 9 percent (13.5 degrees) scheduled permanent disability for loss of his right leg (knee).

On review, claimant contends that he is entitled to a 9 percent award for his 1987 partial medial meniscectomy of the right knee pursuant to former OAR 436-35-230(4)(d). Former OAR 436-35-230(4)(d) provides that a partial meniscectomy to either or both menisci is rated as a proportion of 10 percent of the leg for each. The April 18, 1989 Determination Order awarded claimant 5 percent for this surgery. Claimant contends that he is entitled to 9 percent because there were two tears in the meniscus of his right knee. We disagree. Claimant's injury required only one partial medial meniscectomy surgery and one award for that surgery, regardless of the fact that there were two tears. Accordingly, claimant is not entitled to an increased award for the surgery.

Claimant next contends that he is entitled to a 5 percent award for a chronic condition limiting repetitive use of his right knee pursuant to former OAR 436-35-010(7). In support of his contention, claimant cites a March 20, 1991 medical report from the Orthopaedic Consultants. However, that report does not support a chronic condition award. To the contrary, the report indicates that the right knee

showed full motion with no swelling, effusion or local tenderness. Claimant's attending physician concurred with this report. The record contains no other medical evidence which supports a chronic condition award. Accordingly, claimant has not established entitlement to such an award.

Thus, on review of the April 18, 1989 Determination Order, we conclude that claimant's scheduled permanent disability for the right knee is 5 percent. However, since the insurer does not request a reduction in the 9 percent scheduled award, we do not reduce it.

ORDER

The Referee's order dated June 29, 1992 is reversed. Claimant's hearing request is reinstated. In addition to the April 18, 1989 Determination Order award of 13 percent (41.6 degrees) unscheduled permanent disability, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total unscheduled award to date of 15 percent (48 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the April 18, 1989 Determination Order is affirmed.

In the Matter of the Compensation of
MARY A. SMITH, Claimant
WCB Case No. C3-01387
ORDER ON RECONSIDERATION DISAPPROVING CLAIM DISPOSITION AGREEMENT/ACKNOWLEDGEMENT OF REVISED AGREEMENT
Benjamin W. Ross, Claimant Attorney

Reviewed by Board Members Neidig and Brazeau.

On June 3, 1993, we disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement purported to release a right concerning a matter outside of Chapter 656, i.e., employment rights. See Evelyn Christenson, 43 Van Natta 819 (1991). Moreover, we concluded that the offensive portion of the disposition agreement could not be excised without substantially altering the bargain underlying the exchange of consideration.

Claimant has timely requested reconsideration of our order. OAR 438-09-035(2). Specifically, claimant provides that the offending paragraphs have been excised and the attorney fee has been adjusted.

Here, the initial agreement provided for a total consideration of $16,000 for claimant's release of certain rights to future workers' compensation benefits, except medical services, for the compensable injury. The agreement, as modified, now provides for a total consideration of $14,000 for the release of claimant's future workers' compensation rights. Inasmuch as the modified agreement has substantially altered the amount of consideration underlying the bargain, we continue to conclude that we are without authority to approve the proposed disposition. See Karen Vearrier, 42 Van Natta 2071 (1990).

Accordingly, we treat claimant's revised agreement as a new submission. The proposed disposition is acknowledged as of June 14, 1993 and will be reviewed consistent with established procedure. Claimant's statutory 30-days to request disapproval shall run from that date. ORS 656.236.

Consequently, for the reasons discussed in this order and our prior order, we decline to approve the parties' proposed disposition. Accordingly, as supplemented herein, we adhere to our prior reasoning and republish our June 3, 1993 order in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
STANLEY A. STEVENS, Claimant
WCB Case No. 92-02555
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Paul Roess, Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The self-insured employer requests review of that portion of Referee Howell's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

The Board affirms and adopts the Referee's order with the following supplementation, the purpose of which is to address the employer's arguments on review.

To prevail on his aggravation claim, claimant must prove that, as a result of a worsened condition, he is less able to work. Smith v. SAIF, 302 Or 396, 399 (1986); Lloyd G. Currie, 45 Van Natta 492, 494 (1993). "[E]vidence of receipt of unemployment compensation and the representations made by a claimant in seeking it may be relevant" in making that determination. International Paper Co. v. Hubbard, 109 Or App 452, 455 n 1 (1991).

After he lost his job, claimant represented on an application for unemployment benefits that he was capable of "light duty" work. (Tr. 47). Because claimant was released to "light duty" work at the time of his last arrangement of compensation, the employer argues that claimant failed to prove that he is less able to work. We disagree.

At his last arrangement of compensation, claimant's treating orthopedist, Dr. Bert, M.D., stated that claimant was capable of work activities involving lifting 10 to 15 pounds, with no prolonged sitting or standing. (Ex. 15). He did not specifically limit claimant to "light duty" work. Because claimant did not quantify what he considered "light duty" to be, we cannot determine whether he thought he was more or less capable of working than Dr. Bert previously did. Consequently, we cannot construe that representation as an admission that his ability to work did not decrease.

What is clear is that, after his last arrangement of compensation, claimant began working as a welder and laborer. His employer testified that claimant's physical abilities had changed since he began working, and that claimant was not physically able to perform some of the tasks that he could when he first started. (Tr. 78-81). Claimant's treating physician also noted a marked deterioration in claimant's physical capacities. (Ex. 32). Consequently, the preponderance of the evidence shows that he is less able to work than he was at the time of his last arrangement of compensation.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of aggravation, to be paid by the employer. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $800 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated September 30, 1992 is affirmed. For services on review concerning the issue of aggravation, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
LELAND G. TOWNSEND, Claimant
WCB Case Nos. 91-15802 & 91-14485
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Lumbermen's Underwriting Alliance (LUA) requests review of Referee Brown's order that: (1) set aside its responsibility denial of claimant's aggravation claim for his current cervical condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for that same condition; and (3) awarded claimant an assessed attorney fee payable by LUA. On review, the issues are responsibility and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT AND OF ULTIMATE FACT

We adopt the Referee's findings of fact, with the exception of his finding of fact number 8. We do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee concluded that LUA is responsible for claimant's current neck condition. We agree.

In 1988, LUA accepted claimant's claim for a neck injury . (Ex. 17). In 1991, while working for SAIF's insured, claimant's neck was jolted several times when the tractor that he was operating hung up on a tree stump. Claimant likened the event to being dragged down a flight of stairs by his heels. (Ex. 71). After that event, he noticed increased pain in his neck and arms and sought medical treatment. Both LUA and SAIF denied responsibility for claimant's resulting neck condition. SAIF, in addition, denied the compensability of the neck condition.

Under ORS 656.308(1), when 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 or occupational disease during the subsequent work exposure. SAIF v. Drews, 117 Or App 596, rev allowed __ Or __ (1993); Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, LUA, as the last insurer with whom claimant had a compensable neck injury, remains presumptively responsible. In order to avoid responsibility, LUA has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for SAIF's insured. Gerald K. Mael, 44 Van Natta 1481, 1482 (1992).

In order to prove a "new compensable injury," LUA must show that the 1991 tractor incident was a material contributing cause of claimant's disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The new injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a); 656.005(19); Georgia-Pacific v. Ferrer, 114 Or App 471; 475 (1992). However, LUA need not prove that the 1991 tractor incident was the major contributing cause of claimant's condition, because ORS 656.005(7)(a)(B) is not applicable in the responsibility context. SAIF v. Drews, supra.

Claimant stated that when he began working for SAIF's insured, he remained symptomatic but functional. (Ex. 71). Claimant's statement suggests that the 1991 tractor incident may have only increased his symptoms from his 1988 compensable neck injury. If that is true, responsibility would not shift to SAIF's insured. Michael L. Whitney, 45 Van Natta 446 (1993); Gerald K. Mael, supra. However, although claimant's statement is probative, whether claimant suffered a "new injury" in 1991 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 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The record contains several medical reports concerning whether claimant suffered a new injury.

An independent medical examination (IME) conducted by the Orthopaedic Consultants concluded that the 1991 tractor incident aggravated claimant's prior symptoms and caused additional

symptoms in his left arm, but did not change the "underlying natural history" of claimant's prior neck injury. (Ex. 71). Claimant's treating orthopedist, Dr. Louie, concurred with that report, adding that the 1991 tractor incident was a major contributing cause of claimant's "continuing complaints." (Ex. 73). Nevertheless, he asserted that diagnostic tests did not reveal any objective findings of a new injury to claimant's neck, and that the tractor accident would have caused a new injury only if claimant had been operating the tractor at a high rate of speed; a fact that is not established by the record. (Ex. 80).

An IME conducted by the Medical Consultants Northwest concluded that claimant's symptoms, including his left arm complaints, represent a symptomatic worsening of the 1988 compensable neck injury. A third IME, conducted by Dr. Donahoo, also concluded that claimant was experiencing a temporary worsening of symptoms related to his 1988 injury. (Ex. 79, 81).

All of the medical opinions assert that the 1991 tractor incident caused claimant's increased symptoms. Although some of those reports assert that claimant suffered a "new injury" in 1991, every report acknowledges that the 1991 tractor event did not change the underlying natural history of claimant's prior neck injury. Under those circumstances, we conclude that claimant did not sustain an independent "new injury" when he was jolted by the tractor at SAIF's insured. Rather, he suffered a symptomatic exacerbation of his 1989 injury which had never completely resolved. See Taylor v. Mult. School District, 109 Or App 499 (1991); Michael L. Whitney, supra. Inasmuch as LUA failed to prove that claimant suffered a new injury while working for SAIF's insured, we conclude that it remains responsible for claimant's neck condition.

Attorney Fees

The Referee awarded claimant an assessed attorney fee, because he concluded that LUA had denied compensability. We agree with the Referee that an assessed fee is appropriate. However, we conclude that that fee is payable by SAIF, rather than LUA.

In its denial letter, LUA stated that it was denying responsibility for claimant's condition. (Ex. 64). The denial letter did not mention compensability. Because claimant construed that denial as also denying compensability, LUA expressly asserted immediately prior to hearing that it was denying responsibility only. (Tr. 3). Under those circumstances, claimant is not entitled to an assessed fee from LUA under ORS 656.386(1). See John L. Law, 44 Van Natta 1610 (1992).

SAIF, on the other hand, did deny compensability. (Tr 3). Because LUA was found responsible, and did not contest compensability, claimant received a favorable determination on the question of compensability. Therefore, claimant is entitled to insurer-paid attorney fees under ORS 656.386(1) for services performed at the hearing level. Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993); SAIF v. Bates, 94 Or App 666 (1989). Only SAIF contested compensability of the claim at hearing. Therefore, SAIF, as the insurer that created the need for claimant to establish the compensability of the claim, is responsible for payment of the attorney fee at hearing. James F. Herron, 45 Van Natta 842, 843 (1993).

Although compensability was not raised as an issue on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, to be paid by LUA. 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. Inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for counsel's services on review concerning that issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 14, 1992 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant a $2,800 assessed attorney fee payable by LUA is modified. Claimant is awarded a $2,800 assessed attorney fee for services rendered at hearing, payable by SAIF. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded $800 payable by LUA.

In the Matter of the Compensation of
DEBRA J. FAKHOURY, Claimant
WCB Case No. 92-01941
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Moscato, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Mills' order which upheld the self-insured employer's denial of claimant's aggravation claim for a back strain condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

We add the following findings to the Referee's findings of fact.

Prior to the last arrangement of compensation in August 1990 (see Ex. 116), Dr. Long opined that claimant cannot on a regular basis tolerate her usual work four to five days per week. (See Exs. 105, 112, 115-1). Dr. Long released claimant to her regular work, but limited her to working three days per week (i.e., 24 hours per week). (Ex. 105-2; see also Tr. 6).

Claimant's work hours and activities in 1991 were approximately the same as they had been since she was declared medically stationary and released for work in March 1990, except that during the week ending October 5, 1991, claimant worked 28.7 hours over four days. (Ex. 126A-11).

We adopt the Referee's findings of ultimate fact, except the last sentence. Instead, we find that claimant's exacerbation of back symptoms in the fall of 1991 was greater than the waxing of symptoms contemplated by her last award of compensation.

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. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Here, claimant's back strain condition was closed by a May 7, 1990 Determination Order, awarding 11 percent unscheduled permanent disability. (Ex. 108). That award was increased to 24 percent unscheduled permanent disability by an earlier referee's order following a hearing in August 1990. (Ex. 116). The referee's order included an award for claimant's chronic back condition which limits her ability to repetitively use her back. (Ex. 116-4).

When Dr. Long examined claimant on October 9, 1991, he found asymmetrically reduced range of motion in the cervical spine and observed that claimant's "left neck and shoulder girdle condition has gotten dramatically worse recently." (Ex. 128-1, -2). He diagnosed "acute worsening of left cervical paraspinal and lateral cervical condition." (Ex. 128-2). Dr. Long released claimant from work and prescribed physical therapy. (Id). Accordingly, we find that claimant has established a worsening of her compensable condition by medical evidence supported by objective findings, and that the worsened condition resulted in diminished earning capacity.

In addition, because claimant has received a previous permanent disability award for her injury, she must establish that any worsening is more than a waxing of symptoms as contemplated by the last award of compensation. ORS 656.273(8). If there was medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra; see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

Prior to the earlier referee's order increasing claimant's permanent disability award, Dr. Long, claimant's treating physician, had opined that claimant was unable to work four or five days per work week on a regular basis because she would experience a significant increase in symptoms. Accordingly, we find that there was medical evidence at the time of claimant's last award of compensation which predicted a flare-up of symptoms associated with increased work activity in excess of three days per week. We conclude that these flare-ups were contemplated at the time of the last award of compensation.

The employer contends that the exacerbation which claimant experienced in the fall of 1991 was no more than the waxing of symptoms contemplated by the last award of compensation. We disagree.

Dr. Long, who has treated claimant since shortly after her original work injury in 1988, provided the only medical opinion on the issue. He opined that claimant's condition on October 9, 1991 was more than the "waxing and waning" of symptoms contemplated by her permanent disability award in August 1990. (Ex. 138-2).

Further, we note that Dr. Long predicted that claimant's symptoms would increase if she were to regularly work four or five days per week, rather than three days per week (24 hours per week). If claimant had experienced increased symptoms as a result of regularly working more than three days per week, we might find that her symptoms were no more than the waxing of symptoms predicted by her physician and contemplated by her prior award. See Patricia J. Sampson, 45 Van Natta 771 (1993).

Here, however, the evidence establishes that claimant worked approximately the same number of hours, doing the same type of work, in September 1991 as when she was released for work in March 1990. Yet, claimant experienced an exacerbation of symptoms in October 1991. Since a significant increase in symptoms while claimant was working only 24 hours per week was not anticipated by Dr. Long at the time of the last award of compensation, we conclude that claimant's worsening in October 1991 was more than the waxing of symptoms contemplated by the last award of compensation.

The employer contends that we should give no weight to Dr. Long's opinion, since it is based on the inaccurate history that claimant had been working in excess of 24 hours per week for about one month prior to the flare-up of symptoms. We disagree.

The record reveals that claimant did work nearly 29 hours in the first week of October 1991, whereas Dr. Long thought she had been consistently working over 24 hours per week for about one month. We do not find this discrepancy to be significant. Claimant's misperception of the number of hours she had been working does not undercut Dr. Long's objective findings of a worsened condition.

Thus, we find that claimant's increased symptoms in October 1991 were more than the waxing of symptoms contemplated by her last award of compensation. Accordingly, claimant has established a compensable aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 21, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the self-insured employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
BEVERLY A. KIRK, Claimant
WCB Case No. 92-11018
ORDER ON REVIEW
Flaxel, et al, Claimant Attorneys
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of Referee Bethlahmy's order that declined to assess a penalty under ORS 656.268(4)(g). On review, the issue is claimant's entitlement to a penalty. We reverse.

FINDINGS OF FACT

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

In her request for reconsideration, claimant objected to the Notice Closure's rating of her impairment and nonimpairment findings used in rating her permanent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee refused to assess a penalty under ORS 656.268(4)(g). The Referee relied on OAR 436-30-050(12), which provides an exception to the statutory penalty when an increase in compensation results from new information obtained through a medical arbiter examination or from promulgation of a temporary emergency rule. We reverse.

Since the Referee's order, we reasoned that the Department rule was inconsistent with the clear legislative intent expressed by the statute. Kevin Northcutt, 45 Van Natta 173 (1993). Because OAR 436-30-050(12) purports to provide an exception not contemplated by the statute, we declined to apply the rule. Id.

In this case, a 1989 Determination Order awarded 18 percent unscheduled permanent disability upon initial closure of the claim. After the claim had been reopened for surgery, a Notice of Closure awarded an additional 1 percent. Upon reconsideration, claimant received an additional 15 percent, for a total award of 34 percent.

Thus, the Order on Reconsideration increased claimant's permanent disability award by more than 25 percent, i.e., 15 percent (additional compensation)/19 percent (prior award) = 79 percent (increase). See ORS 656.268(4)(g). As in Northcutt, claimant is at least 20 percent disabled and the Order on Reconsideration increased her permanent disability compensation by at least 25 percent. See Kevin Northcutt, supra. Under these circumstances, claimant is entitled to a penalty in an amount equal to 25 percent of all compensation determined to be due upon reconsideration under ORS 656.268(4)(g). See id. In this regard, we note that unreasonable conduct by the carrier is not necessary for imposition of a penalty under ORS 656.268(4)(g). Compare ORS 656.262(10)(a).

We further note claimant's request that the penalty be divided equally between claimant and her attorney. However, because ORS 656.268(4)(g) expressly provides that this penalty shall be "paid to the worker," we decline to do as claimant requests. Accordingly, a penalty solely payable to claimant is assessed.

Finally, imposition of a penalty under ORS 656.268(4)(g) by itself does not constitute grounds for awarding an assessed attorney fee under ORS 656.382(1). See Jesus R. Corona, 45 Van Natta 886 (1993). Such a fee is awarded if claimant establishes an unreasonable resistance to the payment of compensation.

Here, it is unclear whether claimant seeks such an attorney fee award. However, even if she did, we would decline such a request because we find that the Notice of Closure's permanent disability award was reasonably based on the treating physician's closing examination. Under these circumstances, we would not consider SAIF's conduct to have been unreasonable within the meaning of ORS 656.382(1).

ORDER

The Referee's order dated December 15, 1992 is reversed. The SAIF Corporation is directed to pay to claimant a penalty in the amount of 25 percent of all compensation determined to be then due by the June 18, 1992 Order on Reconsideration.

June 18, 1993 Cite as 45 Van Natta 1079 (1993)

In the Matter of the Compensation of
KAREN L. LEWIS, Claimant
WCB Case No. 92-03950
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Black's order that: (1) upheld the SAIF Corporation's denials of claimant's injury or occupational disease claim for a lumbar strain condition; and (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order and supplement as follows.

SAIF denied claimant's lumbar strain on March 10, 1992, stating:

> "We have reviewed the information in your file and find that there is insufficient evidence that your lumbar strain is the result of either a work-related injury or disease.
>
> "Furthermore, the law requires the worker to report the injury to the employer within 30 days. You did not report your injury within the time provided by law nor have you provided good cause for your failure to do so. * * * *" (Ex. 6).

SAIF amended its denial on March 16, 1992, to delete the second paragraph quoted above. (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Penalty and Attorney Fee

We affirm the Referee's opinion on this issue and supplement as follows.

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

At the time the March 10, 1991 denial was issued, SAIF was in receipt of claimant's 801 form and a treatment form for a different claim. (Ex. 2). Claimant wrote on the 801 form that she slipped off a bus last July and hurt her low back, with low back pain since that time. She continued: "Dr. said injury due to fall (possibly)." Claimant's 801 indicated that she was a bus operator and listed Dr. Emory as her physician. (Ex. 3).

SAIF's claims examiner testified that she issued the denial after a discussion with the employer, based on her own assumption that there was no direct relationship between the July 9, 1991 incident and the claim filed on March 2, 1992, because claimant had not sought medical treatment prior to March 1992 and because the employer had indicated that there had been a significant period between the incident and the recent complaints of back pain, which had arisen about six weeks prior to claimant's filing the claim. (Tr. 19 and 19). After denying the claim on March 10, 1992, SAIF's claims examiner realized that claimant had timely reported the incident to the employer and issued an amended denial on March 16, 1991, deleting the sentence regarding timely reporting.

However, we are persuaded that the evidence available to SAIF should have prompted it to investigate the claim further, by seeking a report from Dr. Emory. Instead, SAIF issued the denial without requesting any medical reports. Under these circumstances, we find that SAIF had no legitimate doubt of its liability for the claim. However, because the claim is not compensable, there are no "amounts due," on which to assess a penalty. ORS 656.262(10). Likewise, there has been no unreasonable resistance to the payment of compensation on which to award an attorney fee under ORS 656.382(1).

ORDER

The Referee's order dated September 10, 1992 is affirmed.

In the Matter of the Compensation of
MARY A. MATTHEWS, Claimant
WCB Case No. 92-04111
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

Claimant requests review of those portions of Referee Neal's order which: (1) found that the insurer properly averaged her wages in determining the rate of temporary disability benefits; and (2) did not award an assessed attorney fee under ORS 656.386(1) for services in overturning a "de facto" denial. On review, the issues are rate of temporary disability and attorney fees.

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

The Referee assessed a penalty pursuant to ORS 656.262(10) for unreasonable resistance to payment of compensation. She found that the insurer was unreasonable in issuing an acceptance of only right carpal tunnel syndrome (CTS), when it had been ordered to accept bilateral CTS. The insurer, however, paid all expenses associated with the left CTS. Because the insurer had accepted only right CTS, claimant requested a hearing on a "de facto" denial.

Claimant contends that an attorney fee is appropriate for overturning a "de facto" denial. We disagree.

At hearing, when clarifying the issues, the insurer stated that there had not been a "de facto" denial but, rather, a clerical error on the notice of acceptance. (Tr. 5). The Referee then asked whether it was "a penalty issue more than an acceptance" issue. (Tr. 6). Claimant's attorney responded in the affirmative. Because claimant did not pursue the attorney fee issue for a "de facto" denial at hearing under ORS 656.386(1) (but rather sought a penalty-related fee under ORS 656.382(1), that issue cannot be considered on Board review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Alternatively, we are not persuaded that there has been a "de facto" denial of claimant's left carpal tunnel syndrome. Bilateral carpal tunnel syndrome was found compensable by a prior Referee's order. The insurer issued an acceptance of just the right wrist, but paid all benefits related to the left

wrist as well as the right. (Tr. 5). Considering the context in which the acceptance arose, and because there has been no manifestation of an intent to deny the claim, we conclude that there has been no "de facto" denial. See Barr v. EBI Companies, 88 Or App 132 (1987).

ORDER

The Referee's order dated July 7, 1992, as reconsidered July 24, 1992 is affirmed.

June 18, 1993 Cite as 45 Van Natta 1081 (1993)

In the Matter of the Compensation of
EVERY MENDENHALL, Claimant
WCB Case Nos. 91-10150, 89-24635 & 91-05946
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Montgomery W. Cobb, Defense Attorney

The insurer requested reconsideration of that portion of our March 31, 1993 Order on Review that found claimant's current condition to be compensable, contending that there is no evidence that claimant's injury or employment caused claimant's L5-S1 disc and antalgia and that these conditions are, therefore, not compensable.

In order to consider the matter, we abated out prior order and granted claimant an opportunity to respond. After receiving claimant's response, we proceed with our reconsideration.

The insurer construes our order finding claimant's current combined condition to be compensable to make claimant's antalgia and L5-S1 conditions compensable. However, we determined only that claimant's current condition and request for treatment was related to his occupational injury. No claim was presented solely for claimant's preexisting conditions. In the absence of a specific claim for treatment limited to noncompensable preexisting conditions, the insurer's denial of those conditions was premature.

We also note that subsequent to our order, the Court of Appeals reconsidered Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993), and concluded that in the context of an initial injury claim, as here, if the injury combines with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment, the injury is compensable only if it is the major contributing cause of the disability or need for treatment. This is the standard we applied on review.

Because claimant's compensation remained at risk on reconsideration, we award claimant's counsel an additional reasonable attorney fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration concerning the compensability issue is $500, to be paid by the insurer. This fee is in addition to the attorney fee awards granted in our prior order. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the motion for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, as modified and supplemented herein, we adhere to and republish our March 31, 1993 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
JAY A. NERO, Claimant
WCB Case No. 92-04986
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of Referee Neal's order which: (1) reduced claimant's unscheduled permanent disability award for a low back injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 5 percent (16 degrees); (2) reduced claimant's scheduled permanent disability award for loss of use or function of the right leg from 11 percent (16.5 degrees), as awarded by an Order on Reconsideration, to no scheduled permanent disability; and (3) declined to assess a penalty pursuant to ORS 656.268(4)(g) due to the increased compensation awarded by the Order on Reconsideration. On review, the issues are extent of scheduled and unscheduled permanent disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following modification in the Referee's second paragraph under "Findings of Fact." A July 1991 MRI of the lumbar spine revealed "early disc degeneration with evidence of fairly pronounced protrusion on the right side" at the L4-5 level and "disc degeneration with mild central protrusion of the disc" at the L5-S1 level. (Ex. 14A).

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

An Order on Reconsideration awarded claimant 12 percent unscheduled permanent disability for his low back injury and 11 percent scheduled permanent disability for the loss of use or function of his right leg, based on the examination and report of medical arbiter Dr. Gritzka. The Referee modified the permanent disability award, relying on the treating physician's closing examination. The Referee found that the report of treating physician Dr. Flemming established, by a preponderance of the evidence, a different level of permanent disability than that found by the medical arbiter. On review, claimant requests that we reinstate the permanent disability award of the Order on Reconsideration.

First, we address the employer's argument that the Department erred in appointing a medical arbiter pursuant to ORS 656.268(7) because claimant failed to explain his specific disagreement with the findings used to rate his impairment, as required by OAR 436-30-050(11)(c). In his request for reconsideration, claimant objected to the impairment findings used in rating his disability at the time of closure. (Ex. 36A-2). Claimant explained that there were no impairment findings, and that he had not been rated for permanent impairment. (Ex. 36A-1). The Referee concluded that the Department had properly referred claimant for examination by a medical arbiter. We agree.

We have previously held that where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is disagreement with the attending physician's impairment findings, then the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992). Unless the requesting party waives appointment of a medical arbiter, we have found the Department's reconsideration order invalid when it was issued prior to consideration of the medical arbiter's report. See Brenton R. Kusch, 44 Van Natta 2222 (1992); Olga I. Soto, supra, 44 Van Natta at 700; ORS 656.268(7). Accordingly, we find no error in the Referee's determination that the Department properly referred claimant for a medical arbiter's examination.

Impairment is determined as provided in OAR 436-35-007(9):

> "Impairment is determined by the attending physician except where a preponderance of medical opinion establishes a different level of impairment. On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment."

The "preponderance of medical opinion" means "the more probative and more reliable medical opinion based upon the most accurate history, on the most objective findings, on sound medical principles and expressed with clear and concise reasoning." OAR 436-35-005(10).

We find that the opinion of the attending physician, Dr. Flemming, does not outweigh the opinion of the medical arbiter, Dr. Gritzka, with regard to the level of claimant's permanent impairment. We find Dr. Gritzka's examination to be thorough and his report based on objective, quantified measurements of impairment, as well as on an accurate history. By contrast, Dr. Flemming did not quantify claimant's lumbar ranges of motion, but noted only that he has "full and complete range of motion of the lumbar spine. . . ." (Ex. 32).

We disagree with the employer's contention that Dr. Gritzka rated a noncompensable L5-S1 disc condition. The employer accepted "herniated disc," which existed at both the L4-5 and L5-S1 levels as a disc protrusion. (Exs. 14A, 19). We find that Dr. Gritzka accurately diagnosed claimant's condition as "[p]rotruded intervertebral disk, L4-5, central disk protrusion, L5-S1," and evaluated the extent of claimant's permanent disability on the basis of this diagnosis. Accordingly, we rely on the medical arbiter's opinion, since we find that the preponderance of medical opinion does not establish a different level of impairment.

The permanent disability award in the Order on Reconsideration was based on and is consistent with the medical arbiter's report. Accordingly, since we also rely on the medical arbiter's report, we reinstate and affirm the Order on Reconsideration.

Penalty and Attorney Fee

Claimant seeks a penalty under ORS 656.268(4)(g) because on reconsideration, the Department ordered an increase by 25 percent or more of the amount of compensation to be paid claimant. The Referee declined to assess a penalty. We agree with the Referee that claimant is not entitled to a penalty under ORS 656.268(4)(g), but we do so based on the following reasoning.

ORS 656.268(4)(g) provides that a penalty shall be paid to the claimant if two conditions are met upon reconsideration of a Notice of Closure: (1) the worker is found to be at least 20 percent permanently disabled; and (2) the Department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability. We have recently held that if the statutory requirements are met, claimant is automatically entitled to the penalty, without regard to whether the carrier's action was reasonable. See Kevin Northcut, 45 Van Natta 173 (1993).

Here, the Notice of Closure awarded claimant no permanent disability. On reconsideration, claimant was awarded 12 percent unscheduled and 11 percent scheduled permanent disability, for a total of 23 percent permanent disability. The amount of compensation awarded claimant for permanent disability was increased from zero to $8,872.50. (See Exs. 34, 39).

We find that the amount of claimant's compensation was increased by more than 25 percent on reconsideration. When the Notice of Closure awards no permanent disability, any amount of increase in compensation awarded by the Order on Reconsideration will be greater than 25 percent, since any amount is infinitely greater than zero. However, claimant is entitled to a penalty only if he is also found to be at least 20 percent permanently disabled.

In this case, a combination of the scheduled (11 percent) and unscheduled (12 percent) permanent disability awards granted by the Order on Reconsideration exceeds 20 percent permanent disability. Together, the awards total 23 percent permanent disability, while separately each award is less than 20 percent. The question is whether the scheduled and unscheduled awards may be combined to achieve the threshold 20 percent permanent disability.

ORS 656.268(4)(g) provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant." (Emphasis added).

We do not find that the statute clearly and unambiguously resolves the question, since it does not address the situation where 20 percent permanent disability may be achieved by a combination of scheduled and unscheduled awards. Therefore, we turn first to legislative history as an aid to determining legislative intent. State v. Leathers, 271 Or 236 (1975). In reviewing the pertinent legislative history, we find no guidance in resolving the present issue.

Next, we turn to the statutory context in which the penalty provision is to be applied. ORS 656.268(4)(g) provides that a penalty shall be assessed, in certain circumstances, upon reconsideration of a claim closed by Notice of Closure. Therefore, we turn to the Director's rules concerning the reconsideration process.

OAR 436-30-050(13) provides that, for purposes of assessing a penalty under ORS 656.268(4)(g), "a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled." See also OAR 436-30-050(12). Here, claimant's award of 12 percent unscheduled disability is equal to 38.4 degrees, and the award of 11 percent scheduled permanent disability for the right leg is equal to 16.5 degrees. The total sum of unscheduled and scheduled disability is 54.9 degrees. Therefore, pursuant to the Director's rule, claimant is not entitled to a penalty because his permanent disability is less than 64 degrees.

We find that, under the circumstances of this case, the Director's rule is not inconsistent with the statute. In doing so, we can envision circumstances where the rule may not be consistent with the statute, such as where the claimant receives any scheduled disability award of 20 percent, which would not be equal to 64 degrees (e.g., 20 percent scheduled permanent disability equals 38.4 degrees for an arm, or 30 degrees for a leg, forearm or hand). However, that is not the case before us. Here, neither award alone is equal to 20 percent disability. The threshold of 20 percent permanent disability is achieved only by combining the scheduled and unscheduled awards. Under such circumstances, we find that the Director's rule is a reasonable interpretation of the statute. Accordingly, based on the facts of this case claimant is not entitled to a penalty under ORS 656.268(4)(g).

In addition to the penalty, claimant seeks an attorney fee pursuant to ORS 656.382(1), presumably based on the employer's alleged unreasonable resistance to the payment of compensation. We decline to award an attorney fee based on ORS 656.382(1) for the following reasons.

First, we have not found claimant to be entitled to a penalty under ORS 656.268(4)(g). Second, in Kevin Northcut, supra, we held that the carrier's permanent disability award need not be unreasonable in order for claimant to be entitled to a penalty under ORS 656.268(4)(g). Therefore, claimant's counsel is not automatically entitled to an attorney fee under ORS 656.382(1). See Jesus R. Corona, 45 Van Natta 886 (May 11, 1993). Here, the employer awarded no permanent disability in its Notice of Closure based on the attending physician's closing examination, which found that claimant had no permanent disability. (Ex. 32). Accordingly, even if claimant were entitled to a penalty, we find that the employer did not unreasonably resist the payment of compensation by closing the claim without an award of permanent disability.

Finally, claimant is entitled to an approved attorney fee equal to the amount of 25 percent of the increased compensation awarded by this order, not to exceed $3,800, payable out of claimant's compensation. Judy A. Jacobson, 44 Van Natta 2393, on recon 44 Van Natta 2450, 2450-51 (1992); see also ORS 656.386(2); OAR 438-15-055(1). However, if the permanent disability award granted by the Order on Reconsideration has been paid, claimant will not receive any additional payment as a result of our order. Nevertheless, claimant's attorney remains entitled to an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by our order from the Referee's reduced award (7 percent increase in unscheduled permanent disability and 11 percent increase in scheduled permanent disability). Therefore, our order may create an overpayment of compensation, equal to the attorney fee awarded by this order. Should those circumstances exist, the employer is authorized to recover the overpayment created by our order against claimant's future awards of permanent disability. Judy A. Jacobson, supra, 44 Van Natta at 2451; see also Kenneth V. Hambrick, 43 Van Natta 1287, 1288 (1991).

Claimant's attorney is not entitled to an assessed attorney fee for services on Board review for the following reasons. The employer did not request review. See ORS 656.382(2). In addition, although the Order on Reconsideration has now been reinstated, it was not reinstated by the Referee in response to the employer's hearing request. See ORS 656.382(2). Finally, no attorney fee is available for counsel's services on review regarding entitlement to a penalty. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated July 10, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which modified the Order on Reconsideration is reversed. The Order on Reconsideration is reinstated and affirmed. That portion of the order which declined to assess a penalty is affirmed. Claimant's counsel is awarded an attorney fee equal to 25 percent of the increased compensation awarded by this order from the Referee's order, provided that the fees awarded under this order shall not exceed $3,800. In the event that this "out-of-compensation" attorney fee award creates an overpayment, the self-insured employer is authorized to recover any such overpayment against claimant's future awards of permanent disability on this claim.

In the Matter of the Compensation of
VIRGIL A. RAY, Claimant
WCB Case No. 90-22395
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Lipton.

Claimant requests review of that portion of Referee Michael V. Johnson's order which upheld the insurer's partial denial of claimant's visual condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

First, the Referee determined that claimant's visual problem arose directly from an on-the-job head injury, rather than as a secondary consequence of the accepted concussion. Therefore, the Referee concluded that claimant's burden is to prove that the work injury was a material contributing cause of his visual condition, rather than the major contributing cause of the condition. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We agree.

The insurer contends that because of the delayed appearance of claimant's visual problems, they must be analyzed as a consequential condition, applying the major contributing cause standard under ORS 656.005(7)(a)(A). We disagree. A condition that arises belatedly is not necessarily a "consequential" condition. The key inquiry is whether the condition or need for treatment is caused directly by the industrial accident, or whether it is caused in turn by the compensable injury. Gasperino, supra, 113 Or App at 415.

Dr. Johnson, optometrist, opined that claimant's visual problem, difficulty in maintaining alignment of the eyes, is related to his head injury. He based his opinion on claimant's initial reports of problems with headaches and difficulty focusing when reading after his head injury. (Ex. 35). We agree with the Referee's finding that claimant began to experience visual problems shortly after his head injury and consistently complained of headaches, particularly associated with reading and driving. (See e.g., Ex. 6-1; Tr. 16-17, 28). In addition, Dr. Johnson opined that trauma is the major cause of eye postural problems. (See Ex. 39-15 to -16). Furthermore, we find no medical opinion which relates claimant's visual problem to the accepted concussion, as distinguished from the head injury itself. Accordingly, we agree with the Referee's determination that claimant must establish that his work injury was a material contributing cause of his visual problem in order to establish compensability.

The Referee found that only Dr. Johnson opined that there was a relationship between claimant's head injury and his current eye condition. Two medical doctors, a neurologist and orthopedist, opined that claimant's visual problems were not related to his head injury. The Referee concluded that the opinion of the medical doctors must prevail over the opinion of the lesser-trained optometrist, and that therefore, claimant failed to prove causation by appropriate medical evidence. We disagree.

When there is a dispute between medical experts, we give greater weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We do not automatically discount the opinion of an optometrist simply because he does not have medical training. Instead, we are guided by the Oregon Rule of Evidence 702, which provides:

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

See also Aetna Casualty Co. v. Robinson, 115 Or App 154, 158 (1992).

Here, Dr. Johnson testified that he is a licensed optometrist, having received a doctorate of optometry degree in 1983. (Ex. 39-6). He further testified that both he and Dr. Epstein, ophthalmologist, examined claimant. Dr. Johnson evaluated the anterior or exterior segment of the eye, including eye muscle balance and positioning, while Dr. Epstein examined the retina. (Ex. 39-9). Claimant's eye examination was normal, except for eye alignment. (Exs. 35; 39-8 to -9, 39-67). Dr. Johnson treated claimant on three occasions, as a result of which he was fitted with prism lenses to realign the vision in his eyes. (Exs. 29, 35). In addition, Dr. Johnson supported his opinion regarding causation of claimant's visual condition with reference to a medical treatise on clinical neuropathy. (Ex. 39-16).

On the basis of his training and expertise, as well as his evaluation and treatment of claimant, we find Dr. Johnson to be appropriately qualified to render an expert opinion regarding causation of claimant's eye alignment problem. Accordingly, we weigh the expert medical opinions, including Dr. Johnson's, on the basis of whether they are well-reasoned and based on complete information.

Dr. Epstein examined claimant on referral from the treating physician, Dr. Hites, for problems with headaches, focusing and reading. (Ex. 39-67). As the Referee found, and we agree, claimant consistently complained of headaches since shortly after his head injury. In his report to Dr. Hites, Dr. Epstein noted claimant's "history of post head injury in April 1990," but reported a normal eye examination except for "a question of convergence insufficiency. Exophoria and hyperphoria were noted." (Id). Dr. Epstein diagnosed "[v]isual fatigue associated with exophoria and hyperphoria following head injury," and he suggested prism glasses to lessen claimant's visual fatigue. (Id.). Subsequently, he reported to the insurer that claimant had received prism treatment and reported "some improvement reading and driving with glasses containing prisms." (Ex. 39-68). In his report to the insurer, Dr. Epstein again referred to claimant's head injury and his problems with headaches, focusing and reading as the reason for the consultation and treatment. (Id.). Accordingly, we find that Dr. Epstein's reports implicate claimant's head injury as the cause of his visual problems. Although Dr. Epstein does not directly express an opinion on causation, we consider his reports in conjunction with Dr. Johnson's medical opinion.

Following Dr. Epstein's recommendation, claimant received prism treatment with Dr. Johnson. (Ex. 35). Dr. Johnson also examined claimant's eyes, specifically including eye muscle balance and positioning, which proved to be out of alignment and the source of claimant's visual problems. (Exs. 35, 39-8 to -9). Dr. Johnson opined that claimant's visual alignment problem is due in major part to the effects of his on-the-job head injury. (See Exs. 35, 37B). After extensive cross-examination, Dr. Johnson adhered to his previously expressed opinion. (Ex. 39-36). In addition, he supported his opinion with research that indicates that trauma is the major cause of eye postural problems. (Ex. 39-16, 39-37).

After our review of the record, we are persuaded by Dr. Johnson's opinion, in conjunction with Dr. Epstein's examination reports, and find that claimant's head injury was at least a material contributing cause of his visual condition.

Dr. Dickerman, neurologist, and Dr. Donahoo, orthopedist, conducted an independent medical examination and concluded that it is doubtful that claimant's disconjugate gaze was due to the April 1990 head injury. (Ex. 22-9). Their opinion was based on a brief eye examination, in which they noted that claimant did not complain of double vision and appeared at times to be able to control his gaze. The examiners concluded that claimant's disconjugate gaze was longstanding, with a degree of amblyopia. (Ex. 22-9).

However, the eye examination of Drs. Epstein and Johnson revealed no amblyopia, but rather normal visual acuity in both eyes. (Ex. 39-39 to -40). Dr. Johnson also opined that, considering the significant degree of misalignment of his eyes, it is likely that claimant would have experienced visual problems previously if his condition were longstanding. (Ex. 39-44 to -45). However, claimant reported that he was an avid reader before his head injury, with no previous headaches or eye problems. (Tr. 17). Furthermore, Dr. Johnson explained that claimant's report of only intermittent double vision is due to his ability to somewhat pull his eyes into alignment. (Ex. 39-24).

Under these circumstances, we find the opinion of Dr. Johnson, in conjunction with Dr. Epstein's reports, to be more persuasive than the opinion of Drs. Donahoo and Dickerman. Accordingly, we find that claimant has established that his visual condition was caused, at least in material part, by his April 1990 head injury.

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 $4,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the appellate briefs, claimant's counsel's attorney fee request, and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 9, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the insurer's partial denial of claimant's visual condition is reversed. The insurer's partial denial of claimant's visual 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. Claimant's attorney is awarded $4,500 for services at hearing and on Board review, to be paid by the insurer.

June 18, 1993 Cite as 45 Van Natta 1087 (1993)

In the Matter of the Compensation of
ANGELA R. SMALLWOOD, Claimant
WCB Case Nos. 91-18143 & 91-05834
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Myers' order which upheld: (1) Aetna Casualty Company's disclaimer of responsibility for claimant's allegedly worsened neck, upper back and shoulder conditions and medical treatment for such conditions; and (2) SAIF Corporation's denial and responsibility disclaimer for the same conditions. On review, the issues are aggravation and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the second paragraph on page 2 of the Opinion and Order. Instead, we make the following findings.

The Medical Director denied Dr. Altrocchi's request for palliative care on March 6, 1991. (Ex. 25).

On June 21, 1991, Dr. Altrocchi submitted a "curative care request" to Aetna Casualty Company (Aetna). (Ex. 27). On July 10, 1991, Aetna responded by pointing out that the Medical Director had already denied a palliative care request, and by requesting additional documentation of an aggravation and of the need for curative care. (Ex. 28). On July 24, 1991, Dr. Altrocchi responded by reiterating that the request was for curative, not palliative, care. He also described objective indicators of a worsening, which he attributed not to a new injury or "re-injury" but to a lack of medical treatment. (Ex. 29).

CONCLUSIONS OF LAW AND OPINION

The Referee upheld both insurers' denials of an aggravation claim. We affirm the Referee's order, but based on the following reasoning.

In order to prove a compensable aggravation, it is claimant's burden to show that, since the last arrangement of compensation, she has a worsened condition resulting from the original injury. ORS 656.273(1); ORS 656.266. A worsened condition is established by evidence of increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396, 401 (1986); Leroy Frank, 43 Van Natta 1950 (1991). The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1).

We do not reach the issue of whether claimant has established a worsened condition by medical evidence supported by objective findings because, were we to find a worsened condition, we find no evidence that it has resulted in diminished earning capacity. See Smith v. SAIF, supra.

Claimant testified that she has not lost time from her current job as an office worker despite increased pain, but continues to work with the aid of pain medications. (Tr. 13-15, 32). She further testified that since beginning her current job in 1989, she has not been limited in performing her work activities, but has actually increased her hours. (Tr. 36; see also ex. 34-3). In addition, Dr. Altrocchi has not taken claimant off work due to her current condition.

Accordingly, we conclude that even if claimant's condition has worsened, the worsening has not resulted in diminished earning capacity. Therefore, we agree with the Referee and conclude that claimant has failed to prove an aggravation of her compensable condition.

ORDER

The Referee's order dated May 4, 1992, as corrected May 6, 1992, is affirmed.

In the Matter of the Compensation of
LYNNE M. TRUEBLOOD, Claimant
WCB Case No. 91-06945
ORDER ON REVIEW
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant requests review of that portion of Referee Nichols' order that declined to award additional benefits for temporary disability. On review, the issue is claimant's entitlement to temporary disability from May 25, 1989 through November 1, 1989. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks review of the Referee's order denying her additional benefits for temporary disability from May 25, 1989 through November 1, 1989. We affirm.

Claimant sustained a disabling compensable injury and, after a brief period off work, returned to modified work in October 1988. On May 25, 1989, she obtained a leave of absence to care for her sick child through August 1, 1989. On June 26, 1989, she was involved in a motor vehicle accident (MVA). Although she had intended to return to work in August, her treating physician authorized time away from work until November 1989.

The Referee correctly held that claimant is not entitled to benefits for temporary disability from May 25, 1989 through August 1, 1989. We agree.

A claimant who has withdrawn from the workforce is not entitled to temporary disability benefits, because benefits are intended to replace lost wages. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). We are not persuaded by claimant's contention that she had returned to the work force in June 1989, because her son's illness actually required her to miss only two to three weeks of work. While the employer contacted claimant in June concerning a light duty position that was available for the summer, we do not consider that evidence sufficient to establish that claimant was willing to be employed prior to her planned return date, especially in light of her testimony that she had decided to take the summer off and return to work on August 1, 1989.

Claimant also points to Dr. Kirkland's chart notes of June 17, 1989 and June 19, 1989 as proof that claimant had returned to the workforce on June 19, 1989, but that Kirkland had recommended that she continue her leave of absence until August 1, 1989. We conclude that the chart notes are essentially silent with regard to the reason behind Dr. Kirkland's recommendation; the chart notes do not suggest that claimant's work injury was causing her continuing need for time off.

The Referee also correctly held that claimant is not entitled to temporary disability benefits for the period from August 1, 1989 through November 1, 1989. Whether claimant is entitled to temporary disability is determined by whether or not she was disabled during that period due to the compensable condition. Botefur v. City of Creswell, 84 Or App 627 (1987). In this regard, we do not find that claimant's condition following the noncompensable MVA in June 1989 constitutes a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). At issue is whether claimant's post-MVA condition remains a direct result of the original industrial accident in 1988, not a result of the compensable injury. Accordingly, we find that the material contributing cause standard applies here. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Although claimant continued to experience symptoms related to her 1988 industrial accident, the record establishes that her inability to work from August 1, 1989 through November 1, 1989 was the result of the disabling off-the-job MVA, and was not caused, in material part, by the 1988 industrial accident. Accordingly, claimant has not established by a preponderance of the evidence that she is entitled to additional benefits for temporary disability.

As a final matter, claimant contends that it would be "unjust" to allow the insurer to accept a lien for proceeds from the third-party claim recovered on account of the MVA, and not to pay benefits for temporary disability based on the symptoms that it caused. As noted by the insurer, the record is unclear on this point, but it appears that the insurer continued to pay for claimant's medical expenses following the MVA. As this litigation establishes, the insurer did not provide temporary disability as a result of the MVA.

It was legally permissible for the insurer to assert a lien for its expenditures for claimant's medical expenses. See ORS 656.593(1)(c). There is no basis in the record for finding that the insurer asserted its lien in an amount exceeding expenditures it had paid in medical expenses following the MVA. Further, the assertion of its lien for medical expenses did not estop the insurer from contesting claimant's entitlement to temporary disability benefits.

ORDER

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

Board member Hooton dissenting.

The majority finds that claimant is not entitled to temporary disability benefits for the period May 25, 1989 through November 1, 1989, first because claimant had voluntarily withdrawn from the labor market for the period May 25, 1989 through August 1, 1989, and, second, because the cause of claimant's disability thereafter was an automobile accident unrelated to her compensable injury. I disagree and, therefore, respectfully dissent.

Temporary disability compensation is intended to replace lost wages. Consequently, a claimant who has voluntarily withdrawn from the labor force is not entitled to temporary disability benefits. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The Supreme Court has noted, however, that a

voluntary withdrawal from the labor force is not necessarily permanent. SAIF v. Stephen, 308 Or 41 (1990). Under the principles established in Stephens, and reiterated in Dawkins, claimant again becomes entitled to temporary disability compensation following a voluntary withdrawal from the labor force when she has established that she is ready and willing to return to the labor force but is prevented by the consequences of her compensable injury.

On May 25, 1989, claimant obtained a leave of absence to care for her son, who had been diagnosed with hepatitis. That leave of absence was to continue until her child no longer needed her attentions. Within two to three weeks claimant's son had recovered and on June 17, 1989 claimant returned to her treating physician with complaints consistent with her compensable condition and indicated her intention to return to work on June 19, 1989. The chartnote of claimant's treating physician of June 19, 1989 suggests that claimant did exactly that. The employer contacted claimant's treating physician on June 19, 1989 to advise the treating physician that it had available, for the remainder of the summer, the position of ticket taker, a modified employment. The chartnote establishes that the treating physician advised the employer that he did not recommend that claimant take that employment, but that claimant should remain off work.

The majority notes that claimant contends that she had returned to the work force on June 19, 1989 when she returned to her employer seeking modified employment. Under the principles outlined in SAIF v. Stephen, supra, claimant's actions are sufficient to establish her return to the labor force. The majority, however, argues that the employer contacted claimant in June and that claimant decided to take the remainder of the summer off and return to work on August 1, 1989. While claimant testified that she did decide to take the remainder of the summer off, her testimony indicates that it was her doctor's conclusion that she should remain off work that influenced that decision. In addition, the chartnote of June 19, 1989, contrary to the contention of the majority, indicates that claimant's treating physician advised the employer, pursuant to the employer's request regarding the suitability of modified employment, that it was his recommendation that claimant remain off work for the remainder of the summer.

The majority further finds, however, that the treating physician does not indicate that the compensable injury caused the claimant's need to remain off work. This finding focuses on the brief chartnote of June 19, 1989 and ignores all of the preceding medical record. Claimant's symptoms related to her accepted and compensable injury had not abated from the time of her injury through the time of her leave of absence on May 25, 1989, and were exacerbated by her work experience. The chartnotes reflect that this continued symptomatic presentation was of concern to the claimant's treating physician. No other illness or consideration is present in the chartnotes which might suggest a cause of disability other than the compensable injury. Though no explanation was presented in the chartnote of June 19, 1989 why the treating physician recommended that claimant remain unemployed throughout the summer, an examination of the record as a whole supports only the conclusion that claimant's doctor recommended that she remain off work for the duration of the summer to permit additional time in which the compensable consequences of her condition could resolve.

The majority further finds that after August 1, 1989 and through November 1, 1989, the claimant is not entitled to temporary disability benefits because her disability during that time was not due to the compensable condition. The majority cites Botefur v. City of Creswell, 84 Or App 627 (1987). I agree with the majority that the claimant is not entitled to temporary disability benefits if the period of disability is due solely to causes other than the compensable condition. However, that is not the case here. Claimant has established a relationship between the compensable condition and the disability if the compensable condition is and remains a material contributing factor in the disability and need for treatment.

On or about June 26, 1989, claimant was involved in an automobile accident that exacerbated her compensable symptoms. At that time her claim remained in open status, and had never been closed. ORS 656.273 was amended in 1990 to provide a defense where the aggravation of a compensable injury was caused in major part by a noncompensable event. However, that statute is not applicable here because those amendments are applicable only in the setting of an aggravation claim. Because those amendments are not applicable to an open claim, claimant remains entitled to temporary disability compensation and compensation for necessary medical services if the injury is a material cause of the disability and need for treatment, even if a subsequently arising noncompensable event is the major cause of that need. Grable v. Weyerhaeuser, 291 Or 387 (1981).

While there is no medical report in this record which directly addresses whether claimant's compensable injury remains a material contributing cause of the need for treatment after June 26, 1989, that conclusion is supported by the record as a whole and is finally confirmed by the actions and stipulations of the insurer.

ORS 656.580 provides in pertinent part as follows:

> "(1) The worker, or beneficiaries of the worker, as the case may be, shall be paid the benefits provided by this chapter in the same manner and to the same extent as if no right of action existed against the employer or third party until damages are recovered from each employer or third party.
>
> "(2) The paying agency has a lien against the cause of actions provided by ORS 656.591 or 656.593 which lien shall be preferred to all claims except the cost of recovering such damages."

Under this section, claimant remains entitled to those benefits which are required by the Workers' Compensation Law even if claimant's disability and need for treatment was caused by a third party. The employer, or insurer, is given a lien against the cause of action against that third party to recover the cost of any benefits properly paid on the claim. It is important to note, however, that claimant is only entitled to the benefits allowed by ORS Chapter 656. Those benefits are available only where the compensable injury is a material factor in the disability or need for treatment.

By providing medical services and participating in the compromise of the third party action to recover its "lien," the insurer acknowledges that claimant was entitled to the benefits which she received from the insurer/employer under the law. If the insurer provided benefits to which the claimant was not entitled under the law, the insurer has no right to recover the cost of those benefits under a supposed lien. In such a circumstance, the insurer is in the position of a mere volunteer, and the voluntary payment of benefits does not give rise to a right of subrogation either under the statute or at common law.

By accepting its statutory share of the recovery from the third party, the insurer acknowledges that there is a material causal relationship between claimant's then-current condition and the compensable injury for which the insurer is solely responsible. The majority, and the Referee, find that the disability after June 26, 1989 was attributable to the automobile accident and was therefore not the result of the compensable injury. The majority misunderstands the nature of the claimant's statutory entitlement.

Claimant is entitled to temporary total disability if her compensable injury is a material contributing cause of that disability. It need not be the sole cause or even the most important cause, the injury must, however, be a significant cause. The claimant here was experiencing at least partial disability related to her compensable condition at the time of the accident. In addition, the accident exacerbated symptoms that were already present, giving rise to the period of total disability. Even though an intervening event contributed to the overall disability, the question still remains whether the injury is a material cause of that disability. Grable v. Weyerhaeuser, supra.

The majority appears to be applying the following analysis. Claimant was not totally disabled at the time of the June 26, 1989 automobile accident. She was totally disabled after that accident. Consequently, "but for" the noncompensable motor vehicle injury, claimant would not have been totally disabled. Therefore, it is the accident and not the injury that is the cause of the total disability, and claimant is not entitled to benefits. As explained above, that analysis is legally incorrect. It is irrelevant that claimant would not have experienced that period of total disability had it not been for the noncompensable accident, if the compensable injury remains a material cause of the disability.

Because I would find that the compensable injury remained a material contributing factor in claimant's disability at all times, based on the record as a whole, I would find that claimant is not entitled to temporary disability compensation from May 25, 1989 through June 18, 1989, the period when she had voluntarily withdrawn from the labor market, but that, thereafter, claimant again became entitled to benefits under the law. Specifically, I would allow temporary partial disability benefits for the period from June 19, 1989 through June 25, 1989 and temporary total disability benefits for the period from June 26, 1989 through November 1, 1989, when claimant returned to her prior partial disability.

The majority concludes that the industrial injury remained a material cause of the need for medical treatment, sufficient to support enforcement of the lien, but not of the disability. Both the need for treatment and the disability derive directly from claimant's then-current condition. If that condition is materially related to the industrial injury, both the need for treatment and the disability are compensable. If the current condition is not materially related, neither the disability nor the need for treatment is related.

Because the majority's analysis relies upon a mischaracterization of the factual record and an inappropriate legal analysis, it has reached the wrong result.

In the Matter of the Compensation of
ANTHONY J. KOSMAS, Claimant
WCB Case No. 92-06897
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Lipton's order that upheld the insurer's June 25, 1992 denial of his aggravation claim for a neck and low back condition. On review, the issue is aggravation.

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

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).

Claimant contends that he has established a worsening of symptoms which represent more than a waxing and waning of symptoms. We disagree.

Prior to claimant's last arrangement or award of compensation, he was released to work. However, due to intermittent problems with left leg pain, he was unable to work full time. A June 26, 1991 MRI revealed: "Normal study. No disc herniation, bonying [sic] spurring or nerve root compression." (Ex. 5).

In June 1992, as a result of developed right leg pain, claimant returned to his treating physician, Dr. Goldberg. Dr. Goldberg took claimant off work from June 8, 1992 until a neurological evaluation could be performed. A July 1992 MRI revealed: "minor disc bulges at L4-5 and L5-S1, but no evidence of herniation and significant neural encroachment." (Ex. 25). Dr. Calhoun, neurosurgeon reported that "there is nothing surgically correctable" to offer claimant. (Id). On July 2, 1992, claimant's range of motion findings indicated improved range of motion since the last award or arrangement of compensation.

Under the circumstances, we find that claimant has failed to establish a worsened condition since the last award or arrangement of compensation. Claimant's MRI remained essentially unchanged and his range of motion findings were improved. Furthermore, we do not find that claimant has shown a worsening that is more than a waxing and waning of symptoms contemplated by the previous permanent disability award.

Claimant's last award or arrangement of compensation does not recite that future waxing and waning was anticipated. Nonetheless, on September 19, 1991 (prior to this last award or arrangement of compensation), Drs. Torkko and Bussanich, rehabilitative services providers, reported in their closing evaluation that claimant would experience intermittent to constant pain in his neck and low back with activity. (Ex. 15). Under the circumstances, we conclude that future waxing and waning of symptoms were anticipated by the last award of compensation. In this case, we do not find that any worsening claimant has experienced is more than the anticipated waxing and waning of symptoms.

Accordingly, we agree with the Referee that claimant has failed to establish a compensable aggravation.

ORDER

The Referee's order dated September 3, 1992 is affirmed.

June 24, 1993 Cite as 45 Van Natta 1093 (1993)

In the Matter of the Compensation of
DeMAR L. BATCHELOR, Deceased, Claimant
WCB Case No. 92-00598
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

The SAIF Corporation requests review of Referee Menashe's order that set aside its denial of claimant's beneficiary's death benefits claim. On review the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had underlying coronary artery disease and myocarditis, predisposing him to ventricular fibrillation. The Referee further found that claimant's work stress was the major contributing cause of a ventricular fibrillation that led to claimant's sudden death. The Referee, therefore, found claimant's death to be compensable. We agree with the Referee and offer the following additional reasoning.

Subsequent to the Referee's order, 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 an occupational disease claim under ORS 656.802." SAIF v. Hukari, 113 Or App 475 (1992). (Emphasis in original). See also Jerry B. Mathel, 44 Van Natta 1113 (1992), on recon 44 Van Natta 1532 (concluding that Hukari holding is equally applicable to current ORS 656.802, as amended effective July 1, 1990).

Here, there is evidence that job stress caused claimant's ventricular fibrillation, which in turn resulted in a heart attack and subsequent death. Claimant must, therefore, satisfy the requirements of establishing a compensable mental disorder under ORS 656.802 in order to establish a compensable claim.

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence by way of medical evidence supported by objective findings. ORS 656.802(2). Additionally, 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).

We find that claimant's work-related stressors existed in a real and objective sense. Dr. Toren found the interoffice letters and memoranda to be "inflammatory" and "upsetting" even "to a lawyer, who might be professionally accustomed to such communication." (Ex. 10-2, 3). Moreover, the testimony of several witnesses establishes that claimant's stressors were both real and objective.

Claimant must also prove that the work stressors are conditions which are not generally inherent in every working situation. The Board has interpreted the phrase "generally inherent in every working situation" to mean those conditions which are usually present in all jobs and not merely the specific occupation involved. See Kathleen M. Payne, 42 Van Natta 1900, 1906 on recon 42 Van Natta 2059 (1990), rev'd on other grounds, City of Portland v. Payne, 108 Or App 771 (1991). Further, the Court of Appeals held in SAIF v. Campbell, 113 Or App 93 (1992), that the Board may determine which conditions are generally inherent in every working situation on a case-by-case basis.

We conclude that tension-filled and emotional interoffice "warring" between workers is not a condition that is generally inherent in every working situation. Specifically, claimant had worked as a partner in his law firm for 27 years. Then, due to interoffice turmoil, he was compelled to either purchase the building where he worked or find another work location. The record establishes that both options involved extensive financial burden and operated to end the partnership. In addition, claimant was concurrently facing two lawsuits related to his law practice.

In reaching this conclusion, we find the present case distinguishable from Michele A. Nugent, 45 Van Natta 189 (1993). In Michele A. Nugent, supra, the claimant was concerned about an associate's business decisions and their impact on the viability and future of the corporation of which the claimant was an officer and a shareholder. In Nugent, we found that the fear over the failing of a business enterprise is common to all employments. Id.

Here, however, claimant was not concerned about a failing business; he was distressed by the extreme turmoil resulting from an interpersonal office breakdown and the imminent termination of a 27-year partnership. He was also distressed about finding another location to perform his work. Furthermore, claimant faced two work-related lawsuits. Under these circumstances, we find that claimant's work-related stressors were conditions other than those generally inherent in every working situation.

We further find that claimant suffered from a mental or emotional disorder which is generally recognized in the medical or psychological community. Dr. DeMots, Head of Cardiology of Oregon Health Sciences University, reviewed claimant's medical and death records and a description of the events that preceded claimant's death. He diagnosed that in the months prior to his death, claimant was under "severe psychologic stress." (Ex. 11). Dr. DeMots acknowledged that the events that claimant experienced would most likely be perceived as stressful. (Id.)

Dr. Toren, cardiologist, reviewed claimant's records and the memoranda generated during the partnership dispute. He reported that claimant had been under "a nearly overwhelming degree of stress" prior to his death. (Ex. 10-2). He further determined that: "An extremely stressful set of circumstances were present, and [claimant] appears to have responded to these circumstances in a highly stressed fashion." (Ex. 10-3). Thus, we conclude from the medical record that claimant suffered from severe emotional distress, a diagnosis recognized by both Drs. Toren and DeMots.

In so concluding, we recognize that we have previously held that "stress" in and of itself, is not a condition which is generally recognized as a "mental disorder." See Nancy L. Lucas, 43 Van Natta 911 (1991); Ronald V. Dickson, 42 Van Natta 1102 (1990); Sharon Schettler, 42 Van Natta 2540 (1990). In those cases, however, the medical providers referred generally to the claimants' "stress" but none provided a diagnosis of a psychological condition.

Here, on the other hand, Drs. Toren and DeMots reviewed claimant's record and specifically diagnosed a "severe psychologic stress condition." Therefore, under the facts of this case, we find that claimant has established that he suffered from a recognized mental or emotional disorder.

Finally, claimant must prove by clear and convincing evidence that his mental condition arose out of and in the course of employment. To be clear and convincing, evidence must establish that the truth of the asserted fact is highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 402 (1987).

Dr. DeMots reviewed claimant's medical records, the Hillsboro Police Department death scene report and the autopsy report. He also considered a description of the stressful events that preceded claimant's death. (Ex. 11). Dr. DeMots found claimant's underlying heart disease to be the major cause of his fatal arrhythmia, and stress to be a minor factor. (Ex. 11-3).

Where, as here, there is a conflict of medical opinion, we rely on the opinion that is well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979). Here, we are not persuaded by Dr. DeMots' opinion because it does not provide a thorough explanation for the physician's conclusion. In contrast, Dr. Toren's opinion is complete and, in light of Dr. Toren's cross-examination at hearing, its analysis is thoroughly explained.

Dr. Toren based his opinion, in part, on the autopsy findings, the State Medical Examiner's report and claimant's past medical records. Those records showed that claimant had coronary disease but no evidence of a myocardial infarction. Toren also considered claimant's environmental stimuli (i.e., the pending malpractice lawsuits and the partnership dissolution) and his response thereto. Dr. Toren concluded that claimant was experiencing considerable stress in the months prior to his death. Moreover, Toren reviewed the memoranda and letters which generated the stressful circumstances in the context in which they were presented to claimant. This evidence was supported by descriptions of the people who had the opportunity to observe claimant during the last months of his life. (Tr. 238). Based on that information, Dr. Toren concluded that claimant's work environment "played a major contributing role" in the ventricular fibrillation that led to claimant's death.[1] (Id.) In addition, Dr. Toren persuasively explained his findings and conclusions at hearing. Inasmuch as we consider Dr. Toren's opinion to be thorough, well-reasoned and complete, we find it persuasive.

Based upon Dr. Toren's persuasive medical opinion, we find it highly probable that claimant's work environment, including the dissolution of his partnership and the personal litigation in which he was involved, constituted the major contributing cause of his psychological condition, which, in turn, led to his fatal fibrillation condition and, ultimately, his death.

Finally, SAIF contends that claimant's claim is not compensable because there was no worsening of his underlying coronary disease. Such a finding is not necessary for the proof of a compensable claim under the pertinent statute.

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

ORDER

The Referee's order dated July 6, 1992 is affirmed. Claimant's counsel is awarded an assessed attorney fee for services on Board review in the amount of $3,500, to be paid by the SAIF Corporation.

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[1] Based on the extreme nature of the stress claimant experienced, Dr. Toren opined that "the stress played a major role" in the causation of claimant's fibrillation and subsequent death. Although Dr. Toren used the phrase "a major role" rather than "the major role" when discussing the causal relationship between claimant's work and his fatal fibrillation, medical evidence is not required to consist of specific incantation or to mimic statutory language. U-Haul of Oregon v. Burtis, 120 Or App 353 (1993); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) (Magic words not required).

In the Matter of the Compensation of
PATSY R. BUTTERFIELD, Claimant
WCB Case No. 92-08212
ORDER ON REVIEW
Davis, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of Referee Brown's order that reduced the 26 percent (83.2 degrees) unscheduled permanent disability awarded by an Order on Reconsideration to zero. On review, the issue is extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a right arm, shoulder and cervical condition. SAIF initially issued a notice of closure in December 1991 awarding 37 percent unscheduled permanent disability and 7 percent scheduled permanent disability. In April 1992, SAIF issued a "corrected" notice of closure awarding no permanent disability. The Order on Reconsideration, based on a medical arbiters' examination, awarded 27 percent unscheduled permanent disability and no scheduled permanent disability.

At hearing, SAIF introduced surveillance films taken between late March and July 1992 of claimant's activities. Based on inconsistencies between claimant's testimony and the films, the Referee found claimant not credible and that, therefore, he could not make findings with regard to age, education or adaptability. The Referee also concluded that there was insufficient evidence of reliable measurements of the cervical and shoulder ranges of motion, thereby preventing him from making impairment findings. Consequently, the Referee concluded that claimant had failed to prove any permanent disability.

We first note 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). 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). In this case, the record includes impairment findings from claimant's attending physician, a panel of medical arbiters, and two independent medical examining panels. However, because there is no evidence that the attending physician concurred in the findings of the independent medical examiners, we do not consider those impairment findings.

With regard to claimant's credibility, we agree with the Referee that claimant's testimony is impeached by the surveillance films. In particular, the film contradicted her testimony that she did not walk without her cane; had not driven since being injured except for once backing up her vehicle a short distance; walked and entered her trailer in a slow and deliberate manner; and had not carried anything in her right hand since acquiring her cane. Although the film showed claimant walking numerous times, the only occasion she limped and used her cane was when entering and exiting medical offices for two independent medical examinations. The film also showed claimant carrying a basket of laundry and driving a pickup truck to a meat market. Therefore, we agree with the Referee that claimant was not a credible witness.

We do not find, however, that claimant's lack of credibility precludes her entitlement to an award of permanent disability. The credibility finding in this case was predicated on the inconsistency between claimant's testimony and surveillance films, neither of which can serve as evidence of impairment; impairment is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). Finding a claimant not credible, therefore, does not necessarily result in a finding that the claimant has no impairment.

We consider the credibility finding relevant to determining impairment in this case, however, because claimant showed that she has a tendency to exaggerate her physical restrictions, thereby raising the inference that claimant's medical examinations were invalid. See Juel L. Fadness, 43 Van Natta 520, 521 (1991) (surveillance films impeached claimant's statements regarding physical restrictions to medical examiners, resulting in unreliable range of motion measurements). This inference is supported by the medical arbiters' report, which questioned whether claimant had exhibited her full abilities with regard to cervical range of motion. (Ex. 63-5).

Claimant's attending physician, Dr. Dunn, in response to an independent medical examiners' report that cervical range of motion measurements obtained by the panel were so inconsistent that they were "totally invalid," stated that his inclinometer readings were "valid." (Ex. 45). Dr. Dunn, however, provided no explanation for this opinion. Furthermore, there is no evidence that Dr. Dunn was aware of either the medical arbiters' report questioning claimant's cervical range of motion or the surveillance films. Under these circumstances, we find no persuasive evidence that Dr. Dunn rendered his opinion regarding the validity of his impairment findings with the knowledge that claimant tended to exaggerate her physical restrictions. Consequently, we find that this opinion is not reliable.

Finally, in light of the evidence showing that claimant is not credible with regard to her physical impairment, we conclude that the record contains no persuasive evidence of measurable impairment. Having failed to prove measurable impairment, claimant is not entitled to an award of permanent disability. See OAR 436-35-007(1), 436-35-270(1).

ORDER

The Referee's order dated September 24, 1992 is affirmed.

June 24, 1993 Cite as 45 Van Natta 1097 (1993)

In the Matter of the Compensation of
MICHAEL C. DEWBRE, Claimant
WCB Case No. 92-08728
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Lipton and Brazeau.

The self-insured employer requests review of those portions of Referee Baker's order that: (1) set aside its denial of claimant's aggravation claim for a left shoulder condition; and (2) awarded claimant interim compensation. On review, the issues are aggravation and interim compensation.

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

Aggravation

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). Furthermore, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

The last award of compensation was the July 7, 1989 Determination Order award of 20 percent unscheduled permanent disability benefits. Prior to that award, Dr. Hayes' closing examination revealed the ranges of left shoulder motion to be 135 degrees of forward flexion and 125 degrees of abduction. (Ex. 22). Dr. Hayes released claimant for work with no excessive use of the left arm above shoulder level, and noted that claimant will need further treatment with nonsteroidal anti-inflammatory compounds. (Id.)

In August 1991, claimant returned to Dr. Hayes with left shoulder pain which was not being completely relieved by the anti-inflammatory compound. (Ex. 14-4). Dr. Hayes found an impingement sign and reduced ranges of motion. An MRI revealed inflammation in the shoulder. (Ex. 14-5). By January 1992, Dr. Hayes recommended no use of the left arm above shoulder level and no lifting, carrying, pushing or pulling of more than 10 to 15 pounds. (Ex. 14-7). By May 1992, claimant's ranges of motion had "significantly" decreased to 90 degrees of forward flexion and 95 degrees of abduction. (Ex. 14-9). Claimant was also receiving injections, though his pain was not completely relieved.

In addition, both Drs. Hayes and Streitz recommended a job change from jitney driving. (Exs. 14-10, 29, 38-93). Although Dr. Hayes later stated that claimant was able to perform the jitney driving job at all times (with the exception of May 1, 1992), he added that the recommendation for a job change was made to alleviate symptoms caused by jitney driving. (Ex. 38-54).

Based on the aforementioned evidence of significantly reduced ranges of motion, impingement sign, inflammation and increased work restrictions, we find that claimant's compensable condition had worsened since the 1989 Determination Order, rendering him less able to work. We also find that the worsened condition was established by medical evidence supported by objective findings. See ORS 656.005(19), 656.273(1). In this regard, we are generally more persuaded by the opinion of Dr. Hayes, claimant's attending physician, because he had the best opportunity to evaluate the progression of claimant's condition since 1989. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

The employer relies on Dr. Hayes' statement that there was no material worsening of claimant's condition, (Exs. 32, 34); however, that statement is not persuasive. In his deposition, Dr. Hayes explained that he had relied on the medical, rather than legal, concept of "material worsening," i.e., a discrete condition that can be specifically addressed by surgery, injection or other similar means. (Ex. 38-31). He stated that, although claimant's increased symptoms could not be treated by surgery, they represented a worsening of his condition. (Ex. 38-32, 38-79).

The employer contends that claimant's condition was no more than a waxing and waning of symptoms contemplated by the previous permanent disability award. We disagree. At the time of the last award, there was some evidence that claimant would require palliative treatment by nonsteroidal anti-inflammatory compounds. (See Ex. 22). However, there was no evidence in existence at that time to show that claimant's functional ability would be impaired to the extent indicated by significantly reduced ranges of motion, impingement sign, inflammation and increased work restrictions.

We acknowledge that Dr. Hayes opined that claimant's condition represented a waxing and waning of symptoms contemplated with a chronic shoulder condition. (Exs. 34, 38-51). We are not persuaded by that opinion, because it does not address the question of whether the waxing and waning of claimant's symptoms was contemplated by the previous award. In order for the waxing and waning of symptoms to have been contemplated by the previous award, there must be medical evidence in existence at the time of the award predicting such flare-ups. See Lucas v. Clark, supra at 691. We do not find that evidence in existence at the time of the 1989 Determination Order. Thus, we find that claimant has sustained his burden of proving that his worsened condition was more than waxing and waning of symptoms contemplated by the previous award. We conclude that claimant has established a compensable aggravation.

Interim Compensation

The Referee awarded claimant interim compensation from May 26, 1992 until claimant returned to work on or about August 7, 1992. On review, the employer argues that claimant did not satisfy the requirements for entitlement to interim compensation. We disagree.

Claimant's entitlement to interim compensation in the form of temporary total disability benefits depends on whether the employer received notice or knowledge of a medically verified inability to work in a medical report that constitutes prima facie evidence in the form of objective findings that claimant's compensable condition had worsened. See ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993).

We agree with the Referee that by May 26, 1992, the employer had sufficient notice of claimant's medically verified inability to work due to a compensable worsening. On that date, the employer had the following documents in its possession: (1) Dr. Hayes' May 11, 1992 chart note reporting the recurrence of claimant shoulder pain, "significantly" reduced ranges of motion since May 1989, and a "fairly significant" impingement sign; (2) Dr. Streitz's May 12, 1992 letter recommending that claimant not continue his jitney driving job and reporting that, without a job modification, claimant faces the possibility of further surgery; (3) Hayes' May 20, 1992 chart note concurring with Streitz's recommendation for job modification and restricting claimant from using his arm above shoulder level or for lifting more than 20 pounds; and (4) Hayes' May 21, 1992 letter concurring with the recommendation for a job change.

Although these reports did not release claimant from work altogether, because the employer did not have another job for claimant to perform, claimant was effectively unable to work due to medically verified restrictions. Moreover, we find that these reports constitute prima facie evidence, supported by objective findings, that claimant's condition had worsened since the previous award of permanent disability and that the worsening was more than a waxing and waning of symptoms contemplated by the previous award. See Stanley Smith Security v. Pace, supra, at 609. Accordingly, the employer was statutorily required to begin the payment of interim compensation no later than the 14th day after May 26, 1992. See ORS 656.273(6).

The employer contends that claimant was not entitled to interim compensation on the basis of Dr. Hayes' July 8, 1992 concurrence that claimant's condition had not materially worsened and that Hayes had not authorized any time loss from work. (Ex. 32). We disagree. Once claimant's entitlement to interim compensation began as of May 26, 1992, the employer was obligated to continue paying compensation until termination of those benefits is authorized by statute. For example, ORS 656.262(2) authorizes termination of interim compensation upon issuance of an aggravation denial. See Stanley Smith Security v. Pace, supra, at 610 n 2. Dr. Hayes' concurrence does not satisfy any statutory authority for termination of benefits already commenced.

Because interim compensation is based on temporary total disability benefits, the employer could terminate claimant's interim compensation in accordance with ORS 656.268(3). See Stanley Smith Security v. Pace, supra, at 610. ORS 656.268(3)(a) provides that temporary total disability benefits may be terminated when the worker returns to regular work. Claimant testified that he returned to his jitney driving job on August 7, 1992, two weeks before the employer issued its aggravation denial. (Tr. 28). Therefore, we find that claimant was entitled to interim compensation until August 7, 1992.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation and interim compensation issues is $1,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 6, 1992 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
GEORGE E. GATCHET, Claimant
Own Motion No. 93-0099M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requested reconsideration of our March 16, 1993 Own Motion Order of Dismissal in which we found that claimant's claim was not within our own motion jurisdiction because he had made an aggravation claim before his aggravation rights had expired. Specifically, SAIF argued that our reliance on Thomas L. Runft, 43 Van Natta 69 (1991), and Robert E. Wolford, 45 Van Natta 435 (1993), was misplaced. On April 15, 1993, we abated and withdrew our order to allow claimant an opportunity to respond. Claimant's response has been received. After conducting our further review, we issue the following order.

On August 19, 1985, claimant's right foot was compensably injured when a piece of plywood fell on it while he was working. On December 19, 1985, SAIF accepted the claim as nondisabling. By a letter dated September 29, 1986, claimant's then-attorney, advised SAIF that "by copy of this letter to it, we are requesting of the Workers' Compensation Department that it issue a Determination Order if such would be timely." The Department apparently interpreted that request as a request to reclassify the claim as disabling. (See letter dated November 3, 1986 from the Department to SAIF).

On January 9, 1987, the Department issued a Determination Order that reclassified the claim as disabling. That order contained a statement to the parties notifying them of their right to request a hearing for a period of one year from the mailing date of the order. SAIF did not request a hearing from that Determination Order.

On January 11, 1988, claimant's claim was first closed by Determination Order which provided that claimant's five-year aggravation rights would expire on January 11, 1993. This Determination Order awarded claimant 30 percent (5.4 degrees) scheduled permanent disability for the loss of use or function of claimant's right great toe. Claimant's claim has not subsequently been reopened.

On November 2, 1992, claimant again sought treatment for his right foot condition. On December 16, 1992, Dr. Lisle, claimant's treating podiatrist, requested that claimant's claim be reopened for surgery. Contending that claimant's 5-year aggravation rights expired on August 19, 1990, SAIF has submitted the request to the Board for consideration under ORS 656.278.

The determinative issue is whether claimant's aggravation rights run from the date of injury, August 19, 1985, or from the date of the first claim closure, January 11, 1988. If claimant's aggravation rights run for five years from the date of injury, his aggravation rights expired on August 19, 1990, more than a year and a half before December 21, 1992, the date SAIF received Dr. Lisle's December 16, 1992 request for surgery. ORS 656.273(4)(b). In that case, claimant's claim would be within our own motion jurisdiction. ORS 656.278(2). However, if his aggravation rights run for five years from the date of the first claim closure, his aggravation rights expired on January 11, 1993, several weeks after receipt of the December 16, 1992 request for surgery. ORS 656.273(4)(a). In that case, the claim would not be within our own motion jurisdiction and SAIF would be required to process the claim pursuant to ORS 656.273, which would entitle claimant to claim closure pursuant to ORS 656.268 when his condition was again medically stationary.

We have own motion jurisdiction of claimant's claim only if his aggravation rights under ORS 656.273 expired prior to SAIF's notice of his request for claim reopening. ORS 656.278(2); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

We do not reach SAIF's contention that our reliance on Robert E. Wolford, supra, was misplaced as we reach the same conclusion based on different reasoning.

Given the facts of this case, we did not need to look beyond the January 9, 1987 Determination Order (which reclassified the claim as disabling) to determine when claimant's aggravation rights expired. On reconsideration, SAIF also overlooks the January 9, 1987 Determination Order and argues that the claim for an aggravation had to be made within five years from the date of injury. However,

SAIF did not appeal the January 9, 1987 Determination Order. If the Department's decision to reclassify claimant's injury as disabling was in error, SAIF's remedy was to request a hearing on the issue. Former ORS 656.268. SAIF made no hearing request.

Since SAIF chose not to contest the reclassification of claimant's injury as disabling within the appropriate time period, it may not do so now. See Donald E. Woodman, 44 Van Natta 2429 (1992); Sharon K. Ackerman, 39 Van Natta 766 (1987). In other words, the law of the case is that claimant's August 1985 injury was disabling. See Contractors, Inc. v. Tri-Met, 111 Or App 21, 25 n.3 (1992) (the court held that its earlier decision regarding the sufficiency of a notice of a claim was the law of the case, even if that decision was wrong). Therefore, even if the Department's decision to reclassify the injury as disabling was wrong, SAIF may not now attempt to go behind the unappealed Determination Order and argue that the 1985 injury was not disabling.

Because claimant's claim was reclassified as disabling and SAIF did not appeal that reclassification, we find that claimant's aggravation rights are governed by ORS 656.273(4)(a). Under that subsection, claimant's aggravation rights expire five years after the first determination order or notice of closure made under ORS 656.268. Here, the first Determination Order issued under ORS 656.268 on January 11, 1988. Therefore, claimant had until January 11, 1993 to file an aggravation claim. By letter dated December 16, 1992, Dr. Lisle requested that claimant's claim be reopened for surgery. On its Own Motion Recommendation form dated February 4, 1993, SAIF stated that claimant's request for reopening was received on December 21, 1992. Thus, we find that claimant filed an aggravation claim prior to the expiration of his aggravation rights.

Therefore, we conclude that we lack own motion jurisdiction to consider claimant's current request for claim reopening and temporary disability benefits. Accordingly, claimant's request for own motion relief is dismissed. This decision does not mean that claimant is not entitled to the requested surgery and related time loss. Instead, it means that SAIF must process claimant's request as a claim for aggravation under ORS 656.273; i.e., either accept or deny the claim and notify claimant of his rights regarding SAIF's eventual claim processing decision. Should SAIF fail to take such action, claimant may wish to consider retaining legal representation and/or file a request for hearing with the Board's Hearing Division.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK H. GLUBRECHT, Claimant
WCB Case No. 90-20161
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by the Board en banc.

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

FINDINGS OF FACT

Claimant is a quadriplegic receiving permanent total disability benefits as a result of a compensable June 1982 industrial injury. In April 1983, SAIF and claimant entered into a written agreement, in which SAIF agreed to pay claimant approximately $20,000 toward the cost of remodeling his residence to accommodate his disability. In June 1988, claimant made plans to purchase a new home and requested SAIF again to pay for accessibility remodeling costs. SAIF refused and, in September 1990, filed a petition with the Medical Review and Abuse Section (MRAS) of the Workers' Compensation Division. SAIF asked that the Director: (1) declare the requested services not to be included within the provisions of ORS 656.245; (2) declare the services noncompensable under ORS 656.327; or (3) determine the amount, if any, of reimbursement under ORS 656.248.

On October 18, 1990, MRAS acknowledged SAIF's petition and requested claimant to submit a response. On October 25, 1990, claimant responded by enclosing copies of a hearing request filed with the Hearings Division of the Workers' Compensation Board. Noting that the hearing request raised as an issue SAIF's "de facto" denial of claimant's home remodeling reimbursement claim, claimant moved for dismissal of SAIF's petition to the Director for lack of jurisdiction. On November 19, 1990, SAIF filed a motion for dismissal of claimant's hearing request, asserting that the Director had assumed jurisdiction over the matter by acknowledging the petition for relief.

On November 20, 1990, MRAS sent a letter to the Presiding Referee for the Hearings Division which concluded that the Director lacked jurisdiction to resolve the dispute pursuant to ORS 656.704 and 656.327. Consequently, MRAS stated that further action on SAIF's petition would be deferred pending the outcome of the hearing before the Hearings Division.

On December 20, 1990, Referee McCullough declined to grant SAIF's motion to dismiss claimant's hearing request. Concluding that the issue presented a "matter concerning claim" under ORS 656.704, he determined that the Hearings Division had jurisdiction to resolve the dispute and set the matter for hearing.

On December 17, 1990, SAIF responded to MRAS' "deferral" letter. It argued that the Director was without authority to defer further action on its petition and requested the Director to issue an appealable order. On February 12, 1991, MRAS responded to SAIF's request, stating that it did not intend to issue an order regarding the matter and concluded that the matter should be resolved by the Hearings Division.

On February 27, 1991, SAIF filed a request for review of the Director's decision with the Workers' Compensation Board. On August 21, 1991, we granted claimant's motion to dismiss SAIF's request, concluding that we lacked authority to consider the matter because MRAS' February 12, 1991 letter did not constitute an appealable order under ORS 656.327(1)(b). Jack H. Glubrecht, 43 Van Natta 1753 (1991).

Meanwhile, on April 11, 1991, a hearing was convened before Referee Holtan, at which time SAIF renewed its motion to dismiss claimant's hearing request. Referee Holtan granted SAIF's motion, concluding that the Hearings Division lacked jurisdiction to decide the appropriateness of the accessibility construction costs. Claimant requests review.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks review of the Referee's conclusion that the Hearings Division lacks jurisdiction to resolve the dispute over the appropriateness of claimant's reimbursement claim for home remodeling costs. We affirm.

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

> "(1)(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, self-insured employer shall so notify the parties and the director."

Claimant contends that ORS 656.327 is inapplicable here, because his claim for home remodeling costs is a claim for "medical services," as opposed to "medical treatment." Claimant explains that, while the term "medical services" has been construed to include such things as the removal of architectural barriers, Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990), the term "medical treatment" is narrower and is limited to services rendered by a practitioner of the healing arts. Thus, based on that distinction, claimant contends that the alternative dispute resolution procedure set forth in ORS 656.327 applies only to disputes regarding the appropriateness of treatment by physicians and other licensed practitioners, and not other types of medical services like those at issue here.

We rejected claimant's argument in Mark L. Hadley, 44 Van Natta 690 (1992). In that case, we held that the Hearings Division lacked original jurisdiction over a dispute as to the appropriateness of providing an injured worker with the use of a vehicle equipped with automatic transmission. We noted that ORS 656.327 expressly refers to "medical treatment," rather than "medical services." We found no statutory basis for distinguishing the two terms, however, and concluded that they had identical meanings for the purposes of applying ORS 656.327.

Home modifications to accommodate the wheelchair of an injured worker constitute compensable "medical services" within the meaning of ORS 656.245(1), or they are not "compensation" at all. Thus, the Director has original jurisdiction over this dispute because it is a dispute over the reasonableness and necessity of a medical service, or the claimant is seeking benefits that the Workers' Compensation Act does not provide. Whether or not the case concerns a "bona fide medical services dispute" (i.e., a dispute over the reasonableness and necessity of a "medical service") is also a question for the Director in the first instance. ORS 656.327(1)(b) states that "[u]nless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section." An appeal from an order finding no bona fide medical services dispute is made directly to the Board. (Id.) The problem here is that the Director has refused both to review the matter on the merits or to issue an order which finds that no bona fide medical services dispute exists. See Jack H. Glubrecht, 43 Van Natta 1753 (1991). Consequently, this matter has been pending before the Director for several years. Under these circumstances, one is tempted to assert jurisdiction, even where one does not have jurisdiction to assert. We have correctly struggled to overcome that temptation. The Director's refusal to act would appear to be a proper subject of a mandamus proceeding.

We obviously disagree with the dissent's narrow interpretation of SAIF's position. Contrary to the dissent's contention, this case does primarily involve the question of whether the remodeling costs were reasonably and necessarily incurred. If less costly alternatives to the claimed medical service are medically suitable, the expense of providing the claimed service has always been considered by the Board or the courts when determining if the service is reasonable or necessary. See, e.g., Roger v. EBI Industries, 102 Or App 457 (1990), on recon 107 Or App 22 (1991) (hot tubs not reasonable and necessary when less expensive alternatives are also available and suitable); Marianne Reith, 43 Van Natta 1071 (1991) (cost of purchasing Nordic Track was not reasonably incurred where claimant did not show unavailability of public alternatives); Debra O'Shea Matthews, 40 Van Natta 1834 (1988) (pool fees, spa membership and related transportation costs are not compensable when home exercising would fulfill the same need).

Here, SAIF is clearly contending that the $32,000 in remodeling costs were not reasonably and necessarily incurred because claimant already had a home that was remodeled to accommodate claimant's disability in accordance with the criteria announced in Stoddard v. Credit-Thrift Corp., supra, for determining the reasonableness of such costs. Whether the remodeled home claimant chose to leave was medically suitable under the Stoddard criteria is an issue for the Director to decide in the first instance.[1] The Director's refusal to review the matter or issue an order finding that there is no bona fide medical services dispute is an issue for the courts.

We conclude that ORS 656.327 provides an alternative proceeding for resolving the medical services dispute at issue here. Accordingly, we agree with the Referee that the dispute is not a "matter concerning a claim," ORS 656.704(3), subject to the original jurisdiction of the Hearings Division.

ORDER

The Referee's order dated July 9, 1991 is affirmed.

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[1] Claimant defends the remodeling costs he incurred on the ground that his prior home, which was remodeled to accommodate his disability, did not have wheelchair access to a shopping center. Having wheelchair access to a shopping center, rather than having to use public bus services (if available), would certainly be a convenience. Whether having such access is medically required would appear to be one of the issues for the Director.

Board Member Hooton concurring in part and dissenting in part.

Citing Mark L. Hadley, 44 Van Natta 690 (1992) the majority finds that the Director has sole jurisdiction to resolve claimant's dispute with SAIF Corporation arising from his request for reimbursement for the cost of remodeling his residence to accommodate his disability. In their combined briefs, the parties raise multiple issues, only some of which are subject to the jurisdiction of the Director. Because I must conclude that the Board and the Hearings Division have jurisdiction to resolve whether claimant's current need for architectural modification was caused by his compensable injury, I would find that the Board has jurisdiction over at least a portion of the present dispute. Therefore, I must respectfully dissent in part from the majority's decision.

The majority cites only a portion of the history of the present claim. Just as its decision resolves only one of the many issues raised by the parties, the history cited only partially tells the story of this claim. The full history of this claim, in combination with the majority resolution of its portion of that history, completes a circle of refusal to accept jurisdiction which effectively deprives this claimant of any forum in which to obtain a resolution of his dispute.

HISTORY OF THE CLAIM

On June 26, 1982, claimant suffered an injury to his cervical spine which left him with permanent quadriplegia. Despite the fact that the employer indicated that he had no question that the claim was compensable, the claim was initially deferred, and then ultimately accepted, by SAIF Corporation. (Ex. 1). As a consequence of the quadriplegia, claimant required architectural modification of his place of residence and, in April 1983, SAIF Corporation paid claimant $19,613 in reimbursement for necessary remodeling of his first home. (Ex. 2). In June 1988, claimant made plans to purchase a new home and requested that SAIF undertake financial responsibility for that portion of remodeling costs attributable to the removal of architectural barriers, and special living needs associated with his quadriplegia. SAIF ultimately refused to pay those costs.

Sometime prior to September 18, 1990, SAIF Corporation petitioned the Director for an order to free it of any obligation to provide remodeling reimbursement in a document entitled "Request for Order Declaring Home Remodel Request Noncompensable Under ORS 656.245 and 656.327. Fee Dispute Pursuant to ORS 656.248." (Ex. 15). In that document, SAIF Corporation argued that home remodeling services are not compensable medical services covered by ORS 656.245. They also argued that such services were in violation of the medical rules adopted by the Director because remodeling services were not provided by a physician or other medically licensed personnel, and was not conducted under the

direct control and supervision of the attending physician. SAIF further argued that the construction services, if otherwise compensable, were excessive and inappropriate, because claimant had already once received the services and the need for a second home improvement was not necessitated by a change in his medical condition. Further, SAIF Corporation argued that even if the construction services were compensable for all other reasons, each of the particular modifications was not reasonable and necessary as to either services or materials. SAIF Corporation provided no further explanation of that portion of its argument. Finally, SAIF Corporation argued that reimbursement for the services could not be made, because the request for reimbursement did not reflect the 75th percentile for medical services. (Ex. 15).

On October 18, 1990, the Medical Review and Abuse Section of the Workers' Compensation Division of the Department of Insurance and Finance, (hereinafter referred to as MRAS), responded to the request from SAIF by requesting that claimant provide any information and written testimony to support claimant's request for services. (Ex. 18).

On October 26, 1990, claimant requested a hearing before the Workers' Compensation Board for "de facto" denial of medical services under ORS 656.245. (Ex. 18A).

On November 20, 1990, the MRAS, by correspondence copied to all parties, notified the Presiding Referee of the Hearings Division that it was the opinion of MRAS that it did not have jurisdiction to resolve the dispute pursuant to ORS 656.704 and 656.327, and that the matter should be resolved by the Hearings Division. MRAS did not comment on SAIF's allegation of a fee dispute pursuant to ORS 656.248. (Ex. 19).

On December 17, 1990, SAIF acknowledged its receipt of the November 20, 1990 letter to the Presiding Referee declining jurisdiction and "deferring" the matter to the outcome of litigation before the Hearings Division. SAIF expressed its opinion that the Department's "deferral" had no basis in statute and requested an appropriate order. (Ex. 19B).

On February 12, 1991, MRAS responded to SAIF's request for an order by letter indicating that the Department had no intention to issue either a Bona Fide Dispute Order or a No Bona Fide Dispute Order in the present case. (Ex. 20).

On February 27, 1991, SAIF requested review of the Director's February 12, 1991 letter on the ground that the letter constituted an order finding no bona fide medical dispute pursuant to Forelaws on Bd. v. Energy Fac. Siting Council, 303 Or 541 (1987).

In the meantime, on November 20, 1990, SAIF filed a motion to dismiss claimant's request for hearing on the ground that the Hearings Division lacked jurisdiction to resolve the claim. An Interim Order was filed in the present claim on December 10, 1990 by Referee John McCullough, which found a distinction between medical services requested by claimant, and the medical treatment to which ORS 656.327 applied. Finding that there was no procedure available under ORS 656.327, Referee McCullough concluded that the Hearings Division had jurisdiction to resolve the dispute and denied SAIF's motion to dismiss.

A hearing was convened on April 11, 1991 and continued to a second day of testimony on April 23, 1991. The hearing was held before Referee Holtan. On July 9, 1991, Referee Holtan issued his Opinion and Order, countermanding the Interim Order issued by Referee McCullough and dismissing the request for hearing for lack of jurisdiction. It is from this order that claimant has now sought Board review.

On August 21, 1991, current Board Members Neidig and Westerband, with former Board Chair Crider dissenting, issued an order finding that the February 12, 1991 letter of MRAS did not constitute an order either as an order in a bona fide dispute case, or as an order finding no bona fide medical dispute, and dismissed SAIF's request for review. Jack H. Glubrecht, 43 Van Natta 1753 (1991). From that order SAIF petitioned for review to the Court of Appeals. However, SAIF subsequently moved for an order dismissing the petition for review, and on November 21, 1991, the motion was allowed and the petition dismissed.

On April 7, 1992, the Board entered its order in Mark L. Hadley, 44 Van Natta 690 (1992), which found that medical treatment and medical services are indistinguishable for purposes of applying ORS 656.327.[1]

With the withdrawal of SAIF's petition to the Court of Appeals, the Board's August 21, 1991 order finding that the February 12, 1991 letter of MRAS did not constitute an appealable order became final as a matter of law. Regardless of the contentions of the parties, the law of the case is that claimant remains entitled to an order from the Department. However, by correspondence on November 20, 1990, to the Presiding Referee of the Hearings Division, and by letter to SAIF on February 12, 1991, the Department has left no doubt as to its belief that the Director lacked jurisdiction to review and decide the present dispute. The majority finds that the Workers' Compensation Board also lacks the authority to resolve this dispute. Consequently, a medical dispute which arose in June 1988, and for which claimant has already borne the economic consequence at a total cost of approximately $32,000, remains undecided nearly five years later and claimant is no closer now than in October 1990 to obtaining a clear indication even of the forum to which he must appeal.

SALIENT FACTS

As could be expected from a two-day hearing, the transcript of record in the current dispute is extensive. However, neither in the Opinion and Order of Referee Holtan, nor in the Order on Review today are there any findings of fact. Although that is to be expected, and is wholly appropriate in an order dismissing a request for hearing for lack of jurisdiction, I am unable to agree in that outcome. Consequently, certain findings of fact are necessary to substantiate the legal argument which follows.

Other matters, relevant to the history and importance of the present claim, make additional specific facts, though not essential to the legal conclusion, of special interest.

SAIF provided reimbursement for removal of architectural barriers and other remodeling expenses beginning in April of 1983 in the amount of $19,613. That amount was provided pursuant to an agreement reached by the parties on April 5, 1983. By the express terms of that agreement SAIF was to have no further responsibility for future remodeling either to claimant's then-current dwelling, or to any dwelling later acquired, "except as noted below." (Ex. 2-1). Item number 3 of that agreement established a reserve from the selling price of claimant's then-current residence to be applied toward the cost of construction or remodeling, except that no reserve would be established if the sale of the claimant's then-current dwelling occurred more than five years from the date of the agreement, or if the sale of the then-current dwelling was necessitated by virtue of claimant's employment requirements with "The Church." (Ex. 2-1). In addition, the agreement contained a specific provision that "nothing in the terms of this agreement shall be construed as a waiver by claimant of his rights under the Workers' Compensation Law of the State of Oregon." (Ex. 2-2.)

The request for subsequent remodeling in June 1988 occurred more than five years after the date of the 1983 agreement.

By April 19, 1990, claimant had consummated the sale of his previously modified residence, and had purchased a new residence in the same community. Linda Meuleveld, Occupational Health Consultant, and an employee of SAIF Corporation, visited claimant's new home for the purpose of evaluating the home modifications requested by claimant. She found, and specifically reported to SAIF, as follows: "The current three bedroom home was recently purchased because of its location. It has wheelchair accessibility to a shopping mall." The bedrooms in the home are not capable of accommodating claimant's bed and a turnaround space for the wheelchair. She also found that bathrooms in the residence were unusable for someone with Mr. Glubrecht's disability. She noted that the garage, attached to the residence, would not accommodate his van.

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[1] The timing of the Board's decision in Mark L. Hadley, 44 Van Natta 690 (1992) is significant insofar as it bears on the decision of Referee Holtan. The parties presented argument on the issue of jurisdiction to Referee McCullough, who resolved that portion of the dispute by finding that the Hearings Division had jurisdiction to resolve the dispute. The principle of finality in litigation suggests that once an issue has been decided, it should remain so, except through the normal course of appeal, unless the interim decision is based on an obvious error of law. Because Hadley was not decided until after the issuance of Referee Holtan's order, efficiency and the principle of finality, rendered the Referee's dismissal on grounds already addressed by Referee McCullough totally inappropriate. Raising the matter again before Referee Holtan, after the issuance of Referee's McCullough's interim order, was also inappropriate conduct on the part of SAIF.

Included among her findings is the following specific finding:

> "[T]he greatest care savings are to be had by keeping the disabled person in his own home, with a supportive family network. Home modifications that help to support this goal are often in addition to those strictly necessary for safety. Those necessary for safety being two entry exit ramps, a bedroom and a bath that are handicapped modified, and widened doorways. In Mr. Glubrecht's (sic) case the provision of garage van access, room and bath for a future care giver, garage to utility room access, lever type doorhandles, and combined ramp/deck will give total household access to the claimant. Access and control help foster independence. Degree of independence relates directly to lowered claim costs." (Ex. 6.)

At the time of that visit, claimant had received at least one bid, and was experiencing considerable difficulty in obtaining additional bids without prepaying the cost of the estimates. To assist in the evaluation of the claim, SAIF sought and obtained a bid from Blue Ribbon Commercial and Residential Construction on June 11, 1990 (two years after the initial request for services), in the amount of $17,116.50. (Ex. 9). A copy of the assessment and bid was provided to claimant on June 15, 1990, with an indication that SAIF would discuss the bid with its legal department on June 18, 1990 and attempt to settle the dispute. (Ex. 10).

SAIF's next act on the claim, established by the present record, occurred in November 1990 when it requested that MRAS declare that home remodeling expenses were not compensable under ORS 656.245 and ORS 656.327, or to determine the appropriate amount of reimbursement pursuant to ORS 656.248.

On December 17, 1990, SAIF demanded an appealable order from the Department. It stated that "the primary reason this case was ever presented to the Department in the first place is that SAIF has hundreds of similar cases every year and absolutely no guidance as to when, how often and how much of these services are 'compensable' (if at all). The intent was to use this case as a test case to get Department guidance in the form of rules announced through a contested case proceeding before the Director that SAIF could apply to the hundreds of other cases and avoid all the litigation."[2]

In that correspondence, SAIF chastised the Director by stating that "with the Department's refusal to act SAIF is left with no option but to litigate those cases one at a time (a very expensive, administratively burdensome and unnecessary task) in order to help define by case law the compensability of these services." (Ex. 19B). A continuation of that desire for guidance was inexplicably interrupted when SAIF dismissed its petition for review to the Court of Appeals on November 21, 1991, and made final a Board's order finding that the Department's response letter was not a reviewable order pursuant to Forelaws on Bd. v. Energy Fac. Siting Council, supra.

ISSUES

Claimant presents only two issues in his request for Board review. The first is whether the Hearings Division of the Workers' Compensation Board has jurisdiction to resolve a dispute arising from SAIF's denial of home remodeling expenses. If the Hearings Division has such jurisdiction, then claimant raises as an issue whether his home remodeling expenses are compensable.

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[2] I find it very disconcerting that the "primary reason this case was ever presented to the Department in the first place" was SAIF's desire for guidance in similar cases. The argument appears to suggest that SAIF really did not dispute the need for services and did not object to paying them in this instance. Two years of negotiation with claimant seems to support that conclusion. Absent some legitimate basis for disputing the request for reimbursement, SAIF should not have selected this case to be its test case before the Director, and the belief that such a test case would assist SAIF in the future cannot alone support the denial. SAIF has journeyed very close to a finding that its denial of services is unreasonable. Oddly enough, the fact that SAIF withdrew its appeal to the Court of Appeals makes it difficult to make such a finding. If, indeed, the primary reason for requesting action from the Department was to obtain future guidance, SAIF should have pursued the appeal as vigorously as possible. By withdrawing it, SAIF has indicated by its gamesmanship that something else is going on here.

Despite the fact that claimant raises only these two issues, claimant readily acknowledges that SAIF has done more than simply deny claimant's request for reimbursement for home remodeling expenses. Claimant's opening remarks indicate that SAIF has challenged home remodeling expenses under the provisions of ORS 656.327(1)(a). However, claimant argues that SAIF's statement of the issues "quite clear[ly]...rests on grounds other than those explicitly delineated in ORS 656.327(1)(a)." Claimant notes that SAIF's primary challenge to its obligation to reimburse claimant for the cost of remodeling expenses centers on the question of whether the remodeling expenses are even medical services within the definition provided in ORS 656.245(1)(c). Claimant argues that only the Workers' Compensation Board, and its Hearings Division, has jurisdiction to resolve this purely legal dispute.

On the other hand, SAIF contends that it has not issued a denial of medical services, either explicit or "de facto," and that it is merely processing the claim in accordance with the requirements of ORS 656.327, which expressly forbids the issuance of a denial. A review of SAIF's opening Respondent's Brief indicates that SAIF's primary argument is that home remodeling expenses are not compensable medical services pursuant to ORS 656.245(1)(c). SAIF contends that only the Director has jurisdiction to resolve this question. Further, however, SAIF contends that claimant's home remodeling expenses are excessive in this instance, because SAIF had previously paid home remodeling expenses in 1983 and claimant has offered no medically necessary reason for his move to new living quarters. Indeed, at one point, SAIF contends that claimant has offered no reason for his move at all. In addition, SAIF argues that claimant's home remodeling is in violation of the medical rules which require that all medical services be provided by or under the direct supervision and control of his treating physician. Further, SAIF identifies specific services which it believes are not reasonable and necessary. These are not as inclusive as the issues originally raised before the Director, and SAIF presents specific argument to support its position. Finally, SAIF contends that if claimant's home remodeling expenses are compensable medical services under ORS 656.245(1)(c), and if the Hearings Division has jurisdiction to resolve that dispute, and even if the requested reimbursement expenses are reasonable and necessary, the amount of SAIF's liability can only be established through the procedures for resolution of a fee dispute question pursuant to ORS 656.248.

OPINION AND CONCLUSIONS

Because the parties are unable to agree on the basic question of whether SAIF has even denied a claim for medical services, the first issue presented for resolution by the parties is whether there has, in fact, been a denial of medical services, and who has jurisdiction to hear and resolve that dispute.

Denial of Medical Services

ORS 656.262(6) requires the insurer or self-insured employer to issue a written notice of acceptance or denial within 90 days of its receipt of a claim for reimbursement, or request for authorization for services. ORS 656.327(1)(c) prohibits the insurer or self-insured employer from issuing a denial when medical services are challenged on the basis that they are excessive, inappropriate or otherwise in violation of the medical rules. There is no evidence in the statute or legislative history that would suggest that the legislature intended the provision of ORS 656.327(1)(c) to overcome the time limits and processing requirements of ORS 656.262. Consequently, when reading these statutes together, I conclude that the insurer is required to do one or more of three things within 90 days of receipt of a request for reimbursement for home remodeling expenses.

First, if it believes the services to be compensably related to the compensable condition, reasonable and necessary, and within the definition of medical services provided at ORS 656.245(1)(c), the insurer must, within 90 days, pay the medical service fees which are undisputed. Second, if it believes that the requested reimbursement expenses are not related to the compensable condition or are not within the medical services contemplated by ORS 656.245(1)(c), the insurer must, within 90 days, issue a written denial of medical services explicitly stating its reasons for denying the claim. Finally, if it believes that the requested services are not reasonable and necessary, excessive, inappropriate or otherwise in violation of the medical rules, the insurer must seek the jurisdiction of the Director pursuant to ORS 656.327(1), also within 90 days. In a case such as the present claim where there are multiple bases for the denial, the insurer or self-insured employer is required to take each of the appropriate steps within the 90-day period. Failure to do so constitutes a "de facto" denial of medical services. Barr v. EBI Companies, 88 Or App 132 (1987); Kurt Kraal, 42 Van Natta 2634 (1990).

Where the insurer or self-insured employer fails to follow the processing requirements of ORS 656.262(6) to issue a written notice of denial, the claimant is denied any guidance as to the evidence which he should obtain and present at the time of hearing. In such circumstances, the claimant must presume that the insurer or self-insured employer's denial extends to every conceivable component of compensability. Consequently, to overturn a "de facto" denial, the claimant must demonstrate that the claim is compensable as to every element or potential issue of compensability.

However, it would be inappropriate to conclude that the insurer may not clarify the basis for its denial at or before the time of hearing. Such a conclusion would require the claimant to present evidence on every conceivable issue, even though only one may remain in dispute.

In the present claim, SAIF failed to take any action on claimant's request for preauthorization or reimbursement for home remodeling expenses for a period of two years. No denial issued, no authorization or moneys were provided, and SAIF did not direct its concern to the Medical Director pursuant to ORS 656.327(1) and ORS 656.248, until just prior to September 18, 1990. Consequently, I conclude that SAIF did "de facto" deny claimant's request for home remodeling reimbursement and that claimant was entitled to request a hearing before the Hearings Division to establish the compensability of those services.

Once SAIF had presented its claim to the Director, it did not automatically deprive the Hearings Division of jurisdiction, but can be deemed to have clarified the basis of its dispute with the claimant regarding the services in question. If the referee concludes that the clarification of the basis for the insurer's denial appropriately identifies only issues subject to the Director's jurisdiction, claimant is entitled to a finding that the claim is related to his compensable and accepted condition. However, if the basis for the denial of medical services provided in the request for Director's review indicates that the relatedness of the medical service to the accepted condition remains at issue, then the subsequent request for Director review does not deprive the Hearings Division of jurisdiction to resolve the dispute, but, based upon the "clarification" specifying that relatedness remains at issue, the referee must proceed with a hearing to establish the relatedness of the medical services to the compensable condition. Michael A. Jaquay, 44 Van Natta 173 (1992).

Basis for SAIF's Denial in the Present Claim

As a matter of law, SAIF contends that home remodeling services are not medical services within the definition of ORS 656.245(1)(c). SAIF argues that only the Director has authority to determine what services are properly within the definition provided. In support of its contention, it cites Pamela J. Panek, 44 Van Natta 1625 (1992) and James F. Schissler, 44 Van Natta 1639 (1992). SAIF's reliance on these cases is misplaced. In each of these cases, the insurer did not contest the relatedness of requested medical services to the accepted condition. Consequently, neither case discusses the question of whether the Board, or the Hearings Division, has jurisdiction to resolve whether specific services constitute medical services pursuant to ORS 656.245(1)(c) when that question is presented in conjunction with a causal relationship question in which the Board retains jurisdiction.

Both the Board and the Director are given jurisdiction to decide specific questions arising under ORS 656.245.[3] In resolving those disputes properly within each forum's specific jurisdiction, both the Board and the Director necessarily retain the capacity to explore and establish the proper meaning of the statute.

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[3] The majority position expressed in Pamela J. Panek, 44 Van Natta 1625 (1992), and James F. Schissler, 44 Van Natta 1639 (1992), tends to indicate that where the only issue in dispute is whether requested medical services are within the medical services contemplated by ORS 656.245(1)(c), the Director is vested with sole jurisdiction. While that issue was not presented in the cases cited and is not presented in the present claim, I am unable to accept that result. Both the Director and the Board have jurisdiction to resolve this issue in conjunction with issues properly before the respective forum. Where it is the only issue, neither the statute nor the legislative history provides any indication that the question falls exclusively within ORS 656.327(1). In the absence of a clear pronouncement of legislative intent that the Board lacks such jurisdiction, I would disavow the majority conclusion in Panek and Schissler on the basis that the Board has jurisdiction over all matters concerning a claim. The Board lacks jurisdiction if, and only if, there is a clear indication in the statute that jurisdiction lies elsewhere.

Claimant contends that explication of the statute is solely within the jurisdiction of the Hearings Division. Claimant is likewise wrong. Such a scheme of dispute resolution would only extend the current confusion and require that the Director defer every medical services claim properly before him in which the precise meaning and application of ORS 656.245 was at issue, even though he may be vested with sole jurisdiction to resolve the balance of the dispute. I would point out that the Director is responsible for the adoption of medical rules to provide for the prompt provision of compensable medical services. In doing so, the Director must have authority to consider the language of the statute and to determine its meaning.

I also note, however, that the Director is limited in his ability to restrict the availability of medical services by the express language of the statute and by the case law which has already determined that specific forms of services are included within the scope of ORS 656.245(1)(c). The Director does not have the authority to ignore the prior statements of the legislature or the courts. Were the Director to reach such a conclusion, that decision would be subject to review by the Board pursuant to ORS 656.327(2) and would be reversed for errors of law.

SAIF further relies upon the case of Lamarr H. Barber, 44 Van Natta 2098 (1992), for its conclusion that the Board lacks jurisdiction over all requests for architectural modifications related to the accepted condition. That reliance is also misplaced. In Barber, the causal relationship between claimant's injury and the requested modification was not at issue, however, the reasonableness and necessity of the modifications were specifically contested. Whether medical services are reasonable and necessary for the accepted condition is a question solely within the Director's jurisdiction pursuant to ORS 656.327(1). That is the basis upon which Barber was decided, and SAIF errs in extending the reasoning of the case beyond that expressly noted by the Board.

Next, SAIF argues that it has stated a claim solely within the Director's jurisdiction when it argues that the requested home remodeling expenses be found excessive. The basis for its contention, however, is that it had previously provided reimbursement for home modification expenses and claimant fails to provide a medically necessary reason for his change in living quarters. SAIF misunderstands the nature of the dispute. Claimant has not presented a claim for reimbursement of moving expenses to new living quarters. If he had, he would be required to demonstrate that the expenses were reasonably related to the claim and were reasonable and necessary expenses for his compensable condition. Only then would the medical cause of claimant's move be subject to challenge.

The real question in the present dispute is whether the requested reimbursement for home remodeling expense is compensably related to accepted conditions from the 1982 compensable injury. What SAIF actually challenges is whether it is required to provide requested home remodeling expense reimbursement more than once, and, if so, under what circumstances. Having relieved itself of that obligation by providing reimbursement in the past, SAIF argues that it is not now required to provide additional services unless claimant's change of residence was made necessary for a medically appropriate reason. In other words, SAIF is arguing that claimant's current need for remodeling services was not caused by the accepted condition, but by claimant's whim.

In its Respondent's Brief, SAIF states that "the Workers' Compensation Act does not restrict claimant's ability and rights to move freely. It does, however, limit the insurer's liability to reimburse medical expenses to only those which are required. Claimant would argue that these medical services are required because claimant moved. Claimant would have the Board ignore the circumstances of the move entirely and simply focus on the housing situation at the end." (Resp. Br. 12, emphasis in the original). This argument indicates that at least one basis of SAIF's denial is its contention that the requested medical expenses do not derive from claimant's accepted condition, but from claimant's voluntary act in selling a previously modified home and moving to a residence that was not so modified.

Claimant contends that he is entitled to reimbursement without regard for the cause of his move. SAIF argues that the need for remodeling was caused solely by claimant's voluntary act of selling a previously modified home and moving into an unmodified dwelling.

In other words, SAIF contends that its obligation to provide medical services for the life of the worker consistent with ORS 656.245(1) ends because claimant's decision to move is an independent, intervening event, unless claimant can demonstrate a medically necessary basis for the move related to

the compensable condition. This position is contrary to the agreement SAIF made with this claimant in 1983, and with SAIF's concession that "the Workers' Compensation Act does not restrict claimant's ability and rights to move freely." Nevertheless, the reliance on the cause of the move as an intervening event demonstrates that causation is, in fact, the real issue presented for decision. Consequently, the causal relationship is directly before us, and the Board has jurisdiction to resolve that issue. Michael A. Jaquay, supra.

Covered Medical Services

SAIF contends that the removal of architectural barriers to accommodate claimant's compensable paralysis is not a covered medical service pursuant to ORS 656.245(1)(c). Because the Board has jurisdiction to resolve disputes regarding the relatedness of compensable medical services to the industrial injury, and since a determination on that issue is necessarily limited to services within the scope of ORS 656.245(1)(c), the Board must first consider whether home remodeling services for the purposes of removing architectural barriers to the compensable condition is a covered medical service pursuant to the statute. SAIF argues that it is not, and that Stoddard v. Credit Thrift, Inc., 103 Or App 283 (1990), does not so hold. SAIF is wrong.

SAIF is correct in asserting that the Court of Appeals in Stoddard failed to finally resolve the case. The case was remanded to the Workers' Compensation Board to consider whether specific architectural modifications were reasonable and necessary for the nature of claimant's injury. However, the court argued that if the Board found that the removal of architectural barriers was reasonable and necessary for the compensable injury, then the removal of those barriers would be compensable pursuant to ORS 656.245(1)(c). Implicit in that holding, is that remodeling for the removal of architectural barriers for claimant's suffering from compensable paralysis is a covered medical service pursuant to ORS 656.245(1)(c).

On remand, the Board found that the requested reimbursement for the removal of architectural barriers and home remodeling services were reasonable and necessary for the nature of claimant's condition, and ordered the payment of such services as covered services pursuant to ORS 656.245(1)(c). Frank L. Stoddard, 43 Van Natta 4 (1991). The Board's resolution of that case controls the resolution of the identical question in the present claim. SAIF's argument to the contrary is without merit.

Causal Relationship

SAIF argues that the Board lacks jurisdiction to consider the relationship of the requested reimbursement for architectural modifications to claimant's compensable quadriplegia. It argues that to establish that relationship, claimant must demonstrate that the move to new living quarters was "necessary" for medically acceptable reasons, and, thus, must show the move itself to have been "reasonable and necessary" and, therefore, solely within the Director's jurisdiction. However, claimant has not requested reimbursement for moving expenses. Therefore, the reasonableness and necessity of the move itself is not before us, and cannot be before the Director.

The attempt to redefine the issue as a question of reasonableness and necessity is a transparent attempt to deprive the Board of that jurisdiction which it does retain over the compensability of medical services. It is not enough to argue that a medical service is not related because it is not reasonable and necessary in order to accomplish that result.

The claimant's need for architectural modification is compensable if the accepted quadriplegia is a material contributing factor in the need for services. The Occupation Health Consultant assigned by SAIF to review the requested reimbursement found that claimant had moved to his new residence because it provided wheelchair access to a nearby shopping center. Given the severity of claimant's injuries and the limited independence that he enjoys, I am unable to conclude that this move represents the kind of vindictive or unreasonable conduct that SAIF alleges will result if they are required to provide architectural modification to more than one residence in the course of claimant's life. I can find no evidence that claimant moved on a whim, without regard for the cost to SAIF. The requested modifications are related to claimant's compensable quadriplegia on a more probable than not basis and that quadriplegia is a material contributing factor in the need for services.

The agreement entered by SAIF in April of 1983 gives tacit, if not express, agreement to claimant's right to move for any reason after a period of five years. While it is not at all certain that claimant must wait that period of time before moving from a modified dwelling, SAIF acknowledged claimant's right to move without economic consequence after that period in this claim. That agreement also permitted claimant to retain all rights pursuant to ORS 656.245, which I can only interpret to mean that claimant retains the right to architectural modification if the compensable quadriplegia is a material factor in the need for services. SAIF's express agreement not to require claimant to reimburse or otherwise economically protect SAIF after five years appears to be an express waiver of the argument made here that claimant's move itself must be required by the compensable condition.

Because I would find that the compensable quadriplegia is, at least, a material factor in claimant's decision to obtain new living quarters, and is undoubtedly the sole factor causing the need for architectural modification, I must conclude that claimant has established that his compensable quadriplegia is a material contributing factor in the need for services.

Reasonableness and Necessity

In its initial request for Director review pursuant to ORS 656.327, SAIF presented a blanket challenge to the reasonableness and necessity of the requested modifications. That challenge was presented without explanation or clarification. In its Respondent's Brief, SAIF clarifies that contention to include a challenge to the reasonableness and necessity of only a few of the many modifications requested by claimant. I would find that SAIF is, therefore, required to provide reimbursement for all services not included in that clarification promptly upon issuance of this order. For those services for which the reasonableness and necessity of services are genuinely at issue, we lack the authority to resolve the dispute and refer the parties to the Director.

Fee Dispute Pursuant to ORS 656.248

In alleging a cause of action before the Director under ORS 656.248, SAIF has demonstrated that it has failed to read the statute upon which the allegation is purportedly based. ORS 656.248(13) provides a procedure for medical service fee disputes which occur between the insurer or self-insured employer and a medical service provider. The claimant is not a party in such litigation. No fee dispute resolution is available on a request for reimbursement in which the insurer disputes its obligations to claimant. This is consistent with the Director's rule which provides that claimant is not obligated to pay medical service fees disapproved by the Director. By the express terms of the statute, SAIF has no cause of action pursuant to ORS 656.248.

* * *

On the basis of the above analysis, I would find that the claimant's request for reimbursement for architectural modifications was "de facto" denied by SAIF. I would further find that SAIF denied the relatedness of the request for reimbursement to claimant's compensable quadriplegia. I would also find, based on the analysis provided by Linda Meuleveld, SAIF's Occupation Health Consultant, that each and every element of the requested reimbursement is reasonably related to the compensable condition. Because SAIF challenges the reasonableness and necessity of only a few of the many modifications requested by claimant, and since no fee dispute procedure exists in ORS 656.248 to resolve a dispute between SAIF and claimant, I would order SAIF to promptly reimburse claimant for the costs of all modifications for which reasonableness and necessity are not challenged, together with interest accrued pursuant to notice by claimant and administrative rule. Finally, I would allow an assessed fee for those medical services not subject to Director review on this record in the amount of $4,000, for services at hearing and on review, and order a penalty equal to 25 percent of the compensation made payable by this award for SAIF's unreasonable delay in properly processing this medical services claim.

Board Member Kinsley concurring in part and dissenting in part.

I agree with the majority that a portion of the issues presented should be resolved by the Director. However, I also find that there are issues presented which are within the Board's jurisdiction and which we should decide.

This case is another unfortunate example of the confusion that the parties and the forums have regarding which forum, the Board or the Director, has jurisdiction to settle the parties' disputes as to medical benefits. This confusion stems from the 1990 amendments to ORS 656.245, 656.327 and 656.704(3) which transferred a portion of the Board's jurisdiction to the Director. As a result of the amendments, the Director, rather than the Board, was granted the authority to resolve disputes "regarding medical treatment" when a dispute resolution procedure before the Director is provided in Chapter 656 of the Oregon Revised Statutes.

It appears that the 1990 Legislature provided the dispute resolution procedures before the Director because they wanted the Director to issue orders in which a doctor (or doctors) directly decides medical treatment questions without a hearing, rather than allowing the parties to introduce medical evidence from doctors at a Board hearing before an attorney-referee who would decide the case. Hearings of the Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A (Ed Redman, witness: "[D]ecisions then would be made by, again, physicians rather than referees according to the appropriateness of that treatment").[1]

However, only a portion of the dispute in this case involves medical treatment questions that are within a doctor's expertise. Those questions are:

> (1) whether living in a flatter area and closer to a wheelchair accessible shopping area is medically required and medically appropriate for claimant; and
>
> (2) whether having wheelchair access to every room of his house is medically required and medically appropriate.

The remainder of this case involves legal questions of:

> (3) whether home remodeling for wheelchair access is a compensable medical benefit available to a claimant pursuant to ORS 656.245; and
>
> (4) assuming it is an available benefit, if there is no medical reason that a claimant in a wheelchair must move to a new residence, does Chapter 656 require an insurer to again pay for home remodeling for wheelchair access at the new residence?

The first two questions are medical treatment issues that are within the Department's jurisdiction for initial resolution. The last two questions are legal issues, that is, "matters concerning a claim," and are within the jurisdiction of the Board for resolution. If the Board would exercise its jurisdiction on the legal questions, we could help move this case toward resolution. By sifting out the legal issues and leaving only clearly defined medical treatment issues, we would also be assisting the Director in reaching and resolving the medical treatment questions raised pursuant to ORS 656.327.

Although the majority does not decide questions (3) and (4), it appears that they may have pointed to the answers by citation to Stoddard v. Credit-Thrift Corp, 103 Or App 283 (1990). However, we are prevented from providing the parties with an answer to question (3) because the majority sees it as a medical treatment issue over which the Director has sole jurisdiction. I agree with Member Hooton's point that there is no statute which divests the Board of its jurisdiction on this matter and which allows only the Director to answer the question of whether a particular service is available to a claimant pursuant to ORS 656.245. To the extent that dicta in Pamela J. Panek, 44 Van Natta 1625, 1626 (1992) and James F. Schissler, 44 Van Natta 1639, 1640 (1992) suggest otherwise, those cases should be disavowed.

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[1] The official legislative history on this point is sparse. Witnesses that testified before the 1990 Legislature apparently conducted much of the policy debate in secret meetings at Mahonia Hall in Salem. As a result, there is no transcript available from those meetings to research the intent of the statutory amendments.

The majority also construes the issue presented in question (4) as a medical treatment issue. The cases cited in support of that determination, Rogers, Reith and O'Shea Matthews, were all decided by the law in effect prior to the 1990 amendments. The prior law allowed the Board to decide both medical and legal issues in medical treatment cases. However, now those questions may not be decided all at one time in one forum because the medical treatment questions must go to the Director. I agree that legal questions have been involved in the cited cases in the past and will, undoubtedly, continue to appear in medical benefit cases. However, due to the change in the law, a case must be carefully analyzed so that the proper forum, either the Board or the Director, addresses the appropriate issues.

The answers to questions (3) and (4) were not included in the medical school curriculum on appropriateness of medical treatment. Those are legal questions that should be addressed in a hearing at the Board. However, the majority's holding that the case be dismissed prevents us from providing the parties with an answer to either question.

The present state of this case is that this dispute has been in litigation since 1990 and both of the forums available to deal with it, the Board and the Director, have refused to do so. Yet, some legislative history indicates that the purpose of the 1990 amendments was to reduce lengthy and costly litigation. This case does not support that premise. Rather, in my view, this case supports the premise that the medical and legal issues in medical benefit cases are often closely intertwined and that delay and cost to the parties is increased due to the bifurcation of issues between the Board and the Director.

In the Matter of the Compensation of
JEAN M. GRAHAM, Claimant
WCB Case No. 92-08352
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Myers' order that affirmed an Order on Reconsideration awarding her no scheduled permanent disability for a left arm condition. On review, the issue is extent of scheduled permanent disability.

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

On review, claimant contends that based on her uncontradicted testimony, she is entitled to an award of permanent disability for her chronic condition. We disagree.

A chronic condition limiting repetitive use of a scheduled body part is entitled to a value of 5 percent. Former OAR 436-35-010(6). However, claimant must establish a causal relationship between her chronic condition and the compensable injury. ORS 656.214(2). That is, she must show that disability resulting from her chronic condition is "due to" the compensable injury. Former OAR 436-35-010(2). We find that claimant has not established the requisite causal relationship.

Dr. Terhune, claimant's treating physician, released her to return to regular work without restrictions. Moreover, he concluded that claimant's symptoms have returned to their pre-injury level. We interpret Dr. Terhune's comments to mean that he does not believe that claimant's continuing symptoms are "due to" her myofibrositis. In light of this medical evidence, claimant's testimony is not sufficient to establish entitlement to an impairment value for her chronic condition. See William K. Nesvold, 43 Van Natta 2767 (1991). Therefore, claimant has failed to establish entitlement to an award of permanent disability.

ORDER

The Referee's order dated September 16, 1992 is affirmed.

In the Matter of the Compensation of
JOSEPH M. PIERCE, Claimant
WCB Case Nos. 92-06898 & 92-10081
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of that portion of Referee Bethlahmy's order that upheld the self-insured employer's denial of his claim for his right shoulder injury. The employer cross-requests review of that portion of the Referee's order that awarded claimant an assessed attorney fee for his counsel's services in setting aside a "de facto" denial of claimant's psychological condition 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

Compensability

We adopt the Referee's Conclusions of Law and Opinion on the compensability issue.

Attorney fees

On review, the employer contends that the Referee should not have awarded an attorney fee for claimant's counsel's services. The employer notes that the Referee found that there was no compensation due claimant as all medical bills had been paid at the time of hearing. The employer cites SAIF v. Condon, 119 Or App 194 (1993), for the proposition that no attorney fee should be awarded in this case.

We do not find SAIF v. Condon, supra, to be applicable in the present case. In Condon, the issue involved an unreasonable resistance to the payment of compensation, and entitlement to an attorney fee pursuant to ORS 656.382(1). Here, however, the Referee's attorney fee award was based upon claimant's counsel's efforts in setting aside the "de facto" denial of a psychological condition.

We agree with the Referee that an attorney fee was proper. A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Here, the Referee found, and we agree, that claimant filed a psychological condition claim with the employer on January 2, 1992. The employer failed to accept or deny the claim within 90 days. Although the employer paid claimant's medical services for his psychological treatment, and contended that it had always treated the psychological component as part of the accepted claim, the mere payment of such bills does not constitute acceptance of a claim or an admission of liability. ORS 656.262(9); Euzella Smith, 44 Van Natta 778 (1992). Moreover, a conclusion that the psychological condition was compensable entitled claimant to compensation beyond the payment of medical bills. ORS 656.005(8); Eurella Smith, supra.

Accordingly, because claimant's counsel filed a hearing request on the "de facto" denial and proceeded to a hearing as a result of which the Referee overturned the "de facto" denial, we conclude that claimant's counsel was entitled to an attorney fee pursuant to ORS 656.386(1). Furthermore, after considering the factors set forth in OAR 438-15-010(4), we conclude that the amount of the assessed fee awarded by the Referee is appropriate.

Inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for his successful defense of the attorney fee 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 September 10, 1992 is affirmed.

In the Matter of the Compensation of
PATRICK J. VALENZUELA, Claimant
WCB Case No. 91-08905
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Eileen G. Simpson, Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The self-insured employer requests review of Referee Black's order that: (1) declined to admit impeachment evidence; and (2) set aside its denial of claimant's claim for a low back condition. On review, the issues are the evidentiary ruling and compensability.

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

The employer objects to the Referee's evidentiary ruling declining to admit impeachment evidence. That evidence consisted of a letter that the employer sent to claimant on the date of claimant's injury. Inasmuch as the letter was not included in the record as an offer of proof, we are not certain of its content. Nevertheless, the parties stipulated that the letter indicates that the employer had investigated charges of sexual harassment that had been filed against claimant, and that it intended to suspend claimant from work for 30 days, demote him and decrease his rate of pay. (Tr 87).

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." That statute gives the Referee broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Moreover, OAR 438-07-017 provides that evidence "reasonably believed relevant and material only for purposes of impeachment of a witness * * * may be offered and admitted solely for impeachment." (Emphasis supplied.) Because the language of that rule is permissive, the Referee has discretion to decide whether to admit impeachment evidence offered under that rule. See e.g., Dean L. Watkins, 43 Van Natta 527, 529 (1991). Consequently, we review for an abuse of discretion.

The employer contends that, because the excluded letter details the seriousness of the allegations against claimant and "was delivered to [claimant] at the critical time," it shows claimant's motive to fabricate an injury to retaliate against the employer. (App. Br. 4).

Generally, without an offer of proof, we cannot determine the harm, if any, resulting from the exclusion of proffered evidence. Nevertheless, we note that claimant filed his claim on April 17, 1991, listing the date of injury of April 15, 1991. (Ex 1). Nothing in the record proves that claimant received the proffered letter before he filed his claim. Claimant did not terminate his employment until more than a month later following the outcome of disciplinary proceedings. Consequently, it is difficult to conceive how that letter could have induced the alleged retaliation of a staged injury. In short, we fail to see how that letter proves what the employer claims that it does.

In addition, the record contains a stipulation that outlines the nature and seriousness of the disciplinary action that was pending against claimant when he filed his claim. According to the employer, the excluded letter would confirm that information, plus provide details of the event that resulted in the disciplinary action. We conclude that, in this case, to the extent that proof of pending disciplinary action impeaches claimant, it is the fact that disciplinary action is pending, not the events which lead to that action, that is probative. The parties' stipulation provided that evidence. Consequently, the proffered evidence is cumulative, and the Referee did not abuse his discretion in denying the employer's request to admit it. See Dean L. Watkins, supra.

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 $750, 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 October 22, 1992 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
NANCY L. COOK, Claimant
WCB Case No. 92-04610
ORDER ON RECONSIDERATION (REMANDING)
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration and abatement of our May 28, 1993 Order on Review that remanded the case to the Referee for further proceedings. Specifically, the employer objects to that portion of our order stating that "the Referee shall allow claimant the opportunity of rebuttal." The employer asserts that, because the employer has the burden of proof in this case under ORS 656.262(6), "it is the employer who should have the opportunity of rebuttal, not Claimant."

Under OAR 438-07-025, the "party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on that issue." Although our order only intended to emphasize claimant's right, inherent in OAR 438-07-025, to rebut the employer's case-in-chief, for the sake of clarity, we modify our order in the following manner:

> "Therefore, we remand this case to the Referee for the admission of additional evidence required to complete the record. In addition, the Referee shall allow claimant the opportunity of rebuttal. However, the employer, since it bears the burden of proof, has the right of last presentation of evidence and argument with regard to the "back-up" denial. OAR 438-07-025. Furthermore, each party may only present documentary and testimonial evidence which it was prepared to offer at the June 24, 1992 hearing. See Mario Miranda, 42 Van Natta 405 (1990)."

Therefore, we withdraw our prior order. On reconsideration, as modified herein, we adhere to and republish our May 28, 1993 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
MICHAEL J. DRAKE, Claimant
WCB Case No. 92-02355
ORDER ON REVIEW
Rose, Senders, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Hazelett's order that dismissed claimant's hearing request concerning temporary disability. On review, the issue is jurisdiction and, if jurisdiction exists, claimant's entitlement to procedural temporary disability. We reinstate claimant's request for hearing and conclude that claimant is not entitled to procedural temporary disability for the disputed period.

FINDINGS OF FACT

The insurer accepted claimant's right groin strain injury claim. (Ex. 3). Claimant was treated by Dr. Tilson from February 8, 1991 through May 16, 1991. On June 24, 1991, claimant began treating with Dr. Mandiberg. (Ex. 14).

In December 1991, a stipulation was approved in which the parties agreed that claimant would receive temporary disability through May 31, 1991. (Ex. 36).

On February 17, 1992, claimant requested a hearing challenging the insurer's alleged failure to pay temporary disability from June 1, 1991 to November 2, 1991, and seeking penalties and attorney fees based on that failure.

On April 15, 1992, a Notice of Closure issued that established a medically stationary date of March 25, 1992, and specified the periods for which claimant was entitled to temporary disability. Among other awards, that notice granted claimant temporary disability for the period of September 11, 1991 through March 25, 1992. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

At the August 4, 1992 hearing, claimant asserted that the insurer had not paid temporary disability from June 1, 1991 through November 2, 1991 and that he was procedurally entitled to such benefits. The Referee found that he lacked jurisdiction to consider claimant's request for hearing, because the April 15, 1992 Notice of Closure had not yet been through the reconsideration process. See ORS 656.268.

Because the Notice of Closure addresses claimant's substantive entitlement to temporary disability, claimant concedes that the Referee did not have jurisdiction to address whether he was entitled to greater temporary disability under the Notice of Closure. However, claimant contends that, because his request for hearing was based on his procedural entitlement to temporary disability benefits, the Hearings Division retained jurisdiction over his Request for Hearing. We agree.

Subsequent to the Referee's order, we held that the Hearings Division has original jurisdiction over disputes concerning an injured worker's procedural entitlement to temporary disability, because that issue is ripe prior to claim closure. Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992). Claimant's hearing request satisfies the Yoakum criteria. First, the hearing request was filed before the claim was closed. Second, the request raised issues regarding the insurer's "pre-closure" conduct. Third, claimant does not seek to obtain a greater temporary disability award than that granted by the Notice of Closure.

Under such circumstances, we conclude that the Hearings Division retained jurisdiction over claimant's hearing request, limited to claimant's procedural entitlement to temporary disability. Consequently, we reinstate claimant's hearing request. Because we find the record sufficiently developed with regard to the issue of procedural entitlement to temporary disability, we proceed with our review.

Pursuant to the December 1991 stipulation, the parties agreed that claimant was entitled to temporary disability through May 31, 1991. Because claimant argues that he is entitled to procedural temporary disability after June 1, 1991, we find him to assert that the insurer was required to resume payment of such benefits after May 31, 1991.

Since the claim was in open status at the time, claimant would not be required to prove a subsequent "worsening" to trigger the resumption of temporary disability. Rodgers v. Weyerheuser Company, 88 Or App 458 (1987). Nevertheless, he must establish that his condition was no longer medically stationary. Id. at page 461. In other words, he must prove that a material improvement in his condition could be expected from medical treatment or the passage of time. Id.

This analysis for the resumption of temporary disability is essentially the same as when evaluating substantive entitlement to such benefits following claim closure; i.e., what period was claimant disabled from work due to his compensable injury before becoming and retaining a medically stationary status. See ORS 656.210; 656.268(4)(b), (5); Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Moreover, since this current litigation involves the same parties, our resolution of the issue would undoubtedly have some preclusive effect.

In light of such circumstances, we conclude that, when the claim has been subsequently closed following a request for hearing regarding a procedural temporary disability issue, the appropriate method for resolution of an issue regarding the resumption of temporary disability is by means of

review of the closure notice/order.[1] In this way, all objections to a notice of closure or determination order are directed through the reconsideration process in accordance with ORS 656.268(5)-(7). See Lorna D. Hilderbrand, 43 Van Natta 2721, 2722 (1991).

Here, since a notice of closure has issued addressing claimant's entitlement to temporary disability and his medically stationary date, we conclude that the appropriate route of appeal for contesting any issues regarding the resumption of claimant's temporary disability rests with the Director's reconsideration proceeding and any subsequent appeals therefrom. Lorna D. Hilderbrand, supra. Consequently, we decline to award claimant additional temporary disability.

ORDER

The Referee's order dated August 4, 1992 is reversed. We reinstate claimant's request for hearing. Claimant's request for additional temporary disability is denied.

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[1] This holding is limited to "procedural" temporary disability disputes where the claim has been closed following the hearing request and the issue involves whether temporary disability should be resumed. Where the "procedural" temporary disability issue concerns an alleged unilateral termination of benefits under ORS 656.268(3), such disputes will be addressed and resolved irrespective of the issuance of a subsequent closure order/notice. Galvin C. Yoakum, supra. Unlike the analysis for the resumption of pre-closure temporary disability, the analysis for unilateral termination of temporary disability under ORS 656.268(3), is not essentially the same as when evaluating substantive entitlement to such benefits following claim closure.

In the Matter of the Compensation of
CURTIS H. ENDICOTT, Claimant
WCB Case Nos. 91-10710 & 92-05200
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Brian L. Pocock, Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Garaventa's order that upheld the denial by Jeld-Wen, Inc. of claimant's aggravation claim for a herniated C6-7 disc condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Jeld-Wen accepted claimant's claim for severe neck and right shoulder pain on November 8, 1989.

Jeld-Wen's acceptance of claimant's claim for symptoms included acceptance of the preexisting disease underlying the symptoms.

Claimant's accepted cervical degenerative condition is the major contributing cause of his current herniated disc condition.

After the August 24, 1990 Determination Order closed the claim, claimant's accepted cervical condition worsened diminishing claimant's earning capacity. The worsening is established by medical evidence supported by objective findings and is greater than a waxing and waning of symptoms contemplated by the Determination Order award of 1 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim fails because he did not establish that his work activities were the major contributing cause of his need for treatment for a herniated C6-7 disc. In reaching this result, the Referee analyzed the claim under ORS 656.005(7)(a)(B), because claimant's cervical degenerative condition preexisted the claim for arm and neck pain which Jeld-Wen accepted.

Claimant argues, inter alia, that ORS 656.005(7)(a)(B) does not apply because his previously accepted condition worsened. Thus, claimant contends that the current claim is for an aggravation under ORS 656.273 and he need only prove a material causal relationship between his recent herniated disc condition and the accepted claim for neck and arm pain. We agree that ORS 656.005(7)(a)(B) does not apply. However, we conclude that claimant must prove that his current condition is caused, in major part, by his accepted condition, under ORS 656.005(7)(a)(A).

Claimant's claim for "severe neck and [right] shoulder pain" was accepted in 1989. (Ex. 3). Thereafter, claimant's pain was attributed to preexisting degenerative disease at C5-7. (See Exs. 7, 8, 10, 12). The medical evidence related claimant's symptoms, but not his preexisting condition, to his work activities for Jeld-Wen's insured. (Ex. 12). Nonetheless, when Jeld-Wen accepted claimant's claim for pain, it also accepted the disease underlying the claimed symptoms. See Rouse v. FMC Corp. Marine-Rail, 118 Or App 25 (1993); Georgia Pacific v. Piwowar, 305 Or 494 (1988) (acceptance of the compensability of specific symptoms includes acceptance of the compensability of the disease causing the symptoms). Accordingly, claimant's degenerative condition at C5-7 is part of his accepted claim.

To prove entitlement to benefits under an aggravation claim, claimant must prove causation and worsening. Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). We first address causation. The issue is whether the relationship between the current herniated disc condition and the accepted degenerative disc condition is sufficient to establish compensability.

As we have stated, the accepted condition includes claimant's preexisting cervical degenerative disease. Under these circumstances, claimant has no preexisting condition within the meaning of ORS 656.005(7)(a)(B). See Richard R. Zippi, 44 Van Natta 1278 (1992); see also Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993).

The persuasive medical evidence in this case indicates that claimant's disc herniation resulted from a "natural progression" of the cervical degenerative condition. (See Exs. 56-6, 62-15). It is clear that claimant did not have a herniated disc when the claim was accepted. In addition, we do not find that claimant's condition as of claim acceptance directly caused his disc herniation or that other work-related causes contributed directly to his current condition. Instead, we find that the current (herniated disc) condition is an indirect consequence of the accepted (degenerative) condition. Consequently, claimant must prove that the accepted condition was the major contributing cause of his current condition. See ORS 656.005(7)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992).

As we have stated, we agree with the Referee's analysis of the evidence and conclusion that claimant's herniated disc resulted from the natural progression of his degenerative condition. We also agree that the portion of Dr. Johnson's opinion addressing the relative contributions of claimant's work exposures is not particularly persuasive or helpful. However, we find that Johnson's opinion as a whole indicates that claimant's degenerative condition caused his herniation and further, that Johnson's opinion in this regard is supported by that of Dr. Woolpert, independent examiner. (See Exs. 39-2, 56-5, 62-15). Since the degenerative disease was accepted, it follows that the degenerated disc condition resulting from that disease is likewise compensable. Accordingly, we conclude that claimant has proved that his accepted degenerative condition was the major contributing cause of his current cervical herniated disc. Consequently, claimant's current condition is compensable under ORS 656.005(7)(a)(A).

On this record, we further conclude that claimant's accepted cervical condition worsened after August 24, 1990, the last arrangement of compensation (a Determination Order), and claimant's earning capacity was diminished by that worsening. Claimant's worsened condition, evidenced by a herniated disc, is established by medical evidence supported by objective findings. This worsening is greater than a waxing and waning of symptoms contemplated by the Determination Order award of 1 percent unscheduled permanent disability. Consequently, claimant has carried his burden of proving a compensable aggravation under ORS 656.273.

Claimant is entitled to an assessed attorney fee for prevailing against Jeld-Wen'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 $3,000, to be paid by the Jeld-Wen. In reaching this conclusion, we have particularly considered the time devoted to the issue (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 September 2, 1992 is reversed in part and affirmed in part. That portion of the order that upheld Jeld-Wen's denial is reversed. Jeld-Wen's denial is set aside and the claim is remanded to Jeld-Wen for further processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an attorney fee of $3,000, payable by Jeld-Wen. The remainder of the order is affirmed.

In the Matter of the Compensation of
RICHARD N. HARRISON, Claimant
WCB Case No. 92-06494
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Bethlahmy's order that: (1) awarded claimant temporary disability compensation for the period from February 19, 1992 through June 9, 1992; and (2) awarded a penalty for the insurer's allegedly unreasonable failure to pay that compensation. On review, the issues are temporary disability and penalties. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable left knee injury on February 3, 1992. He was unable to return to his regular work thereafter.

On February 10, 1992, Dr. Rusch examined claimant's injured knee, authorized time loss and recommended physical therapy. Placing the claim in deferred status, the insurer began paying time loss benefits (interim compensation).

On February 14, 1992, claimant went to the employer's place of business and picked up his paycheck. The employer believes that claimant quit his job voluntarily at that time.

On February 19, 1992, Dr. Rusch approved modified light duty work for claimant. Dr. Rusch's assistant informed claimant of the doctor's approval and claimant telephoned the employer, requesting information about the position. The employer did not provide claimant with a written job offer.

The insurer terminated claimant's temporary disability benefits (interim compensation) on February 19, 1992. The claim had neither been accepted nor denied.

Claimant's left knee problems continued. By March 13, 1992, Dr. Rusch suspected that claimant had suffered a torn medial meniscus.

On May 1, 1992, the insurer accepted claimant's injury claim for an internal derangement of the left knee and a torn left medial meniscus.

On June 9, 1992, Dr. Rusch stated that claimant would be unable to return to any kind of work for four weeks.

ULTIMATE FINDINGS OF FACT

Claimant was working on February 3, 1992, when he suffered a compensable disabling left knee injury. Thereafter, claimant did not return to regular or modified employment; his attending physician did not authorize claimant's return to regular employment; and the employer did not offer claimant modified employment in writing.

The insurer did not pay temporary disability benefits for the period from February 19, 1992 through June 9, 1992.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that temporary disability benefits are due and payable for the period from February 19, 1992 through June 9, 1992, based on the requirements set forth in OAR 436-60-030(5)(c) and Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). We agree that claimant is procedurally entitled to the disputed compensation. However, we base our decision on different reasoning.

Once a carrier begins paying interim compensation, such compensation is payable every two weeks. ORS 656.262(4)(a); Roger G. Prusak, 40 Van Natta 2037 (1988). Interim compensation is payable until a carrier either issues a formal denial, suspends benefits pursuant to ORS 656.262(4)(b)-(d) or terminates compensation in accordance with ORS 656.268(3).

The insurer neither denied the claim nor contends that any of the events set forth in ORS 656.262(4)(b)-(d) are applicable. Consequently, the issue before us is whether the insurer was authorized to unilaterally terminate claimant's temporary total disability compensation on February 19, 1992. The question is controlled by ORS 656.268(3).

Under ORS 656.268(3), an insurer may unilaterally terminate temporary disability compensation in an open claim, without claimant being medically stationary, if any one of the conditions set forth in ORS 656.268(3) are met. See Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992); Rocky L. Coble, 43 Van Natta 1907 (1991), aff'd, Coble v. T.W. Kraus & Sons, 116 Or App 62, 63 (1992). These conditions include: the worker's return to regular or modified employment; the worker's receipt of a written release by his attending physician to return to regular employment; and the worker's receipt 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. ORS 656.268(3)(a),(b),(c).

The insurer argues that claimant is not entitled to TTD for the period from February 19, 1992 until June 9, 1992, because claimant allegedly quit his job on February 14, 1992, and thus, was not working for reasons unrelated to his compensable injury.

Even assuming that claimant did quit his job on February 14, 1992, the critical date for evaluating his initial (procedural) eligibility for temporary disability benefits (in other words, his status as a "worker") is the date of disability associated with the compensable injury. See Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414-15 (1990); Esther C. Albertson, supra; Rocky L. Coble, supra. Here, because claimant was working (i.e., in the workforce) when he became disabled (due to the compensable February 3, 1992 work injury), the insurer was not entitled to unilaterally terminate temporary disability benefits thereafter, in the absence of one of the events described in ORS 656.268(3). Moreover, because the insurer has not established that any of the events set out in ORS 656.268(3) occurred, it was not authorized to unilaterally terminate claimant's TTD benefits under the open claim.

Finally, we agree that claimant is entitled to a penalty based on the insurer's unreasonable resistance to the payment of compensation, for the reasons stated in Albertson, supra.

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 temporary disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated September 1, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
KENNETH A. HINKLEY, Claimant
WCB Case No. 92-07254
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Mills' order which: (1) found that claimant's low back and gluteal muscle condition claim is precluded by an unappealed denial; and (2) affirmed an Order on Reconsideration awarding no permanent disability. In his brief, claimant contends that if his condition is found compensable, the Order on Reconsideration should be set aside as prematurely issued because the low back/gluteal condition was not medically stationary at the time of closure. On review, the issues are res judicata and, if the claim is not barred, compensability and premature closure. We reverse.

FINDINGS OF FACT

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

Claimant sustained a work injury on September 17, 1990, when he was kicked in his right side and fell backwards onto his back. (Ex. 3). In October 1990, claimant developed right-sided low back, buttock and leg pain, which was diagnosed as "sciatica." (Ex. 7).

On November 27, 1990, the insurer accepted the claim arising out of the September 1990 work injury. The accepted conditions were "probable rib fracture, right trapezius muscle spasm and secondary acute bronchitis." (Ex. 10).

In March 1991, claimant began treating with Dr. Czarnecki, D.O. (Ex. 11). Dr. Czarnecki diagnosed right sacroiliac sprain with inflammation, right gluteal spasm and right hamstring spasm. (Exs. 11, 12). He felt these conditions were related to the September 1990 work injury. (Ex. 18).

By June 1991, Dr. Czarnecki found claimant's right sacroiliac sprain markedly improved and his sciatica apparently resolved. He prescribed continued treatment and expected to do a closing examination in two months. (Ex. 21).

On August 27, 1991, claimant sought treatment for right-sided flank, lateral rib, lateral dorsi muscle, sacroiliac, and gluteal pain, resulting from an off-work horseplay incident. Dr. Czarnecki diagnosed right-sided thoracic, sacroiliac and gluteal sprains, representing an exacerbation of claimant's prior condition. (Ex. 24).

On November 8, 1991, the insurer issued a partial denial which stated, in part:

> "We have recently received information that you are seeking treatment since August 27, 1991 which is unrelated to your injury. After reviewing the information in your file, we are hereby denying your current condition on the grounds that the compensable injury (the compensable injury of probable rib fracture, right trapezius muscle spasm and secondary acute bronchitis condition) is not the major contributing cause of your current disability or need for treatment. Therefore, we must issue this partial denial." (Ex. 28-1).

Dr. Geist, orthopedist, performed a second independent medical examination on December 16, 1991. He opined that the August 1991 horseplay incident, for which claimant sought treatment on August 27, 1991, may have temporarily aggravated claimant's symptoms, but it did not perpetuate his symptoms or influence his condition in the long run. (Ex. 29-4 to -5).

In January 1992, claimant began treating with Dr. Maness for low back pain, among other conditions. (See Exs. 29a, 29b). Dr. Maness opined that claimant's low back condition was probably related to his September 1990 work injury. (Ex. 37).

On May 12, 1992, an Order on Reconsideration issued, awarding additional temporary disability, but otherwise affirming the October 15, 1991 Notice of Closure, which had awarded no permanent disability. (Exs. 27, 33). Claimant's low back/gluteal condition was not rated. (See Exs. 31-4, 33-4).

Claimant requested a hearing on May 26, 1992, contesting the Order on Reconsideration and compensability of the low back/gluteal condition. At hearing, claimant asserted that the insurer's "de facto" denial should be set aside and the low back/gluteal condition found compensable. (Tr. 1-2).

CONCLUSIONS OF LAW AND OPINION

Claim preclusion

The Referee found that claimant's claim for his low back/gluteal condition is barred because claimant failed to contest the November 8, 1991 partial denial of his current condition. He reasoned that since claimant's condition at the time of the denial included low back/gluteal complaints, the low back/gluteal condition allegedly related to the September 1990 work injury was encompassed in the insurer's "current condition" denial. The Referee also found that the denied condition did not subsequently change. Consequently, the Referee concluded that claimant was precluded from litigating compensability of his low back/gluteal condition allegedly caused by the work injury. We disagree.

An uncontested denial bars future litigation of the denied condition, unless the condition has changed and claimant presents new evidence to support the claim that could not have been presented earlier. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563-64 (1989); Mary H. Morris, 44 Van Natta 1273 (1992).

First, in order to determine whether the claim is barred, we must determine what condition was denied. The insurer's denial identifies treatment that claimant sought since August 27, 1991, which the insurer asserts is unrelated to the compensable injury of "probable rib fracture, right trapezius muscle spasm and secondary acute bronchitis." (Ex. 28-1). The insurer then denies claimant's "current condition" on the ground that the compensable injury was not the major contributing cause of claimant's current disability or need for treatment. (Id). Thus, we must determine what claimant's "current condition" was in order to determine what condition the insurer denied.

Since the denial refers to claimant's treatment since August 27, 1991, we understand claimant's "current condition" to mean that condition for which he sought treatment on and after August 27, 1991. On August 27, 1991, claimant sought treatment for symptoms resulting from an off-work horseplay incident. Dr. Czarnecki diagnosed right thoracic, sacroiliac and gluteal sprains, which he identified as an exacerbation of claimant's prior injury. Thus, we conclude that the insurer denied treatment for claimant's exacerbated condition, which we find was the "current condition" for which claimant sought treatment on and after August 27, 1991.

Claimant did not contest the November 8, 1991 denial. Therefore, he is barred from claiming compensation for the same condition which was denied. See Popoff v. J.J. Newberrys, 117 Or App 242 (1992).

Here, subsequent to the insurer's denial, orthopedist Dr. Geist performed an independent medical examination. Dr. Geist opined that claimant may have had a temporary exacerbation of symptoms as a result of the August 1991 incident, but that incident did not perpetuate his symptoms or influence his low back/gluteal condition in the long run. (Ex. 29-4 to -5). Thus, based on Dr. Geist's opinion, we find that claimant's exacerbated condition was only temporary and had resolved by the time

of Dr. Geist's examination in mid-December 1991. Accordingly, we find that claimant's subsequent low back/gluteal condition, for which he sought treatment with Dr. Maness beginning in January 1992, after his temporary exacerbation resolved, is not the same condition which the insurer denied. Therefore, we conclude that claimant's low back/gluteal condition claim, allegedly related to the September 1990 work injury, is not barred.

Compensability

Because we find that claimant's low back/gluteal condition claim is not barred, we now turn to the merits of whether the condition is compensable. We conclude it is.

In September 1990, claimant sustained a work injury when he was kicked by a 180-pound student in the right upper quadrant and flank area. Claimant was thrown backward onto his back. On November 27, 1990, the insurer accepted a claim for "probable rib fracture, right trapezius muscle spasm and secondary acute bronchitis condition" resulting from the work injury. (Ex. 10).

When claimant initially sought medical treatment, he was experiencing intense muscle pain about his back and around his chest. (Ex. 3). On October 31, 1990, claimant reported having discomfort for about the past two weeks radiating from his right lower back and right buttock down to behind his right knee. Claimant's treating doctor diagnosed right sciatica. (Ex. 7).

In March 1991, claimant began treating with Dr. Czarnecki for right sacroiliac sprain and right gluteal and hamstring spasm, which Dr. Czarnecki believed to be the same condition which Dr. Cook had diagnosed as sciatica. (Exs. 11, 18). Based on Dr. Czarnecki's chart notes and reports, we find that claimant made a claim for a low back/gluteal condition in early 1991. (See Exs. 11, 12, 14, 15, 17, 18). We further find that the insurer never accepted or denied that condition.

Dr. Czarnecki opined that the trauma of the work injury caused claimant's right sacroiliac sprain, which resulted in significant spasm of the gluteal muscle and subsequently caused sciatica and claimant's pain in the right posterior leg. (Ex. 18). There is no contrary medical evidence. Thus, we find that claimant's low back/gluteal condition was directly caused by the September 1990 work injury. Therefore, the condition is compensable if claimant establishes that his work injury was at least a material contributing cause of the low back/gluteal condition. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Here, we find that the medical opinions are unanimous in concluding that claimant's low back/gluteal condition is related to the September 1990 work injury. (See Exs. 18, 23-6, 29-5, 37). Moreover, we find that the August 1991 horseplay incident, which temporarily exacerbated claimant's symptoms, had no lasting effect on his low back/gluteal condition. (See Ex. 29-4 to -5). In addition, we find that the low back condition which Dr. Maness began treating in January 1992 was caused by claimant's September 1990 work injury. (See Ex. 37). Accordingly, we find that the September 1990 work injury was at least a material contributing cause of claimant's low back/gluteal condition, and we find the condition compensable.

Furthermore, were we to find that claimant's low back/gluteal condition is a secondary consequence of his compensable injury, requiring claimant to meet the major contributing cause test, we would still find the claim compensable, based on the above-cited medical opinions. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

Premature closure

The claim was closed by a Notice of Closure issued October 15, 1991, finding claimant to be medically stationary as of July 15, 1991 and awarding no permanent disability. (Ex. 27). Upon reconsideration, the Department made it clear that claimant's low back/gluteal condition was neither accepted nor rated. (See Exs. 31, 33). Claimant contends that, if his low back/gluteal condition is compensable, his claim was prematurely closed because the low back/gluteal condition was not medically stationary as of October 15, 1991. Because we have found the low back/gluteal condition compensable, we turn now to the issue of premature closure of the claim.

It is claimant's burden to establish that he was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, we will consider post-closure medical reports if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning, supra.

The last record of treatment prior to the October 15, 1991 closure is on September 10, 1991, when Dr. Czarnecki treated claimant for right sacroiliac and gluteal sprains, and right rib contusion/sprain. (Ex. 25). At that time, Dr. Czarnecki prescribed medication and noted that physical therapy would be considered if claimant did not show improvement in 10 days. (Id.). Therefore, we find that as of September 10, 1991, claimant's low back/gluteal condition was not yet medically stationary. Subsequently, Dr. Czarnecki reported that when he last saw claimant in October 1991, he was not yet medically stationary and required further treatment for pain in his sacroiliac joint. (Ex. 38).

Although Dr. Geist believed claimant's low back/gluteal condition was medically stationary on December 16, 1991, his opinion is based on an improvement in claimant's condition after the closure date. (See Ex. 29-4 to -5). Therefore, we do not consider Dr. Geist's report in determining whether claimant's low back/gluteal condition was medically stationary on October 15, 1991.

We find that only Dr. Czarnecki's chart note and statement regarding claimant's treatment in October 1991 are relevant to a determination of claimant's condition at the time of closure. Accordingly, based on Dr. Czarnecki's chart note and opinion, we find that claimant's low back/gluteal condition was not yet medically stationary on October 15, 1991. Therefore, we set aside the Order on Reconsideration, which affirmed the October 15, 1991 Notice of Closure, on the ground that the claim was prematurely closed.

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 $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, statement of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated.

Inasmuch as our finding of premature closure will result in increased temporary disability benefits, we conclude that claimant's counsel is also entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); Earl F. Childers, 40 Van Natta 481, 485 (1988). Consequently, in accordance with claimant's retainer agreement, we award claimant's counsel 25 percent of the increased temporary disability benefits created by this order, not to exceed $1,050. This award is in addition to the assessed fee awarded above. Dianne M. Bacon, 43 Van Natta 1930 (1991).

ORDER

The Referee's order dated September 23, 1992 is reversed. The insurer's "de facto" denial of claimant's low back/gluteal condition is set aside, and the claim is remanded to the insurer for processing in accordance with law. The May 12, 1992 Order on Reconsideration and October 15, 1991 Notice of Closure are set aside. Claimant's attorney is awarded $4,500 for services at hearing and on Board review concerning the compensability issue, to be paid by the insurer. In addition, claimant's attorney is awarded an attorney fee payable out of the increased compensation created by this order, not to exceed $1,050, to be paid by the insurer directly to claimant's attorney.

In the Matter of the Compensation of
NORMA J. HODGES, Claimant
WCB Case No. 92-03360
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Menashe's order that upheld the self-insured employer's denial of her claim for a cervical strain injury. The employer cross-requests review of the Referee's "advisory findings." Contending that the employer is not seeking any relief in its cross-appeal, claimant has moved to strike the employer's cross-reply brief. On review, the issues are motion to strike, and compensability. We deny the motion and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike Brief

Claimant has moved to strike the employer's cross-reply brief on the grounds that the employer is not seeking any genuine relief on appeal. The employer asserts that it cross-requested review because it believes that the Referee's "advisory findings" are in error and should be "reversed."

Claimant filed a request for Board review of the Referee's order on September 25, 1992 and the employer cross-requested review on September 29, 1992. OAR 438-11-020(2) allows a cross-appellant to file a cross-reply brief within 14 days of the mailing date of a cross-respondent's brief. Here, the Referee made "advisory findings" to be considered on review in the event the Board disagreed with the Referee's decision that claimant's claim was not compensable because it was not supported by objective findings. The employer was entitled to preserve its objection to the Referee's advisory findings by cross-appealing the order and presenting its position on review. Under the circumstances, we deny the motion to strike the cross-reply brief.

Compensability

The Referee found that claimant's injury claim was not compensable on the basis that it was not supported by objective findings. We disagree.

To establish the compensability of her cervical strain injury claim, claimant must establish that the November 1991 work incident was a material contributing cause of her disability and need for medical treatment. Mark N. Weidle, 43 Van Natta 855 (1991). In addition, the injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a). The "objective findings" requirement can be satisfied if a physician's evaluation of a claimant's physical condition is based on her description of the pain she is experiencing. The report, however, cannot merely recite claimant's complaints of pain, but rather must indicate that the claimant does, in fact, experience symptoms. Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

Drs. Rosenbaum, Sabo and Scourfield all believed claimant's reports of increased cervical pain beginning on November 30, 1991. Rosenbaum concluded that if claimant's history was accurate, claimant had sustained a strain injury on that date. Dr. Scourfield also concluded that claimant had suffered a strain injury on November 30, 1991. Dr. Sabo, on the other hand, felt the the cervical symptoms were due to claimant's preexisting degenerative disc disease rather than an injury. Based on these physician's reports, which indicate that they believed that claimant experienced cervical symptoms on November 30, 1991, we conclude that claimant has satisfied the objective findings requirement of ORS 656.005(7)(a).

Claimant has degenerative arthritis of the cervical spine. The primary issue is whether or not claimant's cervical symptoms arising on November 30, 1991 were caused by her preexisting condition or by a strain injury at work. Because claimant suffers from a preexisting condition which may be responsible for her symptoms, identifying the cause of her cervical pain in November 1991 presents a complex medical question. Consequently, expert medical evidence is required in order for us to resolve the compensability issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

There are four opinions addressing the cause of claimant's neck condition. Dr. Rosenbaum, a neurologist, saw claimant for her neck condition. By the date of his deposition, Dr. Rosenbaum knew that claimant had been treated in the past by Dr. Scourfield for prior cervical strains. He was also aware that claimant had preexisting degenerative disc disease in her cervical spine and that claimant had neck complaints due to a motor vehicle accident in the 1960s. In addition, Dr. Rosenbaum was also aware of Dr. Sabo's opinion that claimant's symptoms were due to her preexisting degenerative condition. Nonetheless, Dr. Rosenbaum adhered to his earlier opinion that if claimant's history regarding the November 30, 1991 incident was correct, the medical probability was that claimant sustained a muscle strain at work on that date.

Dr. Scourfield, an osteopath, has been claimant's treating physician since the 1960s. He indicated that claimant's findings on December 2, 1991 were those of cervical strain. He opined that the major contributing cause of claimant's cervical strain was the lifting injury on November 30, 1991.

Claimant was also seen by Drs. Schultheis, and Dr. Sabo, both osteopathic physicians. Dr. Schultheis opined that, based on his review of Dr. Scourfield's records, there were no objective findings of an injury on November 30, 1991. Taking into account claimant's underlying degenerative condition, her previous motor vehicle accidents and her longstanding history of neck and back complaints and treatment, Dr. Sabo concluded that claimant did not suffer a new injury on November 30, 1991. Rather, Dr. Sabo felt that it was more probable that claimant's complaints on or after November 30, 1991 resulted from her underlying condition which was neither caused nor worsened by her work activity.

We defer to the Referee's credibility finding and conclude that claimant's history of the events of November 30, 1991 is correct. On this record, we find Dr. Rosenbaum's opinion to be the most well reasoned and based on the most complete information. See Somers v. SAIF, 77 Or App 259 (1986). Therefore, we are persuaded by his opinion that claimant suffered a muscle strain and that her cervical symptoms resulted from that strain injury rather than from her underlying degenerative condition of the cervical spine. We note that Rosenbaum's opinion is supported by that of Dr. Scourfield, the treating physician.

Accordingly, we conclude that claimant has established the compensability of a cervical strain occurring on November 30, 1991. Thus, the employer is responsible for providing benefits for claimant's disability and medical treatment resulting from her November 30, 1991 cervical strain injury.

We note that in reaching this decision, we are not finding that claimant's underlying degenerative disease of the cervical spine is compensable. Rather, we have concluded, based on Dr. Rosenbaum's opinion, that claimant's cervical symptoms resulted solely from a muscle strain injury rather than the underlying degenerative condition. Therefore, we do not find that claimant's injury combined with the preexisting cervical condition to cause disability or a need for treatment. See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon, 120 Or App 590 (1993) (a work-related injury which combines with a preexisting condition to cause disability or a need for treatment is compensable only if it is the major contributing cause of the disability or need for treatment).

Claimant is entitled to an assessed attorney fee for prevailing on the compensabilty 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 $5,060, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services and appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 14, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for acceptance and processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,060 payable by the employer.

In the Matter of the Compensation of
RYAN F. JOHNSON, Claimant
WCB Case No. 91-17398
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The self-insured employer requests review of Referee Livesley's order that: (1) admitted post-hearing medical reports (Exhibits 20 and 21) in evidence; and (2) set aside its denial of claimant's occupational disease claim for Raynaud's Phenomenon. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

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

On February 14, 1992, claimant was examined by Drs. Dordevich and Podemski at the employer's request. A copy of the independent medical examination (IME) report was first submitted to claimant's attorney's office on Friday, February 21, 1992. Because claimant's attorney was away from the office on business that day, he did not review the report until Monday, February 24, 1992.

On the morning of February 25, 1992, Dr. Dordevich was deposed; claimant's attorney participated in that deposition. That afternoon, the hearing was convened. Claimant objected to admission of the IME report and deposition and, alternatively, requested an opportunity to submit rebuttal evidence. The Referee admitted the IME report and deposition into evidence, (Exs. 18, 19), and later ruled that claimant could submit rebuttal evidence.

By letter dated May 20, 1992, claimant's attorney sent copies of the IME report and deposition to Dr. Teal, the attending physician, and requested his response. The letter contained four questions concerning Raynaud's Phenomenon and its interaction with cold exposure. Dr. Teal sent these materials to Dr. Wasner, consulting rheumatologist, and requested his opinion. On May 26, 1992, Dr. Wasner issued a report responding to the aforementioned questions. Based on that report, Dr. Teal issued his responsive report on June 1, 1992. Claimant offered the reports of Drs. Teal and Wasner into evidence. The Referee received those reports into evidence, over the employer's objection. (Exs. 20, 21).

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, the employer contends that the Referee erred in admitting Exhibits 20 and 21 because: (1) they are reports from two doctors, rather than just the attending physician; and (2) the reports are not "rebuttal evidence." We disagree.

OAR 438-06-091(3) provides, in relevant part, that a referee may continue a hearing for further proceedings "[u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence." "Rebuttal evidence" is defined to include evidence "which tends to explain or contradict or disprove evidence offered by the adverse party." Black's Law Dictionary 658 (Abr. 5th ed. 1983).

Here, the IME report and Dr. Dordevich's deposition addressed the nature and cause of Raynaud's Phenomenon, its interaction with stimuli (such as cold exposure and emotional stress), and the effect of claimant's work exposure on his condition. (See Exs. 18, 19). Likewise, the reports from Drs. Teal and Wasner addressed those same issues, sometimes directly responding to statements made in Dr. Dordevich's deposition. Therefore, we find that the reports from Drs. Teal and Wasner were submitted to "explain, contradict or disprove" evidence offered by the employer. Moreover, the Referee did not limit claimant's rebuttal evidence to a report from the attending physician. Accordingly, we conclude that the Referee did not abuse his discretion in admitting those reports as rebuttal evidence. See James D. Brusseau II, 43 Van Natta 541 (1991).

Compensability

The Referee concluded that claimant had sustained his burden of proving an occupational disease under ORS 656.802(1)(c), reasoning that his work exposure to cold temperatures was the major contributing cause of a worsening of his Raynaud's Phenomenon. We agree with the Referee's conclusion, but rely on the following reasoning.

Claimant has the burden of proving that employment conditions were the major contributing cause of the disease or its worsening. ORS 656.802(2). Existence of the disease or its worsening must be established by medical evidence supported by objective findings. Id. Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. Weller v. Union Carbide, 288 Or 27, 35 (1979). However, if the medical evidence supports a finding that the manifested symptoms are the disease, the condition may be compensable. See Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia-Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

The Referee concluded that there was insufficient medical evidence to find that claimant's manifested symptoms are the disease. We disagree.

In Warren, supra, there was medical evidence that the carpal tunnel syndrome, for which the claimant sought compensation, was separate from the ideopathic, underlying disease, "entrapment neuropathy." The medical evidence further indicated that the underlying disease was neither caused nor worsened by employment exposure. Nevertheless, the court held that there was substantial evidence to support the Board's finding that the carpal tunnel symptoms for which compensation was sought were the compensable disease. The court regarded the existence of the underlying entrapment neuropathy to be irrelevant to the determination that the symptoms are the disease. See id.

Based on the medical evidence in this case, we find that claimant has Raynaud's Phenomenon, an ideopathic, underlying condition which results in vasospasms of the small blood vessels that temporarily reduce blood flow, causing pain and discoloration of the hands and fingers. The vasospasms are triggered by stimuli such as cold exposure and emotional distress; however, those stimuli do not affect the underlying hyperreactivity of the phenomenon itself. The vasospasms and resulting symptoms are the only manifestations of the phenomenon. Prolonged exposure to triggering stimuli can cause permanent tissue damage.

We are not persuaded by the statements of Drs. Wasner and Dordevich that the symptoms of Raynaud's phenomenon are not the "disease." The doctors may be correct that, in a medical sense, the underlying disease process (i.e., tendency to vasospasm) is not the same as the manifested symptoms. However, in reviewing their opinions in detail, it is apparent that they believe that the underlying disease process is only manifested by symptoms precipitated by certain stimuli. (See Exs. 19-24, 19-39 through -40, 20-1). Dr. Teal persuasively explained that Raynaud's Phenomenon is a predisposition which is not necessarily symptomatic until there is harmful exposure (to cold or emotional distress, for examples). (Ex. 21).

Based on this record, we conclude that claimant was disabled and required treatment for symptoms which are the only manifestations of Raynaud's Phenomenon. Therefore, we find that claimant's symptoms are the disease for purposes of ORS 656.802. See id. Further, we find the existence of those symptoms is established by ample medical evidence supported by objective findings. See ORS 656.802(2).

Turning to causation, Dr. Teal opined that claimant's cold exposure at work was the major contributing cause of the Raynaud's symptoms. (Ex. 17). Drs. Wasner and Dordevich, on the other hand, gave opinions on the issue of whether claimant's cold exposure at work caused or worsened the underlying Raynaud's Phenomenon. Inasmuch as that is not the relevant issue, those opinions are not persuasive. Drs. Wasner and Dordevich opined that cold exposure would result in claimant's symptoms. (Exs. 18-4, 19-17, 20-2). Claimant's testimony establishes that his most significant cold exposure occurred at work. Under these circumstances, we find that claimant's cold exposure at work was the major contributing cause of his Raynaud's condition. Accordingly, we conclude that his occupational disease claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 28, 1992 is affirmed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
DAVID K. KRUEGER, Claimant
WCB Case No. 90-19087
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Lipton and Gunn.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) assessed an attorney fee for claimant's counsel's services in connection with obtaining a pre-hearing rescission of its denial; and (2) assessed a penalty for its allegedly unreasonable denial. On review, the issues are penalties and attorney fees.

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

We agree with the Referee that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing and adopt his explanation. Also, we note that counsel's request for hearing preserved claimant's right to challenge the employer's denial. See Kimberly Wayne, 44 Van Natta 328 (1992). We further note that ORS 656.386(1) authorizes an assessed attorney fee under these circumstances, but does not require a certain quantum of instrumentality.

We agree with the Referee's penalty assessment in this case. See Kenneth A. Foster, 44 Van Natta 148 (1992) (The employer cannot have legitimate doubt for lacking knowledge of facts that would have been disclosed by a reasonable investigation).

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 November 12, 1992 is affirmed.

In the Matter of the Compensation of
VERNON E. LIPSCOMB, Claimant
WCB Case No. 91-13446
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Paul Roess, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of those portions of Referee Schultz's order that: (1) set aside its "de facto" denial of claimant's thumb and right wrist tendinitis condition; and (2) assessed an attorney fee for an allegedly unreasonable refusal to provide discovery. On review, the issues are compensability and penalty-related attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

On June 12, 1991, Dr. Lundquist placed claimant on light duty work. On June 14, 1991, Dr. Koch diagnosed claimant's condition as carpal tunnel syndrome, right. (Ex. 2A). On June 17, 1991, Dr. Lundquist continued to diagnose claimant's condition as "tendinitis of the wrist," and arranged for claimant to have nerve conduction studies to rule out carpal tunnel syndrome. (Ex. 3-1). On June 28, 1991, claimant continued to have aching in his right wrist even when not at work. (Ex. 3-2). On September 6, 1991, Dr. Weeks continued claimant on light duty. (Ex. 5). Dr. Weeks released claimant to regular work as of November 4, 1991. (Exs. 8B and 8CC).

Claimant filed an October 18, 1991 Request for Hearing on a standard form which demanded copies of all medical reports and other documents pertaining to the claim whether or not the employer intended to rely upon them at hearing.

The hearing was held on December 18, 1991. Claimant raised the issue of the employer's failure to provide a copy of a taped statement it took from claimant. During the hearing, the employer offered an employee's accident report that had not been provided to claimant. Claimant objected and the Referee sustained his objection. The Referee closed the record at the conclusion of the December 18, 1991 hearing.

On December 23, 1991, claimant requested that the record be reopened because the insurer had not provided any chart notes from Drs. Koch, Hendricks or Weeks.

On January 2, 1992, the Referee issued an "Order Reopening Record," which required the employer to provide claimant's counsel with treatment records and chart notes from the three doctors that had not been provided to claimant, as well as a copy of the tape or a transcript of the tape and any accident reports.

On January 28, 1992, the employer provided a June 14, 1991 chart note from Dr. Koch (now Ex. 2A). The employer claimed that this exhibit had been provided to claimant prior to November 8, 1991, when copies of the other documents pertaining to the claim were sent to him. The employer also claimed that it had not been provided with "chart notes" from either Dr. Hendricks or Dr. Weeks: The one report by Dr. Hendricks had been marked and received as Exhibit 4 and Dr. Weeks had not provided the employer with any chart notes.

On February 10, 1992, the employer provided claimant with a transcription of the recorded statement taken on July 22, 1991.

Claimant wrote to Dr. Weeks and received Exhibits 6A, 6B, 8BB and 8CC.

The Referee received Exhibits 2A, 6A, 6B, 8BB, 8CC, 12, 13 and 14 into evidence. The record was closed on March 4, 1992.

FINDINGS OF ULTIMATE FACT

Claimant's accidental injury arose out of and in the course of his employment. It required medical services and was established by medical evidence supported by objective findings.

The employer failed to timely provide claimant with copies of all discovery materials in its possession, namely a copy of claimant's recorded statement.

The employer did not have exhibits 6A, 6B, 8BB and 8CC in its possession.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's right wrist and thumb tendinitis was compensable. The employer contends that claimant failed to prove that his tendinitis claim is compensable because the medical evidence was not supported by objective findings. We disagree and affirm the Referee's opinion with the following supplementation.

A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings. ORS 656.005(7)(a). "Objective findings" in support of medical evidence include, but are not limited to, range of notion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings. ORS 656.006(19).

In Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992), the Court of Appeals upheld our analysis of "objective findings" in Suzanne Robertson, 43 Van Natta 1505 (1992), in which we held that findings based on a doctor's objective evaluation of a claimant's subjective complaints are sufficient to constitute "objective findings" pursuant to ORS 656.005(7)(a) and 656.005(19).

Here, the record shows that claimant sought treatment from Dr. Lundquist on June 12, 1991, for pain in his right wrist radiating into his right thumb. On examination, although claimant's wrist and thumb were not tender, claimant reported pain with flexion of the thumb. Dr. Lundquist diagnosed claimant's condition as tendinitis of the thumb, prescribed a wrist splint, and returned claimant to light work. Two days later, Dr. Koch diagnosed carpal tunnel syndrome and prescribed anti-inflammatory medication. When claimant returned to Dr. Lundquist, Lundquist continued the use of the wrist splint and anti-inflammatories and referred him to Dr. Hendricks for nerve conduction studies, which revealed slightly abnormal median and ulnar nerve conduction. Both Drs. Weeks and Lundquist opined that work was the major contributing cause of tendonitis of the thumb and wrist of the right hand.

The doctors' findings, diagnoses and treatment of claimant's tendonitis of the right thumb and wrist condition were based on their objective evaluation of claimant's subjective complaints. Georgia Pacific v. Ferrer, supra. Consequently, we conclude that claimant's injury has been established by medical evidence supported by "objective findings."

Penalty-related Attorney Fees for Unreasonable Discovery

The Referee concluded that the employer failed to provide claimant's counsel with requested discovery, including a copy of claimant's recorded statement, and awarded an attorney fee pursuant to ORS 656.382(1) for the employer's unreasonable failure to produce discovery. The employer contends that its failure to produce discovery was not unreasonable, maintaining that claimant should have made a specific request for the tape recording or a transcript of it and that the employer did not have the remaining documents in its possession.

The applicable portions of ORS 438-07-015 provide:

"(2) Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing or a written demand * * * to the insurer or self-insured employer. Within fifteen (15) days of said mailing, the insurer or self-insured employer shall furnish the claimant and other insurers, without cost, originals or legible copies of all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim(s). Upon specific demand by the claimant, payroll records shall be obtained by the insurer from the employer and provided in the same manner as other documents.

"* * * * *

"(4) Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents.

"(5) It is the express policy of the Board to promote the full and complete disclosure of all facts and opinion pertaining to the claim being litigated before the Hearings Division. Failure to comply with this rule shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10)." (Emphasis added).

The employer does not assert that the tape at issue does not contain facts and opinion pertaining to the claim. Moreover, the employer does not contend that it reasonably believes that the statements were relevant and material only for purposes of impeachment. See OAR 438-07-017. Rather, the employer contends that claimant should have specifically requested the tape or a transcript of it. The only documents for which claimant must make specific demand are payroll records. See ORS 438-07-015(2). The employer does not contend that the tape contains payroll records. Accordingly, because the rule provides for disclosure by both parties of all documents pertaining to the claim, we find that the Referee properly found that claimant was entitled to disclosure of the tape and that the employer's failure to so disclose was unreasonable.

The next question is whether it was unreasonable for the employer not to obtain, as well as discover, claims material, or whether it was required only to provide discovery of material in its possession.

OAR 436-10-030, which was promulgated under authority granted by ORS 656.262(1), requires medical care providers, including treating, consulting and examining physicians, to regularly submit reports to insurers. The Director's rules further provide that workers and their representatives shall generally obtain copies of those reports from the insurer, although they may obtain them directly from the provider upon the payment of a charge. OAR 436-10-030(15).

The employer has the duty to obtain ongoing medical reports as part of its claim processing duties. Here, Exhibits 5 and 8 are reports of Dr. Weeks and Exhibit 8B is a letter to Dr. Lundquist from Dr. Weeks. Each of these exhibits was provided to the employer by the medical provider. Exhibits 6A and 8BB are copies of Dr. Weeks' work releases. The reports by Dr. Weeks include the work release information and were timely provided to claimant. (See Exs. 5, 8 and 8B). Exhibit 6B is a copy of Dr. Weeks' chart notes, which refer directly to the reports listed above. If, as here, the employer judges the reports to be complete, the employer has fulfilled its duty. Under the circumstances of this case, it had no obligation to seek out medical documents the provider had not seen fit to submit.

It is claimant's burden to prove that the employer had in its possession the documents at issue prior to hearing. No such proof was offered. Accordingly, we conclude that it was not unreasonable for the employer to have failed to produce these exhibits.

We distinguish this case from Penni L. Mumm, 42 Van Natta 1615 (1990), in which we concluded that a claimant is entitled to rely on the insurer to obtain medical reports. In Mumm, the claimant requested remand for the submission of evidence discovered after the order issued. The issue was whether the evidence was unobtainable with due diligence before the hearing. The claimant made a routine request to the insurer to provide documents. The insurer produced a number of documents, including some pertaining to the claimant's hospital admission. During a continuance, the claimant's attorney advised the insurer that it appeared that the hospital records were incomplete. The insurer

advised the attorney that all hospital records had been provided. After the order issued, the claimant demanded her medical records from the hospital. Among those documents were a number that the insurer had not produced, among them documents relevant to the question of compensability and of the type routinely provided by providers to insurers.

Although the record did not establish that the newly discovered evidence was in the insurer's possession at the time of hearing, we nevertheless concluded that the claimant had exercised due diligence when she not only made a standard request for claims information but also queried the insurer concerning the apparent incompleteness of the records disclosed pursuant to the request. Further, because a claimant is entitled to rely on the insurer to obtain medical reports, and because providers are required to regularly submit reports to insurers, we concluded that the claimant's attorney exercised due diligence by relying on the disclosure provisions of the rules. We accordingly held that remand was appropriate when the claimant had not received medical reports, without which the record was insufficiently developed, pursuant to a request to the insurer, provided that the reports are of the type that should have been submitted to the insurer, even where the insurer is without fault. Mumm, supra.

In contrast, the issue in the case before us is whether a penalty should be assessed against the employer for unreasonably failing to obtain materials not in its possession. Here, we found that the documents that the employer failed to supply duplicate evidence that had been provided to claimant in reports of the type routinely provided by providers to insurers. Claimant did not put the employer on notice that any relevant evidence might be missing until after the hearing. Thus, as we concluded above, if the employer believes the reports submitted by the providers to be complete, it has no obligation to seek out additional medical documents.

We accordingly modify the Referee's order that awarded an assessed attorney fee for the employer's unreasonable refusal to provide claimant with full discovery. Because it was not unreasonable for the employer to fail to obtain the exhibits it did not have in its possession, we reduce the penalty-related attorney fee from $500 to $400. In reaching this conclusion, we have considered the factors set forth in OAR 438-15-010(4), particularly the complexity of the issue and the value of the interest involved.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review on the issue of compensability. 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 statement of services), 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-related attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 23, 1992 is affirmed in part and modified in part. The Referee's award of $500 as an assessed fee for the employer's unreasonable refusal to provide discovery, is reduced to $400. The remainder of the order is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
PETRONILO LOPEZ, Claimant
WCB Case No. 91-07116
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Lipton and Westerband.

Claimant requests review of those portions of Referee Spangler's order that: (1) upheld the SAIF Corporation's compensability denial of claimant's claim for a left knee condition; (2) determined that claimant was not entitled to interim compensation; and (3) declined to assess penalties or attorney fees for SAIF's allegedly unreasonable failure to provide interim compensation and for an allegedly unreasonable discovery violation. In its respondent's brief, SAIF contends that the Referee erred in concluding that claimant was not an independent contractor. Noting that SAIF did not file a cross-request for review on the independent contractor issue, claimant has moved to strike that portion of SAIF's respondent's brief. On review, the issues are the motion to strike, subjectivity, compensability, interim compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On April 20, 1990, claimant reported to the employer, through his son Tony, that he had injured his left knee while moving a tree.

On June 12 and July 11, 1991, claimant's counsel sent letters to SAIF seeking to discover records documenting the employer's business relationship with claimant. Specifically, claimant's counsel sought claimant's personnel file, including all payroll information, the employer's business income tax returns, and documents containing the names and addresses of the employer's other employees or the other independent contractors that the employer dealt with.

On July 19, 1991, SAIF notified claimant's counsel that it thought that some of the requested information was not discoverable, but that it would provide copies of all materials concerning the employer's relationship with claimant. SAIF subsequently provided claimant with a copy of a cancelled check representing a payment from the employer to claimant. It also provided claimant with a letter that detailed all of the employer's payments to claimant. That letter indicated that that information was "based upon records" of dealings with claimant. However, SAIF did not provide those underlying records to claimant.

FINDINGS OF ULTIMATE FACT

Claimant left work on April 20, 1990 due to the injury.

Claimant was not free from the direction and control of the employer concerning the means and manner of providing his labor and services. The employer did more than merely specify the desired results.

Claimant did not furnish all of the tools and equipment necessary to perform the tasks directed by the employer.

Claimant did not file federal or state income tax returns in the name of a business for the taxable year 1990.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant has moved to strike the portion of SAIF's respondent's brief that contends that he is an independent contractor, because SAIF did not file a cross-request for review on that issue. We have previously held that we have authority to consider issues which are not raised via formal cross-requests for review. Cameron D. Scott, 44 Van Natta 1723, 1724 (1992); Kenneth Privatsky, 38 Van Natta 1015 (1986). Consequently, we deny claimant's motion and proceed to the merits.

Independent Contractor

We adopt the Referee's order on this issue, with the following supplementation.

ORS 656.005(29) provides that "'[i]ndependent contractor' has the meaning for that term provided in ORS 670.600." Relying on our decision in Gregory L. Potts, 43 Van Natta 1347, 1349 (1991), the Referee concluded that claimant was not an independent contractor, because he did not satisfy each and every element of ORS 670.600. Subsequent to the Referee's order, the Oregon Court of Appeals affirmed our decision in Potts. See Liberty Northwest Ins. Corp. v. Potts, 119 Or App 252 (1993). Consequently, we reject SAIF's argument that the court's decision in Wood v. Dunn, 109 Or App 204 (1991), establishes the test for what constitutes an independent contractor. The Referee properly applied ORS 670.600.

Compensability

The Referee concluded that claimant's claim was not compensable. The Referee reasoned that claimant's evidence of an on-the-job injury was countered by SAIF's evidence that claimant fabricated his injury because he was angry with the employer. We disagree.

The medical evidence indicates that claimant's left knee condition resulted from a discrete injurious event. Consequently, to prove compensability, claimant must show that an on-the-job injury was a material contributing cause of his disability or need for treatment. Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant must establish the existence of his condition with medical evidence supported by objective findings. ORS 656.005(7)(a).

The medical reports conclusively establish that claimant injured his left knee. The issue is whether his work activities with the employer were a material contributing cause of that injury. The medical reports make that attribution. However, SAIF contends that those reports are not reliable, because claimant's report of an on-the-job injury is not credible.

We are not persuaded that the question of medical causation in this case is a complex one requiring expert medical evidence, rather than lay evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Nevertheless, we do agree that, to prove compensability, claimant must present persuasive, credible evidence of a work-related injury. Although the Referee found claimant's evidence to be unpersuasive, he did not make a specific finding regarding the credibility of any witness. 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, 285 (1987).

Claimant testified that he injured his knee on April 20, 1991, when he lifted a tree while working for the employer. He also testified that he had his son, Tony, report the injury to the employer on that date. Tony testified that he saw claimant picking up the tree and the root ball hit his foot. He also testified that he reported the injury to the employer for claimant, whose English is limited. Claimant's brother, Juan, testified that he saw claimant lifting the tree, that claimant slipped while doing so and that his knee cracked. All three of those witnesses testified that, on that same date, claimant and the employer had a dispute concerning wages from past employment.

Concerning the circumstances on the date claimant was injured, the employer's testimony was similar to the other witnesses' in every important respect, except one. He testified that claimant did not report an injury on that date, and that he first received notice of the injury when claimant filed his claim two weeks later. He also testified that, on prior occasions, claimant had alluded that he might use an injury to gain some advantage against him.

The Referee concluded that the inconsistencies between the witnesses as to the precise timing of events were minor and easily explained by the passage of time. We agree. Consequently, the only evidence suggesting that claimant did not suffer a work-related injury is the employer's testimony that claimant did not inform him of the injury, and that claimant was angry and had previously alluded that he could make trouble for the employer. We do not find that evidence sufficient to discredit claimant's testimony.

Every witness who was at the job site on April 20, 1991 testified that claimant and the employer were involved in a dispute concerning past wages. Claimant also testified that his left knee was not bothering him much when he was talking with the employer. Under those circumstances, it is probable that he did not stress the injury in his conversations with the employer. It is also probable that the report did not memorably impress the employer, because the employer considered claimant to be an independent contractor who was responsible for his own injuries. We have previously concluded that an employer's failure to recall an injury report is insufficient, in the absence of other contradictory evidence, to conclude that the claimant is not credible. See Gregg M. Baker, 44 Van Natta 2478, 2479 (1992).

We also do not consider the employer's allegations, that claimant was angry and had previously alluded to using an injury to gain some advantage over the employer, sufficient to discredit claimant's evidence. Assuming those allegations could impeach claimant's credibility, two other witnesses testified to seeing the on-the-job injury. That claimant may have been inclined to file a false claim does not undercut the other witnesses' testimonies.

The only evidence purportedly impeaching claimant's son is the fact that he is a minor and is, therefore, financially interested in the outcome of this dispute. In the absence of a credibility finding based on demeanor, we are not persuaded that that is a sufficient reason, in and of itself, to discredit his testimony.

Because we find no reason to discredit claimant's testimony, and because his testimony is corroborated by other witnesses, we are persuaded that he is credible and that he suffered a work-related injury involving his left knee while working for the employer on April 20, 1991. Accordingly, his claim is compensable.

Interim Compensation

Because the Referee found that claimant's evidence was not persuasive, he concluded that claimant failed to prove that he was entitled to interim compensation. As discussed above, we find claimant's evidence credible and persuasive. Consequently, we find that the employer was notified of claimant's injury on April 20, 1991. We also find that claimant left work on that date due to his injury. Every witness reported that claimant stopped work on that date, before the job was completed. The record also shows that claimant did not work again until June, although his brothers continued to work for the employer. Under such circumstances, claimant was entitled to temporary disability compensation, in the form of interim compensation, beginning April 20, 1991, pending acceptance or denial of his claim. ORS 656.262(4)(a); Bono v. SAIF, 298 Or 405, 408-410 (1984). Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800. OAR 438-15-055(1).

Penalties and Attorney Fees

Discovery Violation

The Referee declined to award a penalty for SAIF's failure to provide requested discovery. SAIF contends that no penalty is warranted, because it provided claimant with all documents pertaining to the claim. We conclude that a penalty for a discovery violation should be assessed.

To obtain evidence to support his contention that he was not an independent contractor, claimant sought to discover the employer's personnel file, including all payroll information, concerning claimant (Ex 12). See OAR 438-07-015(2). After SAIF failed to respond to that request, claimant requested those materials again, and further sought to discover the employer's tax records and any records concerning payments the employer made to his employees or any independent contractors. (Ex 17). SAIF initially responded to that request by providing claimant with a copy of a single check the employer had issued to claimant. (Ex 19). Subsequently, it also provided claimant with a letter that listed all of the employer's payments to claimant. (Ex 20). The letter specifically said that the information that it contained was "based upon records" of dealings with claimant. However, SAIF did not provide the underlying records to claimant. (Tr 18).

In Mickey L. Wood, 40 Van Natta 1860, 1866 (1988), we concluded that documents that contain information used to prepare other claims documents are themselves documents that pertain to a claim. As Exhibit 20 indicates, some of the employer's business records were used by SAIF to prepare the exhibit that SAIF offered into evidence to support its case. Therefore, the underlying business records involved should have been produced for claimant's inspection, because they were documents which pertain to the claim. Id.

We conclude that SAIF's unreasonable failure to provide discovery justifies the assessment of a penalty equal to 25 percent of all compensation due on the date of hearing (as a result of this order), one half of which is payable to claimant's attorney in lieu of an attorney fee. ORS 656.262(10); OAR 438-07-015(5).

Failure to Pay Interim Compensation

Because the Referee concluded that claimant was not entitled to interim compensation, he necessarily concluded that SAIF's failure to pay that compensation was not unreasonable and, therefore, declined to award a penalty. We have concluded that claimant is entitled to interim compensation. Because the employer had notice that claimant had been disabled by his injury, we conclude that SAIF's failure to pay interim compensation constitutes unreasonable resistance to the payment of compensation. ORS 656.362(10); J.C. Daniels, Jr., 43 Van Natta 489, 490 (1991). Because we have already assessed a 25 percent penalty for SAIF's discovery violation, we may not assess a further penalty. Kim L. Haragan, 42 Van Natta 311, 313 (1990). However, we may assess an attorney fee pursuant to ORS 656.382(1). Id.; Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). We find it appropriate to do so in this case.

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 SAIF's failure to pay interim compensation is $350. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

Attorney Fee/Hearing-Board Review

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs), 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. Those portions of the Referee's order that upheld SAIF's denial, concluded that claimant was not entitled to interim compensation and declined to award penalties for SAIF's unreasonable failure to pay interim compensation and provide discovery are reversed. SAIF's denial is set aside and the claim is remanded to SAIF for acceptance and processing according to law. For services at hearing and on Board review concerning the compensability issue, claimant is awarded an assessed fee of $3,500 to be paid by SAIF. For its unreasonable failure to provide discovery, SAIF is assessed a penalty equal to 25 percent of the compensation due on the date of hearing as a result of this order, payable in equal shares to claimant and his attorney. For SAIF's unreasonable resistance to the payment of interim compensation, claimant is awarded an attorney fee of $350, to be paid by SAIF. Claimant is awarded interim compensation from April 20, 1991 through the date of SAIF's denial. Claimant's counsel is awarded 25 percent of this increased compensation, not to exceed $3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CURTIS LULL, Claimant
WCB Case No. 91-08846
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of Referee Black's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a low back and right leg condition; and (2) declined to award a penalty and related attorney fee for the insurer's allegedly unreasonable "de facto" denial. On review, the issues are aggravation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and supplement as follows. We do not adopt the Referee's findings of ultimate fact.

On July 13, 1986, the insurer accepted the claim as disabling. The acceptance did not specify the accepted condition.

Claimant did not seek medical treatment for his occasional episodes of low back pain.

During claimant's bicycle ride, he remained on pavement, either streets or bike paths. He did not go off any curbs, ride down stairs, fall off his bike or do anything else to injure his back. He experienced no unusual pain on the day of the bike ride.

Claimant himself sought treatment from Dr. Roy, who took claimant off work for one day. (Ex. 25-3). When Dr. Roy declared claimant medically stationary on February 5, 1991, he also restricted claimant from heavy lifting and the repetitive use of his low back.

FINDINGS OF ULTIMATE FACT

Since the last arrangement of compensation, claimant has sustained a symptomatic worsening of his low back that has resulted in diminished earning capacity. The worsened condition is established by medical evidence supported by objective findings.

The insurer did not accept or deny claimant's aggravation claim within 90 days of notice of that claim.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Relying in part on ORS 656.273(1), the Referee concluded that claimant had failed to establish a compensable aggravation claim because the major contributing cause of claimant's "need for treatment and disability" was an injury not occurring in the course and scope of employment, namely the 1990 bicycling event. 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). The test for establishing a compensable worsening is the "material contributing cause" test, i.e., the original injury must be a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1678 (1991). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

However, if an off-the-job injury is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992); see also Annette M. Cochran, 43 Van Natta 2628 (1991). The burden to prove that the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment is on the carrier. Roger D. Hart, 44 Van Natta 2189 (1992).

Here, the primary issue is the cause of claimant's current worsened condition. The record contains conflicting medical evidence. Because the cause of claimant's low back condition is a complex medical question, we rely on expert medical opinion to resolve the issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Woolpert hypothesized that claimant had a degenerative low back condition that preexisted the 1986 injury, which was a symptomatic exacerbation of that preexisting condition. He opined that the bicycle riding episode was the major contributing cause of the current disc rupture and that the underlying degenerative disc disease was the major contributing cause of claimant's current condition.

Dr. Jarvis stated: "It would be hard to state categorically that this was an absolutely new injury or whether this was an aggravation of a pre-existing condition, brought on by the mountain bike ride. Certainly, the bike ride was the inciting factor, but there was a pre-existing predisposition."

We are more persuaded by the opinion of Dr. Roy, claimant's attending physician, than that of Dr. Woolpert, whose report is contradictory and based on an unsupported hypothesis, or that of Dr. Jarvis, whose report avoided committing to a major cause.

Dr. Roy initially reported:

> "Two to three weeks ago [claimant] started developing pain on the posterior aspect of his right thigh which seemed to relate to cycling but did not occur while he was doing this. * * * [T]he pain has increased in severity, and [claimant] has pain particularly with sitting and even more so when sitting and driving." (Ex. 17-1).

Dr. Roy diagnosed right-sided sciatica, related to a disc protrusion in the lower lumbar spine. This diagnosis was confirmed by an MRI. (Ex. 18-1 and 19-1).

When asked his opinion on the cause of claimant's low back pain and disc protrusion, Dr. Roy responded:

> "[Claimant] suffered a significant disc protrusion which came on spontaneously approximately two to three weeks prior to being seen in November of 1990. And * * * was most likely due to the initial injury. Therefore, I feel [claimant] suffered a worsening of the lower back strain of March 04, 1986 and that this was a spontaneous development of the underlying injury. I am not aware of any separate incident or injury subsequent to the March 04, 1986 episode.
>
> "While I understand that [claimant] has not received treatment over the last four and a half years, he has been symptomatic during this time. I feel that it is medically probable that his recent flare-up was related to the 1986 injury." (Ex. 20).

We conclude that claimant has carried his burden to prove that his 1986 injury is a material cause of his current low back condition. See Robert E. Leatherman, supra.

The next inquiry is whether the insurer carried its burden of proving its assertion that the off-the-job bicycle ride is the major contributing cause of the worsened condition. See ORS 656.273(1); Roger D. Hart, supra. As previously discussed, Dr. Roy based his opinion on claimant's history of continuing pain since the 1986 incident and the fact that the current worsened condition did not occur during the bicycle ride but arose spontaneously several days later. He explained that the 1986 injury predisposed claimant to the likelihood of a later disc herniation. We did not find the other medical opinions on causation, by Drs. Woolpert and Jarvis, to be persuasive. Accordingly, we conclude that the insurer has failed to prove that the major contributing cause of claimant's worsened condition was the off-the-job bicycle ride.

We also find that claimant has proved the worsened condition with medical evidence supported by objective findings. Dr. Roy diagnosed a worsening of claimant's low back condition based on expert analysis of his examination findings and claimant's reported symptoms. Such evidence meets the definition of "objective findings." See Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991); Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991).

We are also persuaded that claimant experienced an increase in low back symptoms in November 1990 that rendered him less able to work than at the time of the June 1986 Determination Order. 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). We conclude that claimant has established a general reduction in his ability to work.

Here, claimant was awarded no permanent disability compensation when his claim was closed on June 25, 1986. Claimant testified that, although he continued to have recurrent low back pain after returning to work pulling greenchain following the 1986 incident, he was able to work and did not seek treatment until November 1990. In November 1990, he experienced severe low back pain with pain radiating into the right leg. Even though claimant lost only one day from work, Dr. Roy concluded that he will probably develop further back symptoms in the future, and restricted him from heavy lifting and repetitive use of the low back. Accordingly, we find that claimant has established a worsened low back condition since the last award of compensation. Consequently, we find claimant's aggravation claim compensable.

Penalty and Attorney Fees for Failure to Process

Claimant contends that the insurer's failure to process his aggravation claim was unreasonable. We agree.

Penalties may be assessed when a carrier "unreasonably delays acceptance or denial of a claim." ORS 656.262(10). ORS 656.273(6) provides that an aggravation claim shall be processed by the insurer in accordance with the provisions of ORS 656.262. The carrier has 90 days within which to accept or deny a claim. ORS 656.262(6).

On December 14, 1990, the carrier received copies of Dr. Roy's progress reports which included objective findings; and, on March 4, 1991, it had received a response to its query, in which Dr. Roy attributed claimant's worsening to the 1986 injury. Because the insurer's failure to process is unexplained, it is unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984). However, there is no evidence of unpaid compensation due at the time of the insurer's failure to process. Consequently, claimant has not proved that there were amounts "then due," supporting a penalty in this case. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988); Jeffrey D. Dennis, 43 Van Natta 857, 858 (1991).

Nevertheless, ORS 656.382(1) warrants an attorney fee when a carrier engages in conduct which constitutes unreasonable resistance to the payment of compensation, when there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Here, as we have noted, the insurer did not timely accept or deny claimant's aggravation claim. Its unexplained nonaction had the effect of delaying benefits under the compensable claim. Therefore, the insurer unreasonably resisted the payment of compensation to claimant and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. See Richard J. Stevenson, 43 Van Natta 1883, 1884 (1991).

Having considered the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services concerning the failure to process the claim is $300. In reaching this decision, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this

case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,200, 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 appellate briefs, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 2, 1992 is reversed. The insurer's de facto denial of claimant's aggravation claim is set aside and the aggravation claim is remanded to the insurer for processing according to law. For services regarding the aggravation issue at hearing and on review, claimant's attorney is awarded an assessed attorney fee of $3,200, to be paid by the insurer. Regarding the insurer's unreasonable claim processing, claimant's attorney is awarded a reasonable insurer-paid fee of $300.

In the Matter of the Compensation of
MAXIMINO MARTINEZ, Claimant
WCB Case No. 91-03359
ORDER ON REVIEW
Angelo Gomez, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Barber's order which upheld the insurer's denial of claimant's low back condition. On review, claimant requests that we remand this case to the Referee for the taking of additional evidence on the ground that translation at the original hearing was inadequate. 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

Claimant moves to remand this case to the Referee for the taking of additional evidence on the ground that translation at the original hearing was inadequate. Specifically, claimant contends that the Referee's finding that both claimant and his witness lacked credibility was based on their hearing testimony, which claimant alleges was inaccurately translated. Therefore, claimant requests remand for the taking of additional testimony with the aid of a more accurate interpretation.

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). A compelling basis 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 consider the proffered evidence only to determine whether remand is appropriate.

Claimant submitted portions of the record in which he identified alleged inaccuracies in translation. After our review of the proffered evidence, we find that the only significant discrepancy in meaning concerned claimant's testimony regarding his ability to drive a car following his alleged injury.

Claimant identified portions of the record where his testimony was inaccurately translated to indicate that he cannot drive a car, while claimant alleges he testified that he cannot drive a lot. (See Tr. 19-20). Claimant also testified that he does sometimes drive, but after the injury he drives less. (See Tr. 20-21). The Referee noted the apparent inconsistency, and it apparently formed part of the basis for his credibility finding. However, this discrepancy in testimony was not the Referee's sole basis for finding claimant lacking in credibility.

The Referee based his credibility finding on claimant's demeanor at hearing, as well as on substantive discrepancies in the record. Although the Referee has no advantage in evaluating inconsistencies in the record, we generally defer to his credibility evaluation based on his observation of the witnesses' demeanor at hearing. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). The Referee found that claimant's behavior at hearing, when compared with his behavior on videotape (Ex. A), grossly exaggerated his disability and indicated an intent to deceive the Referee regarding his present physical condition. We defer to this aspect of the Referee's credibility finding, since we have no basis for comparing claimant's behavior at hearing with the videotape.

The Referee concluded that based on the impeachment evidence in the videotape alone, claimant was not credible. Because he found claimant dishonest in part, he disregarded the remainder of claimant's testimony, including his testimony that he sustained a work injury.

Thus, even if we were to find that claimant's testimony regarding whether he can drive a car was inaccurately translated, and that the inaccurate translation influenced the Referee's credibility finding, we do not find that remanding to the Referee is reasonably likely to affect the outcome of this case. Were we to disregard the Referee's credibility findings based on discrepancies between the witnesses' testimony and claimant's activities shown on the videotape, we would nevertheless find claimant not credible, relying on the Referee's credibility findings based on a comparison of the videotape with claimant's demeanor at hearing.

In addition, we find that discrepancies in claimant's description of the mechanics of his injury also undermine his credibility. Specifically, claimant testified at hearing that he fell from a ladder, while to medical personnel he described slipping and falling on a wet or greasy floor. (Compare Tr. 11 with Exs. 1, 2, 3, 5, 9-1, 13-1). Claimant also testified that he lost consciousness when he fell, but he first reported loss of consciousness to medical personnel when he changed his treating physician to Dr. Goldberg on January 9, 1991. (See Tr. 12, Ex. 10). We find that these discrepancies in the record further undermine claimant's credibility. Moreover, we find that claimant did not identify any inaccuracies in translation that would substantially alter the meaning of his testimony pertaining to the mechanics of his injury. For these reasons, we conclude that additional testimony, even with the aid of more accurate translation, is not reasonably likely to affect the outcome of this case.

Furthermore, even if we were to find that additional testimony is reasonably likely to affect the outcome of the case, we would also have to find that the evidence was not obtainable at the hearing before we can find a compelling basis for remand. Compton v. Weyerhaeuser Co., supra.

Here, we find that the evidence could have been obtained at the hearing. Claimant's English-speaking attorney could have objected at the hearing to inaccuracies in translation that materially affected the meaning of claimant's testimony. Although claimant's attorney does not speak Spanish, as claimant's counsel it is reasonable to assume that counsel was familiar with the content of claimant's testimony. Any material deviations from the expected testimony could have been clarified by additional testimony at the hearing. Accordingly, we find that the additional testimony claimant seeks to admit on remand could have been obtained with due diligence at the hearing. Claimant's 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).

Because we find that the additional testimony claimant seeks to admit on remand was obtainable with due diligence at the hearing, and because even if such evidence is admitted, it is not reasonably likely to affect the outcome of the case, we deny claimant's motion to remand.

Compensability

We affirm and adopt the Referee's order which upheld the insurer's denial of claimant's low back condition, with the following supplementation.

To establish a compensable injury, claimant must prove that he sustained an injury at work which required medical services or resulted in disability. In addition, he must establish his injury with medical evidence supported by objective findings. ORS 656.005(7)(a).

Here, we find that even if we were to accept claimant's testimony that he sustained an injury at work, his claim would fail because the injury was not established by medical evidence supported by objective findings. We agree with the Referee that there were no objective findings of an injury when claimant first sought treatment, either at the emergency room or when he treated with Dr. Gavlick five days after the alleged injury. (Exs. 2, 3). The first report of objective findings was on December 21, 1991 by Dr. Berovic, chiropractor. (Ex. 7). We do not find Dr. Berovic's chart note sufficient to establish the alleged injury, since Dr. Berovic does not relate his findings to the injury. (See Exs. 6, 7, 8). Furthermore, several medical examiners have found significant symptom magnification and subjective complaints unsupported by objective findings. (See Exs. 3, 9, 13). Dr. Berovic's findings do not account for potential symptom magnification; therefore, we do not find his chart notes persuasive. Accordingly, we find that claimant failed to establish his injury with medical evidence supported by objective findings.

ORDER

The Referee's order dated June 4, 1992 is affirmed.

In the Matter of the Compensation of
TERRIE G. PALUMBO, Claimant
WCB Case No. 91-12100
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Lipton.

The insurer requests review of those portions of Referee Hazelett's order that: (1) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree; (2) found claimant medically stationary as of January 18, 1991; (3) directed it to pay $537.20 in temporary disability benefits; and (4) awarded a penalty for its allegedly unreasonable failure to pay the latter. Claimant cross-requests review, seeking an attorney fee for enforcing the payment of $537.20. On review, the issues are rate of scheduled permanent disability, offset, enforcement, claimant's medically stationary date, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," "Stipulated Facts," and Findings of Ultimate 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, rev den 315 Or 271 (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 20, 1989 compensable injury. ORS 656.202(2); former ORS 656.214(2).

Medically Stationary Date

We adopt the conclusions and reasoning concerning the medically stationary date as set forth in the Referee's order.

Temporary disability/offset

The amount in controversy ($715.26 less 25 percent previously paid to claimant's attorney) became due pursuant to that portion of Referee Bethlahmy's October 3, 1991 order which found that claimant's temporary disability benefits had been paid at an incorrect rate. On review, we affirmed that portion of the order. See Terrie G. Palumbo, 44 Van Natta 2090 (1992). Thus, claimant is entitled to an additional $537.20. In the present case, Referee Hazelett directed the insurer to pay this amount.

The insurer first argues that it was entitled to stay payment of this compensation under ORS 656.313(1). Second, it contends that the Referee's order to pay $537.20 to claimant effectively creates an administrative overpayment, contrary to Lebanon Plywood v. Seiber, 113 Or App 651 (1992). We disagree with both contentions.

The Referee found that the insurer was not entitled to stay payment of this compensation under ORS 656.313, stating, "[t]he statute does not permit the insurer to rely on claimant's appeal of the order to justify withholding the compensation awarded by the Referee's order." (O&O p. 5, emphasis added). We agree. ORS 656.313 expressly states that payment of compensation is stayed upon filing of request for hearing, board review or court appeal "by an employer or the insurer." ORS 656.313(1)(a) (emphasis added). Accordingly, we adopt the Referee's opinion in this regard.

Concerning the insurer's second contention, we acknowledge that the Seiber court held that, "[i]f processing delay does not result in overpayment, the Board has no authority to impose one." 113 Or App at 654. Here, however, Referee Hazelett's enforcement of that portion of Referee Bethlahmy's order which directed the insurer to pay claimant temporary disability at a corrected rate does not create an overpayment. Rather, it enforces payment of temporary disability benefits to which claimant is entitled. Since the enforcement of Referee Bethlahmy's order awarding temporary disability compensation to which claimant is entitled does not "impose" or create an overpayment, Seiber does not apply.

Moreover, the issue here is not whether the insurer may recover an overpayment of TTD by offsetting it against current compensation benefits due. Rather, the issue is whether the insurer may do so without prior approval. Although the insurer did have authorization to offset overpaid temporary disability benefits accruing prior to Referee Bethlahmy's order, it did not have authorization to offset the temporary disability benefits awarded by Referee Bethlahmy.

Accordingly, we conclude, as did the Referee, that the insurer may not unilaterally recoup an overpayment, but must first obtain approval from the Evaluation Division, a referee or the Board. See Forney v. Western States Plywood, 66 Or App 155 (1983). In other words, there is no statute which authorizes unilateral action by an insurer to recover an overpayment in this situation. Argonaut Insurance Company v. Mock, 95 Or App 9 (1989). Consequently, we affirm Referee Hazelett's order requiring payment of the benefits withheld by the insurer.

Penalties

We adopt the portion of the Referee's order which addresses the penalty issue, on pages 4 and 5 of the Opinion and Order.

Attorney Fees

Although he was previously awarded 25 percent of the increased compensation created by Referee Bethlahmy's order, claimant's counsel contends he is entitled to an additional 25 percent of that same compensation for obtaining enforcement of Referee Bethlahmy's order. We disagree. Referee Hazelett did not award any further compensation. Rather, he ordered that the amount fixed by Referee Bethlahmy be paid. Inasmuch as no additional compensation was awarded by Referee Hazelett, claimant's counsel is not entitled to an additional out-of-compensation attorney fee. See OAR 438-15-055(1).

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the temporary disability and medically stationary date issues is $300, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated June 19, 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 is reversed. Claimant's scheduled award shall be paid at the rate in effect at the time of her compensable injury. The remainder of the order is affirmed. For services on review claimant's counsel is awarded an assessed attorney fee of $300, payable by the insurer.

In the Matter of the Compensation of
ROBERTO SANCHEZ, Claimant
WCB Case No. 90-16219
ORDER ON REVIEW
Kelley & Kelley, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Michael V. Johnson's order that affirmed a Determination Order awarding 30 percent (96 degrees) unscheduled permanent disability for a low back injury and no scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for lumbar strain and was awarded 30 percent unscheduled permanent disability. Claimant also has severe bilateral congenital club feet. The Referee affirmed the award granted by the Determination Order.

Extent of Scheduled Permanent Disability

Claimant first asserts that he is entitled to scheduled permanent disability for loss of use or function of his legs, contending that he showed diminished sensation and increased weakness in his right leg and radiation of pain into his hips. The medical evidence showed that sensation in the right calf was slightly diminished as compared to the left and that pain occasionally radiated into both hips. (Ex. 15-1). This evidence also reported claimant's statement that he had more strength in his left lower leg than the right. (Id. at 2).

The medical evidence did not clearly attribute the findings of diminished sensation and loss of strength to claimant's injury, as opposed to his unrelated club feet. Even if we assumed that such conditions were due to his injury, loss of surface sensation in the leg is not considered disabling, former OAR 436-35-230(1) (WCD Admin. Order 6-1988), and the applicable standards limit ratings for weakness to the foot and thigh, former OAR 436-35-230(5). Furthermore, we find no evidence that any loss of strength sustained by claimant as a result of his injury resulted in any disability which would otherwise entitle claimant to a scheduled permanent disability award. See former OAR 436-35-010(2)(a).

We agree, however, that claimant is entitled to a scheduled permanent disability award for radiation of pain into his hips. Pain was considered under the standards to the extent that it resulted in measurable impairment. Former OAR 436-35-010(2)(b). Furthermore, because the medical evidence found that the pain radiated into claimant's hips from his low back, we find that this condition was due to his injury. (See Ex. 15-1). The internal rotation of both hips was limited to 10 degrees, entitling claimant to a rating of 8 percent per hip. Former OAR 436-35-220(9). Claimant also demonstrated 45 to 50 degrees of external rotation of both hips, which does not entitle him to a rating. Former OAR 436-35-220(10). Claimant, therefore, is entitled to 16 percent scheduled permanent disability. Former OAR 436-35-220(11).

Because we have awarded additional permanent partial disability, claimant's attorney is entitled to 25 percent of the increased compensation, not to exceed $3,800, to be paid out of the increased compensation.

Extent of Unscheduled Permanent Disability

Claimant next contends that he is entitled to an award for a chronic condition based on the fact that his treating chiropractor, Dr. Buttler, restricted him from repetitively lifting and bending and twisting from the waist. (Ex. 7-2). Under former OAR 436-35-320(4), a worker received 5 percent impairment for "chronic conditions limiting repetitive use of an unscheduled body part." We conclude that Dr. Buttler's restrictions is evidence entitling claimant to impairment for a chronic condition. See Susan E. Vandusen, 43 Van Natta 2277 (1991) (claimant entitled to an award for a chronic condition limiting repetitive use of her low back based on IME's recommendation that claimant restrict repetitive bending).

Claimant next asserts that he is entitled to a higher adaptability rating than the factor of 4 found by the Referee. Claimant was restricted to lifting 15-20 pounds based on his back injury. (Ex. 15-2). Thus, claimant is entitled to an adaptability factor of 4. Former OAR 436-35-310(4)(c). Although Dr. Smith also recommended that claimant avoid standing for a long period of time and found that walking and carrying objects would be difficult, these findings were based on claimant's deformed feet. (Id.) Thus, these findings are not relevant in determining claimant's adaptability.

Finally, claimant contends that he is entitled to additional disability "outside" of the standards because he proved by clear and convincing evidence that his disability is greater than that provided by the standards. Former ORS 656.283(7), 656.295(5). Claimant bases this assertion on evidence by a vocational consultant that claimant's limited ability to speak English severely limits his access to jobs appropriate for his physical limitations since a majority of such work requires language skills beyond that possessed by claimant.

The Referee found that claimant was not fluent in English and was able to speak only a few simple words and phrases in that language. There also was evidence that it is 75 percent more difficult to locate and obtain suitable employment for a non-English speaking person compared to an English

speaking person. (Ex. 17A-2). We conclude that, even assuming that claimant's access to jobs is limited by language deficiencies, claimant's inability to speak fluent English is not a basis for finding that the degree of permanent disability is greater than his entitlement indicated by the standards.

Permanent disability benefits, both scheduled and unscheduled, are based on the permanent disability that results from an injury. ORS 656.214(2), 656.214(5). Claimant's limited English speaking ability preexisted his low back injury. There is no evidence that his injury had any effect on his speaking skills. Thus, claimant's limited access to the job market due to his inability to speak English was the same before the injury as it was after the injury. Therefore, because claimant's language skills are not related to his permanent disability that resulted from his injury, his inability to fluently speak English is not a basis for awarding additional permanent disability benefits.

We disagree that Daniel Mercado-Nuno, 42 Van Natta 2814 (1990), which claimant relies on, requires a contrary conclusion. In that case, we noted that the claimant was unable to read or write a simple message, finding that his "language handicap was such that he was never qualified to perform many jobs." We further found that claimant had lost 50 percent of his earning capacity, as opposed to the 24 percent awarded by a Determination Order.

We do not interpret the references to the claimant's "language handicap" in the Mercado-Nuno case as showing that permanent disability outside of the standards was awarded because the claimant's language skills affected his earning capacity. On the contrary, our order indicated that it determined earning capacity by considering the effect of the claimant's injury on various factors in comparison with those factors before the injury. The order clearly indicated that the claimant's access to the labor market previously available to him was substantially reduced based on his physical impairment that resulted from his injury. Thus, we do not find that the case supports claimant's assertion that he is entitled to additional permanent disability because he has limited English-speaking skills.

Furthermore, unlike the claimant in Mercado-Nuno, claimant here presents no evidence that his permanent disability due to the lumbar strain is greater than that provided by the standards. Consequently, we conclude that his assertion with regard to this issue fails.

Having awarded additional impairment for a chronic condition, we now compute claimant's unscheduled permanent disability. The parties do not dispute the Referee's finding that claimant is entitled to a value of 6 percent for range of motion. Adding that value with the 5 percent for a chronic condition results in an impairment value of 11 percent. There is no dispute that claimant's value for age and education is 6. Multiplying that value with claimant's adaptability factor of 4 results in a value of 24. To that value is added claimant's impairment value of 11 percent, for a total award of 35 percent unscheduled permanent disability.

ORDER

The Referee's order dated September 18, 1992 is modified. In lieu of the Referee's award and the August 2, 1990 Determination Order, which awarded no scheduled permanent disability, we award 18 percent (27 degrees) scheduled permanent disability for loss of use or function of the legs. Furthermore, in addition to the Referee's and Determination Order awards of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total of 35 percent (112 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
WILLIAM A. STRAMETZ, Claimant
WCB Case Nos. 91-17385 & 91-10418
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of that portion of Referee Lipton's order that upheld the SAIF Corporation's denial, on behalf of Spectrum Motorwerks Ltd. (a noncomplying employer), of claimant's occupational disease claim for malignant mesothelioma. In its brief, SAIF/Spectrum Motorwerks Ltd. (SAIF/SML) requests dismissal of claimant's request for review. SAIF, on behalf of Spectrum Motorwerks Inc. (SAIF/SMI), requests that it be dismissed as a party to this proceeding. On review, the issues are dismissal, compensability and responsibility.

We deny the motions to dismiss, and affirm and adopt the Referee's order with the following supplementation.

Motions to Dismiss

In support of its motion to dismiss claimant's request for review, SAIF/SML contends that the request for review did not vest the Board with jurisdiction to review the Referee's final order upholding SAIF's denials. We disagree.

By Opinion and Order dated April 2, 1992, the Referee upheld SAIF's denials. The order included a notice to the parties that they have 30 days to request Board review of the order. On April 7, 1992, claimant requested reconsideration of the order. On April 10, 1992, the Referee issued an Order on Reconsideration which supplemented the April 2, 1992 order and stated, in pertinent part: "The Opinion and Order of April 2, 1992 is affirmed as supplemented herein. Appeal rights will be extended to run from the date of this order." On April 14, 1992, claimant requested Board review of the Referee's order "dated the 10th day of April, 1992."

SAIF/SML argues that the April 2 order was neither abated nor republished by the Referee's April 10 order. It argues, therefore, that the April 2 order constituted the Referee's final, appealable order. Because claimant requested Board review of the April 10 order, but did not mention the April 2 order, SAIF/SML argues that the April 2 order became final by law and is not subject to our jurisdiction.

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

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

Here, the Referee's April 2 order was not expressly abated, stayed or withdrawn; however, it was modified by the April 10 order, which, in response to claimant's motion for reconsideration, affirmed the April 2 order "as supplemented." Inasmuch as claimant's request for Board review was mailed within 30 days of the issuance of the Referee's April 10, 1992 order and since the order modified the April 2, 1992 order, we conclude that we have jurisdiction to consider this matter. See ORS 656.289(3); Farmers Insurance Group v. SAIF supra; Michael A. Ferdinand, 44 Van Natta 1167 (1992); Robert D. Billick, 40 Van Natta 1041 (1988). Accordingly, SAIF/SML's motion is denied.

SAIF/SMI requests to be dismissed as a party to this proceeding on the grounds that the Referee found claimant not to be a subject worker while employed by SMI and that claimant does not challenge that finding on Board review. We deny the motion.

In claimant's response to the motion, claimant asserts that SAIF/SMI is responsible for his claim, if SAIF/SML is not. Therefore, claimant is maintaining his claim against SAIF/SMI. Further, because SAIF/SMI was a party at hearing and we have de novo review authority of the Referee's order, SAIF/SMI is not relieved of potential liability. That is, we could find SAIF/SMI liable for the claim based on our de novo review of the record, notwithstanding claimant's contentions on review. For these reasons, we conclude that SAIF/SMI shall remain a party on Board review. See Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992) (A party to a referee's order remains a party on Board review).

Compensability

When compensability and responsibility are both at issue, as in this case, the threshold issue is compensability. See Runft v. SAIF, 303 Or 493, 498-99 (1987); Elizabeth Coomer, 41 Van Natta 2300, 2302 (1990). In order to prove the compensability of his malignant mesothelioma, claimant must prove that work exposures were the major contributing cause of the mesothelioma. See Runft v. SAIF, supra, 303 Or at 499.

Dr. Dobrow, oncologist, opined that claimant's lifetime exposure to asbestos caused the mesothelioma. Dr. Dobrow explained, however, that there is generally a latency period of 30 to 40 years between the time of asbestos exposure to the onset of mesothelioma. Based on his research and experience, Dr. Dobrow added that he knew of no cases in which the latency period was less than 10 years. (Ex. 36-9).

Based on claimant's history of chest pains, Dr. Dobrow opined that the mesothelioma was in place as early as March 1990. Therefore, based on Dr. Dobrow's opinion, we find that the asbestos exposure causing the mesothelioma must have occurred by March 1980, or 10 years prior to onset.

The record shows that claimant was not employed by an Oregon employer on or before March 1980. Rather, prior to that time, claimant had been in the Navy and had been employed as a mechanic in California and Florida. Claimant was not employed in Oregon until 1984. (Ex. 8).

Based on the medical record, each and every potentially causal Oregon employment has demonstrated that it was impossible for them, individually or as a group, to have contributed o the causation of this condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Based on Dr. Dobrow's opinion that there is a 10-year latency period prior to the onset of mesothelioma, we find that claimant's work exposure while employed by any Oregon employer could not have contributed to the causation of the mesothelioma. Accordingly, claimant's condition is not compensable.

ORDER

The Referee's order dated April 2, 1992, as reconsidered April 10, 1992, is affirmed.

In the Matter of the Compensation of
ROSA L. SULFFRIDGE, Claimant
WCB Case No. 92-03603
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's partial denial of a gastrointestinal condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 55 years old at hearing, compensably injured her low back on February 10, 1988. On February 26, 1988, Dr. Golden, M.D., diagnosed acute lumbosacral strain with referred pain into the legs, without radiculopathy. Dr. Freeman, neurosurgeon, found evidence of degenerative arthritis and bulging discs at different levels, but no neurological compromise.

SAIF accepted a lumbosacral strain. The claim was closed by a March 2, 1989 Determination Order awarding 25 percent unscheduled disability compensation.

Claimant, who had sought treatment in 1988 from Dr. Sharp, osteopath, returned to him in March 1989, complaining that she was unable to sit while at school. Sharp diagnosed chronic low back pain and prescribed Ansaid, a non-steroidal anti-inflammatory, as well as Robaxin and Tylox. (Ex. 5a). In April 1989, claimant reported that Ansaid was effective for her back and leg pain. Sharp added Amitriptyline to claimant's prescription regime. (Ex. 6a).

On June 6, 1989, claimant was examined for SAIF by Dr. Woolpert, an orthopedic surgeon. Based upon his examination findings and claimant's medical history, he diagnosed chronic lumbar strain, minimal degenerative changes of the lumbar spine, and minimal spinal stenosis. He approved of claimant's current medication regime, although he recommended reduction to non-prescription drugs, given claimant's chronic pain pattern. (Ex. 6).

On June 20, 1989, claimant's unscheduled permanent disability award was increased to 37 percent.

On July 1, 1989, claimant was evaluated by Dr. Smith, neurosurgeon, who found lumbar stenosis at L4-5 and foraminal narrowing at L5-S1. He recommended surgical exploration and decompression.

Claimant returned to Dr. Sharp on December 4, 1989, complaining of continuing low back pain. Dr. Sharp continued to diagnose chronic pain syndrome and continued to prescribe Ansaid, Robaxin and Amitriptyline. He approved a refill of the prescriptions in January and again in March 1990.

During this period, claimant also used a back brace and a TENS unit for back pain.

On May 16, 1990, claimant was seen by Dr. Kullar, orthopedist, who reported extreme depression and found some desiccation at the L3-4 disc, but no significant stenosis. She also found tenderness to light touch and no spasm.

On September 13, 1990, Dr. Smith, neurological surgeon, opined that claimant had the same complaints as she had had in July 1989, when he first proposed low back surgery, based on x-ray evidence of stenosis. Nevertheless, after concluding that a 1990 MRI was reasonably normal, he ruled out stenosis, and withdrew his recommendation for surgery.

On November 30, 1990, Drs. Donahoo and Brown also evaluated claimant. They concluded that claimant's condition had not worsened and that her pain complaints were the major cause of her current need for treatment. They recommended against surgery.

On December 10, 1990, claimant was admitted to a hospital for black, tarry stools, nausea and vomiting of bloody material. She was diagnosed with upper gastrointestinal bleeding.

On December 11, 1990, Dr. Engstrom performed an endoscopic examination of claimant's upper gastrointestinal tract, which revealed erosive gastritis and duodenitis. (Exs. 8B & 11). After this incident, claimant discontinued taking Ansaid.

On December 27, 1990, Dr. Smith took issue with the report generated by Drs. Donahoo and Brown, stating that claimant had spondylotic changes and a chronic pain problem that should be surgically explored.

On February 15, 1991, Dr. Woolpert again performed an examination for SAIF. He diagnosed claimant with chronic lumbosacral sprain, degenerative disc disease of the lumbar spine, and spinal stenosis per x-ray report at L4-5. He concluded that claimant's condition had not worsened and that claimant's subjective complaints were due to her degenerative disc condition and stenosis.

A June 24, 1991 Opinion and Order upheld SAIF's denial of an aggravation claim and the surgery recommended by Dr. Smith.

On February 19, 1992, Dr. Heinonen, a gastroenterologist, reviewed claimant's medical records for SAIF. He concluded that claimant's gastrointestinal condition was caused by her use of Ansaid with no other significant contributing causes.

On March 11, 1992, SAIF issued a denial, stating:

> "You filed a claim for a work-related injury to your low back, which occurred on or about February 10, 1988, while employed at Pat's Kozy Kitchen. The claim was accepted for lumbosacral strain and benefits were provided according to law.
>
> "We have recently received information that you wish to reopen your claim because you feel your condition has worsened.
>
> "Information in your file indicates that the major cause of your condition, diagnosed as erosive duodenitis and erosive gastritis is your intake of medication related to a non-compensable degenerative lumbar stenosis condition. Therefore, we must deny your request to reopen the claim." (Ex. 16).

On May 3, 1992, Dr. Woolpert examined claimant a third time for SAIF. Woolpert's diagnoses were the same, including chronic lumbosacral sprain, degenerative disc disease and spinal stenosis. He found no worsening of claimant's underlying condition, and stated that if claimant's symptoms have worsened, it would be due to the natural progression of underlying degenerative changes or the results of a recent motor vehicle accident.

FINDINGS OF ULTIMATE FACT

Claimant's prescribed treatment with Ansaid is materially related to her compensable 1988 low back injury.

Claimant's 1988 compensable low back injury was the major contributing cause of her consequential gastrointestinal condition.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing regarding SAIF's March 11, 1992 partial denial of her gastrointestinal condition. Although SAIF's denial is couched in aggravation language, the Referee characterized the issue at hearing as compensability of the gastrointestinal condition or medical services for the same condition. Relying on ORS 656.005(7)(a)(A), the Referee concluded that the medical services for claimant's gastrointestinal condition were not compensable because the condition was not caused, in major part, by the compensable injury. We disagree and reverse.

On review, claimant contends that the pharmaceutical treatment of her accepted low back condition was the major contributing cause of her gastrointestinal disorder. SAIF, who concedes that claimant's intake of Ansaid caused her erosive duodenitis and gastritis condition (Resp. Brief at 2), contends that Dr. Sharp prescribed Ansaid for claimant's subjective complaints of general back and leg pain, not attributable specifically to a single condition supported by objective medical findings.

Claimant is entitled to medical services that result from her compensable low back injury. ORS 656.245(1)(a). Furthermore, because claimant's gastrointestinal condition was not directly caused by her compensable industrial injury, claimant must prove that her compensable industrial injury was the major contributing cause of her consequential gastrointestinal condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

Dr. Sharp has been treating claimant's compensable back condition since March 1988. On March 24, 1989, Dr. Sharp diagnosed chronic low back pain and prescribed Ansaid, a non-steroid anti-inflammatory medication, for treatment of that condition. He continued to prescribe Ansaid for that condition and claimant continued to take the drug on a daily basis as instructed until December 1990, when she was hospitalized with gastrointestinal bleeding. Dr. Sharp stated, without equivocation, that he had prescribed Ansaid primarily to treat claimant's compensable chronic lumbar strain. (Ex. 18a-2).

On this record, there is no reason to disbelieve or decline to rely on Dr. Sharp's assertion. There is no evidence that Dr. Sharp prescribed this drug primarily for spinal stenosis, a psychological condition, or for any condition other than claimant's chronic lumbar strain. The fact that Dr. Woolpert or any other physician may believe that Dr. Sharp misdiagnosed claimant's condition during the period of Ansaid treatment has no effect on the fact that Dr. Sharp prescribed the drug for claimant's compensable chronic lumbar strain. We have no reason to doubt Dr. Sharp's credibility on this issue.

Therefore, whether or not claimant required Ansaid for her compensable condition, her physician prescribed Ansaid for that purpose, claimant took the drug as prescribed, and it resulted in erosive duodenitis and gastritis.

We note that the issue of whether the treatment was reasonable and necessary is not before us.

Consequently, we conclude that: (1) the Ansaid prescriptions are compensable, in that the treatment was materially related to the compensable injury; and (2) claimant has met her burden to prove that her 1988 injury was the major contributing cause of her consequential gastrointestinal condition. ORS 656.245(1)(a); ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

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 $3,250, 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 10, 1992, is reversed. The SAIF Corporation's March 11, 1992 denial is set aside in its entirety and the claim is remanded to SAIF to process according to law. Claimant's attorney is awarded $3,250 for services at hearing and on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JOHN L. WILLHITE, Claimant
WCB Case No. 92-01633
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of Referee Myers' order which affirmed the Medical Director's order finding a proposed surgery to be inappropriate. On review, the issue is whether substantial evidence supports the Director's order. We affirm.

In his February 14, 1992 order, the Medical Director concluded that claimant's proposed L4-5 surgery was inappropriate. Under ORS 656.327(2), review of the Director's order is 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."

Substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988); Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992); Armstrong v. Asten-Hill Co., supra at 206.

Here, the record contains divergent medical opinions concerning the appropriateness of the proposed L4-5 microdecompression and microforaminotomy surgery. Dr. Berkeley, neurosurgeon and claimant's treating physician, recommends the surgery to treat advancing foraminal stenosis at the L4-5 level and to relieve claimant's radicular symptoms. Independent medical examiners Dr. Logan, orthopedist, and Dr. Kloos, neurosurgeon, believed the recommended surgery would provide only partial and temporary relief of claimant's symptoms, in light of his diffuse findings and previous surgeries which provided only temporary benefit. Dr. Michels, radiologist, interpreted the imaging studies as not revealing significant foraminal stenosis.

After conducting our review, we agree with the Referee's finding that the Director's order is supported by substantial evidence. We find that the record, viewed as a whole, would permit a reasonable person to find that the proposed surgery was inappropriate. Moreover, such a finding is reasonable in light of countervailing as well as supporting evidence. Therefore, the Director's order is supported by substantial evidence and is affirmed. ORS 656.327(2).

Claimant contends that the Director erred by not deferring to the treating doctor's opinion. Claimant relies on Weiland v. SAIF, 64 Or App 810 (1983), where the Court of Appeals, in conducting de novo review, announced that "[w]hen the medical evidence is divided, we have tended to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so." 64 Or App at 814. Although the Board adheres to this principle in weighing medical evidence, claimant points to no statute or rule which requires the Director to accord greater weight to the treating physician's opinion when medical evidence is divided. Accordingly, we find no error in the Director's order which found the opinions of the independent medical examiners to be more persuasive than the treating physician's opinion. See Queener v. United Employers Insurance, supra.

ORDER

The Referee's order dated July 10, 1992 is affirmed.

In the Matter of the Compensation of
JOHN G. WILLIAMSON, Claimant
WCB Case No. 91-12264
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of Referee Podnar's order that: (1) increased claimant's scheduled permanent disability award for the loss of use or function of the right foot from 5 percent (6.75 degrees), as awarded by Determination Order, to 18 percent (27 degrees); and (2) directed SAIF to pay the award at the rate of $305 per degree. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and supplement as follows.

SAIF accepted claimant's right leg stump cellulitis on May 16, 1988. (Ex. 6-2).

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Partial Disability

We affirm and adopt the Referee's conclusions and opinion on this issue, supplementing as follows.

An award of 15 percent impairment pursuant to OAR 436-35-200(4) requires objective medical evidence of inability to walk or stand for greater than two hours. Here, although Dr. McKillop stated that he could not provide objective findings for claimant's inability to walk or stand for greater than two hours, he nevertheless concluded that claimant was unable to walk or stand for more than two hours. (Cf. Exs. 20-4 and 20-2). Similarly, Dr. Thomas thought claimant's ambulatory potential was very limited (Ex. 14-3), yet his physical examination of the stump appeared negative: The stump looks good, without blisters or callouses, is non-tender, has full range of motion, no pain and the prosthesis is wearing well (Ex. 14-2). The record shows that each physician's conclusion regarding claimant's inability to walk or stand for more than two hours was based on his evaluation of the worker's description of his limitations, which is sufficient to establish "objective findings." Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992).

Rate of Scheduled Permanent Partial Disability Award

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 partially 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 extent of scheduled permanent disability issue is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 20, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that directed SAIF to pay claimant's scheduled permanent partial disability award at the rate of $305 and awarded an "out-of-compensation" attorney fee payable from this increased compensation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JEFFREY PULLEN, Applicant
WCB Case No. CV-93001
FINDING OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Allison Tyler, Attorney
Diane Brissenden, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Martha J. Brown, special hearings officer, on April 22, 1993 at Salem, Oregon. Applicant, Jeffrey Pullen, was present and represented by Allison Tyler. The Department of Justice Crime Victims' Compensation Program ("Department") was represented by Diane Brissenden, Assistant Attorney General. Janet Henson, claims examiner, was also present on behalf of the Department. The court reporter was Angela Trafton. Exhibits 1 through 14 were received and admitted into evidence, as well as certain exhibits received for impeachment purposes. The three documents submitted for impeachment purposes are marked and identified as: Exhibit A, a December 3, 1991 Clackamas County judgment, Exhibit B, a Clackamas County custody report, and Exhibit C, an Oregon State Police computer printout arrest record. The record was closed April 22, 1993.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated October 12, 1992 and December 4, 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 substantial contribution to his injury through the provocation of his assailant, and due to conflicting statements in the police report.

FINDINGS OF FACT

The following facts are not in dispute. On January 31, 1992, applicant filed an application for benefits with the Department. He claimed that he had been the victim of an assault on August 21, 1991. Specifically, applicant claimed that, "after a brief argument over campground noise," the suspect returned to applicant's campsite, "clubbed his friend and shot (applicant)."

On October 12, 1992, the Department issued its Findings of Fact, Conclusions and Order. The Department concluded that, because of conflicting statements in the police report and the victim's intoxicated state, the Department was unable to determine if the claim met the eligibility criteria as provided in ORS 147.015(5). Relying on ORS 147.015(5), the Department denied the claim for benefits.

On November 6, 1992, applicant requested reconsideration of the Department's decision. Applicant contended that, even if he had been involved in an altercation with the suspect, his actions did not establish "substantial provocation," which would justify the suspect's shooting him.

The Department issued an Order on Reconsideration on December 4, 1992, which adhered to its prior order. Thereafter, applicant requested timely review by the Workers' Compensation Board.

After reviewing the record and considering the testimony, I make the following findings concerning the facts which are in dispute.

On August 21, 1991, applicant and Keri Johnson arrived at the Pine Point campground at Timothy Lake, in the early afternoon. Applicant and Johnson were later joined by some acquaintances, Rick Buzis and "Jay." Applicant and the others spent the afternoon and evening canoeing and setting traps for crawfish. Applicant and his friends were also drinking during that time, and yelled at each other and played a car radio.

At approximately 9:30 p.m., the suspect, who was camping nearby, came over to applicant's campground and asked applicant and his friends to quiet down, as the suspect's group was getting ready to go to bed. Applicant and his friends agreed to quiet down, but they continued to make noise.

Approximately 15 to 20 minutes later, the suspect and a woman reappeared. One of applicant's friends warned the suspect to leave because "everybody was drunk and he might get hurt." The suspect hit Rick Buzis with a flashlight. After further words were exchanged, there was an altercation and the suspect shot applicant in the chest.

Applicant was admitted to the hospital approximately two hours after the shooting. His blood alcohol level was found to be .123. The following day, applicant underwent surgery to have the bullet removed from his chest/abdomen.

Following the shooting, Officer Long took a statement from Rick Buzis. Buzis told the officer that they had been drinking and were having a party and being loud. According to Buzis, the suspect initially came over to ask them to keep the noise down. The suspect returned approximately 15 minutes later and confronted them again. Buzis reported that he told the suspect to leave because they were drunk and he might get hurt. The suspect then hit Buzis along the side of the head and pulled out a handgun, pointed it at Buzis, and pulled the hammer of the gun back. Buzis stated that applicant "pushed the gun aside" and told him to take cover. Applicant and Jay argued with the suspect and told him to put the gun away. The suspect began to back up while pointing the gun at everyone. Buzis dove into some trees and then heard the gunshot.

Keri Johnson was stopped on his way back to town following the incident. Officer Lamothe took Johnson's statement. According to Johnson, their group had agreed to quiet down, but the suspect began to get "mouthy." Johnson stated that the suspect pulled a gun out. Johnson told applicant that "the guy's got a gun." The suspect and the woman accompanying him said that the gun was only a water pistol. Johnson stated that the suspect then shot applicant.

Approximately a week after the shooting, Officer Turner took the statement of Benjamin Hazelton, a counselor who was at the campground that night with a group of his students. According to Hazelton, he heard the argument and, intending to ask the group to quiet down, Hazelton went to applicant's campsite. He stopped about 10 to 15 feet away from the parties who were arguing. Hazelton stated that he heard a woman's voice say that they were scaring the kids, and asking the men to go away. Hazelton stated that he saw a man in a red shirt holding a flashlight and shining it in the face of a man in pink shorts. Hazelton reported that the man in the pink shorts looked and sounded intoxicated.

According to Hazelton, the man in pink shorts stated, "that's no water pistol, you can't have that here...put that away." The man in pink shorts then knocked the other man's flashlight away. The man in pink shorts came at the man in the red shirt and pushed him. As the man in the red shirt fell backward, the man in pink shorts came forward toward him. The man in the red shirt, who had fallen, stated that, "you shouldn't have done that." It was then that Hazelton heard the shot.

Hazelton believed that the men were 3 to 4 feet apart. He stated that, prior to the shooting, the man in the pink shorts "was pacing back and forth in front of the man in the red shirt, and on a couple of occasions he ... pushed the man in the red shirt." Hazelton thought that the only voice he heard arguing with the man in the red shirt was the man in the pink shorts.

Following the incident, Hazelton returned to his campsite and took his group back to the school.

On September 3, 1991, Officer Tuner took applicant's statement. According to applicant, he had been drinking a little wine and a couple of beers. Applicant stated that the evening of the altercation, the suspect initially came to the campsite to ask them to quiet down, as his wife and children were trying to sleep. Applicant agreed to quiet down, but the suspect returned and yelled at them, saying that they had not listened. After the suspect struck Buzis with the flashlight, the confrontation began.

The suspect then pulled a gun out from a bag, and applicant yelled to the others that he had a gun. The woman accompanying the suspect stated that it was only a squirt gun. Applicant stated that he had gone through some brush to get away, but when he heard it was a squirt gun, he returned and came back through the brush and stood in front of the suspect. After facing the suspect, applicant stated that it was at this point that he was shot as he "turned to run from the man after coming back to face him."

Applicant stated that he did not remember pushing the suspect down. He stated that he did not remember whether one of his friends confronted the woman accompanying the suspect. Applicant also denied that the language being used by his group was or could be considered to be offensive.

Charges against the suspect were dropped by the District Attorney's office.

CONCLUSIONS OF LAW

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

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

At hearing, applicant testified that throughout the day of the shooting incident, he had consumed 4 to 5 beers and some wine. He believed that, "to some extent," he was intoxicated. Applicant testified that, when the suspect reappeared at their campsite the second time, he ran into the bushes. Applicant stated that the suspect's flashlight was never shone in his face, and he would not have run back out of the bushes to face the suspect. Finally, applicant testified that he was wearing a white t-shirt, pink shorts and blue "footies" that evening. Applicant testified that Keri Johnson was wearing violet colored shorts and was not wearing a shirt.

Applicant's friend, Keri Johnson, testified that in his estimation, both he and applicant had consumed approximately 6 to 8 beers that afternoon and evening. He considered himself to have been intoxicated at the time. Johnson testified that the second time the suspect came back to their campsite, the suspect hit "Jay" with a flashlight. Johnson then told the suspect to get out of their campground. Johnson stated that he was approximately 4 to 5 feet from the suspect at that time. Johnson stated that the suspect either fell, or he may have pushed him. Johnson further stated that during that time, applicant was behind him. Johnson testified that he, not the applicant, was the one who knocked the flashlight away from the suspect. Johnson testified that applicant did not push the suspect during the confrontation.

After comparing the testimony to the record in this case, I conclude that there are numerous inconsistencies in the testimony of both applicant and Keri Johnson. For the following reasons, I do not consider such testimony to be reliable. Thus, I base my conclusions on the written record.

I conclude that applicant's testimony is not reliable for several reasons. First, there are inconsistencies concerning the amount of alcohol involved during the afternoon and evening prior to the shooting. Following the shooting, the officer who first contacted applicant noted that applicant had a "very strong odor of an alcoholic beverage and very red, bloodshot eyes." When interviewed by Officer Turner, applicant reported having had a "little wine" and a "couple" of beers during that time. Applicant reported to Officer Turner that he was not intoxicated at the time of the incident.

However, at hearing, applicant testified to having wine and 4 or 5 beers throughout the day, while Keri Johnson testified that applicant consumed between 6 to 8 beers. In light of the circumstances (and particularly applicant's blood alcohol level of .123), I conclude that applicant has been less than candid regarding the degree of his intoxication.

Next, I note that discrepancies exist with regard to applicant's testimony at hearing and statements previously obtained from Mr. Buzis and applicant concerning applicant's involvement in the confrontation. Mr. Buzis reported that applicant pushed the suspect's gun away. Furthermore, applicant himself reported to Officer Turner that, after running into the brush, applicant returned back to face the suspect. Yet, at hearing, applicant testified that he would not have run back to face the suspect.

I further conclude that, for the following reasons, the testimony of applicant's friend, Keri Johnson, is not reliable. First, Johnson testified that the suspect hit "Jay" with the flashlight. However, Richard Buzis reported that he was the one the suspect struck with the flashlight. Applicant's statement to the police also confirmed that it was Buzis who was struck with the flashlight.

Johnson testified that it was he, rather than applicant, who was primarily involved in the confrontation with the suspect. Johnson testified that applicant actually stood behind him during the confrontation. Yet, as noted above, both Buzis and applicant reported to the police officers that applicant was the one who faced the suspect. Furthermore, I note that none of the statements taken from any of the witnesses, including applicant, Buzis and Johnson, report any involvement on the part of Keri Johnson. Finally, there is no indication why Keri Johnson's alleged involvement or the alleged "misidentification" of applicant was not brought out in prior statements or at the time of reconsideration. Moreover, there has been no explanation of how applicant happened to be shot in the chest if he was standing behind Johnson during the confrontation.

As I find that neither applicant nor Mr. Johnson have provided reliable testimony, I next consider the written record. In particular, I rely upon the statement taken from Mr. Hazelton, an uninterested witness who was only 10 to 15 feet away while the altercation occurred. Applicant has conceded that he was wearing pink shorts on the night of the incident. Accordingly, I find it more likely than not that applicant was the person in pink shorts as described by Mr. Hazelton. I base this conclusion on Mr. Hazelton's description of the incident, particularly because applicant was wearing pink shorts on that night, and because applicant's wound to the chest/abdomen area is consistent with his proximity to the suspect as described by both Buzis and Hazelton. I further find that the location of claimant's wound is consistent with Hazelton's statement that applicant pushed the flashlight away, pushed the suspect, and was then shot.

I conclude that the facts of this case are similar to Billy Jack Kuykendall, 39 Van Natta 1120 (1987). In Kuykendall, the Department reduced the applicant's benefits on the ground that the applicant's conduct contributed to his injuries. Although the suspect initiated the confrontation, the applicant in Kuykendall exacerbated the situation by leaving the bar in order to fight the suspect. Once outside the bar, the applicant struck the suspect, and was then shot by the suspect. The Department, therefore, justifiably reduced the applicant's benefits. Kuykendall, supra.

In the present case, I conclude that applicant's conduct provoked, or at least contributed to his injury. Prior to the incident, applicant and his friends had been drinking and the noise from their campground disrupted other campers in the area. Furthermore, based upon Hazelton's statement, I conclude that applicant engaged in a verbal altercation with the suspect after the suspect appeared for the second time. Based upon Hazelton's statement that applicant pushed the suspect himself, I further conclude that applicant engaged in a physical altercation with the suspect.

Considering the fact that applicant was intoxicated and that he eventually engaged the suspect in verbal and physical confrontation, I conclude that the preponderance of persuasive evidence establishes that applicant's conduct contributed to the final outcome. Nevertheless, I am not persuaded that applicant's actions were sufficiently substantial so as to preclude him entirely from receiving benefits. Here, the suspect appeared twice at applicant's campsite, struck applicant's friend with a flashlight and then pulled out a gun and eventually shot the applicant at chest level. Consequently, I conclude that it was the suspect who primarily initiated the violent aspect of this incident and who also contributed to the escalation of the situation.

Accordingly, considering the statements of Buzis and Hazelton, I find that applicant's aforementioned conduct either provoked or, at least, contributed to his injury. See ORS 147.125(3). However, considering the excessive degree of force used by the suspect, who twice returned to applicant's campground to confront the group and who eventually shot applicant in the chest, I conclude that applicant's actions in responding to the situation were not sufficiently substantial to entirely preclude him from receiving compensation. See ORS 147.015(5); OAR 137-76-010(7), 8; Billy Jack Kuykendall, supra.

Under the circumstances, I find applicant eligible to receive an award of compensation under the Act. However, I find that, considering the circumstances described above, a 75 percent reduction in benefits is appropriate. See ORS 147.125(3).

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated October 12, 1992 and December 4, 1992, be reversed. I further recommend that applicant's claim for benefits be remanded to the Department with instructions to accept and process the claim in accordance with law. However, I recommend that applicant's benefits be limited to 25 percent of his medical and hospital expenses, up to the statutory maximum.

In the Matter of the Compensation of
ROBERT W. BANKS, Claimant
WCB Case No. 91-12156
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Nichols' order that increased claimant's unscheduled permanent disability award for a back injury from 1 percent (3.20 degrees), as awarded by a Determination Order and affirmed by an Order on Reconsideration, to 11 percent (35.20 degrees). The insurer cross-requests review of that portion of the Referee's order that found that the temporary rules adopted in WCD Admin. Orders 15-1990 and 20-1990 were invalid. On review, the issues are the validity of the rules, and extent of permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer has moved for reconsideration of our administrative ruling rejecting its request for an extension of the briefing schedule and the refusal to accept its respondent's brief as untimely. Asserting that its timely filed extension request was based on an office staff member's vacation and noting that claimant's attorney had no objection to the request, the insurer requests that its brief be considered. In light of such circumstances, we have granted the insurer's request and considered its brief on review. OAR 438-11-020(3).

Because claimant was declared medically stationary after July 1, 1990 and the Determination Order issued on December 3, 1990, 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 only the rules promulgated in WCD Admin. Order 6-1988.

The insurer asserts that the Referee lacked authority to declare the temporary rules invalid and that she was bound to apply them in determining the extent of claimant's permanent disability. We agree.

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 (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.

In accordance with Ferguson, we are statutorily required to apply the standards adopted by the Director at the relevant time. ORS 656.295(5); Eileen N. Ferguson, supra. As we found above, the applicable standards here are those contained in WCD Admin. Order 6-1988, as amended by WCD Admin. Orders 15-1990 and 20-1990. Thus, we address the extent of claimant's entitlement to permanent disability under those rules.

In evaluating the extent of claimant's permanent disability, the Referee declined to consider a post-closure "questionnaire" report from Dr. Newby, claimant's treating physician. Claimant objects to the Referee's decision, contending that the report should be considered under ORS 656.268(5). We need not resolve that question because even if the report was admissible, we would not find its "findings" to be persuasive.

Prior to claim closure, MedReview performed an independent medical examination. After describing claimant's ranges of motion (which indicated a slight reduction in lumbar extension), the MedReview panel concluded that there were minimal objective findings to substantiate claimant's subjective complaints. Determining that claimant's condition was medically stationary with no permanent impairment, MedReview recommended that he continue working in his normal capacity without any job sheltering or modification.

Dr. Newby agreed with the MedReview report. Concluding that claimant would eventually be able to return to his normal work capacity, Dr. Newby recommended that claimant begin on a light-duty basis.

Thereafter, the claim was closed by a Determination Order. Based on Dr. Newby's concurrence with MedReview's reduced range of motion findings, claimant was awarded 1 percent unscheduled permanent disability. Claimant requested reconsideration. Thereafter, an Order on Reconsideration affirmed the Determination Order.

At hearing, claimant submitted a post-closure "questionnaire" report from Dr. Newby in which the physician responded to "check-the-box" and fill-in-the-blanks" questions posed by claimant's counsel. The report noted claimant's retained range of motion findings in the thoracic and lumbar areas. In addition, Dr. Newby answered "yes" to questions regarding whether claimant had an unoperated L4-5 rupture, bulge or other disc derangement and whether claimant had a chronic condition. Finally, Dr. Newby rated claimant's physical capacity at "medium +2." The "questionnaire" provided no explanation for this apparent change in Dr. Newby's opinion from his prior concurrence with the MedReview report.

The Referee declined to consider the report. Nevertheless, after application of the disability standards in existence prior to the adoption of the temporary rules, the Referee increased claimant's unscheduled permanent disability award from 1 percent to 11 percent.

Relying on Dr. Newby's "questionnaire" report, claimant contends that his award should be increased to 30 percent. Assuming for the sake of argument that the report can be considered, we do not find the report and its findings to be persuasive.

As previously noted, Dr. Newby had agreed with the MedReview's report which found no objective findings to support claimant's subjective complaints and concluded that claimant had suffered no permanent impairment. In light of such a concurrence, Dr. Newby's conclusory "yes" and "retained range of motion" notations on a questionnaire without further explanation are insufficient for us to reject the MedReview findings to which Dr. Newby had previously concurred. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Arlene J. Koitzsch, 44 Van Natta 2067 (1992).

The Referee refused to apply the Director's temporary standards. Inasmuch as we have concluded that the decision was erroneous, we now apply those standards.

The MedReview report (as concurred in by Dr. Newby) establishes that claimant has 20 degrees of lumbar extension. Consequently, claimant is entitled to a value of 1 percent permanent impairment. Former OAR 436-35-360(7).

The Referee also awarded 4 percent for an unoperated L4-5 rupture, bulge, or other disc derangement. Yet, no value is given for such a condition under the applicable Director's temporary disability standards. Former OAR 436-35-350(2). Consequently, claimant's permanent impairment totals +1.

As found by the Referee, the record does not establish that claimant either earned or acquired a high school diploma or GED certificate. Therefore, claimant is entitled to a value of +1. Former OAR 436-35-300(3)(b).

The highest SVP for a job performed by claimant during the 10 years preceding the time of determination is (2) as a green chain offbearer (DOT 663.686-018). Such a SVP entitles claimant to a value of +4. Former OAR 436-35-300(4)(e).

Prior to his compensable injury, claimant could perform medium work. Following his injury, he could also perform medium work. Thus, claimant is entitled to an adaptability value of +1. Former OAR 436-35-310(3)(d).

The education and training values are added (1 + 4) and their total (5) multiplied by claimant's adaptability value (1). The product of these calculations (5) is added to claimant's permanent impairment value (1) for a total of 6. Accordingly, the Referee's 11 percent unscheduled permanent disability award is reduced to 6 percent.

ORDER

The Referee's order dated January 15, 1992 is modified. In lieu of the Referee's award, and in addition to the Order on Reconsideration award of 1 percent (3.2 degrees), claimant is awarded 5 percent (16 degrees) for a total award to date of 6 percent (19.2 degrees) unscheduled permanent disability. Claimant's attorney fee shall be modified accordingly.

June 14, 1993 Cite as 45 Van Natta 1163 (1993)

In the Matter of the Compensation of
JAMES BILLINGS, Claimant
Own Motion No. 92-0651M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Whitehead, et al., Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our April 15, 1993 order on reconsideration in which we continued to decline to reopen claimant's claim for temporary disability benefits on the basis that he had not established that he was in the work force at the time his compensable low back injury worsened in August 1992. Claimant argues that he remained in the work force because he was helping with his wife's nutritional business. With his request for reconsideration, claimant submits a copy of his wife's 1992 tax return, copies of room rental contracts for the business, and copies of attendance sheets for training sessions held for the business.

On May 4, 1993, we abated our prior orders (January 29, 1993 Own Motion Order; February 26, 1993 Own Motion Order on Reconsideration; April 15, 1993 Second Own Motion Order on Reconsideration) and allowed the insurer an opportunity to respond to claimant's motion. We have received the insurer's response and proceed with our reconsideration.

In Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989), the court listed three situations where a claimant is deemed to be in the work force: (1) the claimant is engaged in regular gainful employment; (2) the claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or (3) the claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because a work related injury makes such efforts futile.

A worker who has voluntarily withdrawn from the work force at the time of a compensable worsening of a work injury is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). The critical time for determining whether claimant has withdrawn from the work force is at the time of his disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990). Claimant has the burden of proving that he was in the work force at the time of his disability.

In order to establish entitlement to temporary disability benefits, claimant must prove that he was in the work force at the time his compensable condition worsened. Here, in August 1992, claimant's compensable injury worsened requiring surgery.

Previously, claimant submitted tax information which indicated that he was self-employed during 1990 and 1991. However, although that information established that claimant was in the work force during those years, it did not establish that he was in the work force at the time of his worsening in August 1992. Also, claimant contended that he was in the work force during the relevant period because, although he remained willing to work, he was unable to work or seek work in 1992 due to his compensable injury.

Dr. Poulson, who became claimant's treating orthopedist, first examined claimant on August 24, 1992 and provides the only evidence regarding claimant's ability to work in 1992. In a letter dated December 15, 1992, Dr. Poulson stated that claimant "has been on off work status since 8/24/92." In a "follow-up treatment form" dated January 5, 1993, Dr. Poulson stated that claimant "isn't working - can't - too much pain" and noted that time loss was authorized from December 1, 1992. Finally, in response to an inquiry from claimant's attorney, Dr. Poulson checked a box indicating that it would have been futile for claimant to look for work since he was last self-employed. However, Dr. Poulson also added the explanation "I do think he was capable of sedentary work."

We do not question Dr. Poulson's releases from work and his statement that claimant is not working due to pain. However, these do not establish that claimant was in the work force at the time of his worsening in August 1992. In addition, Dr. Poulson stated that claimant was able to do sedentary work between the period of his last self-employment in 1991 and his worsening in August 1992. Thus, the medical record does not support claimant's contention that, since his last period of self-employment, he was unable to work or seek work due to his compensable injury.

Apparently as an alternative argument, claimant also contends that he remained in the work force at the time of his worsening because he helped with his wife's part-time nutrition business. As proof of this contention, he submits copies of: (1) his wife's 1992 tax form for her sole proprietorship (Form 1040, Schedule C); (2) room rental contracts with Chemeketa Community College for September 28, 1992, October 5 & 26, 1992, November 2 & 23, 1992, January 26, 1993, February 22, 1993, and March 22, 1993; and (3) sign up sheets indicating that claimant was a speaker at training sessions held on October 5, 1992, November 2, 1992, December 15, 1992, and January 26, 1993.

This information fails to establish that claimant was in the work force at the time of his worsening in August 1992. First, the information does not relate to the relevant time period. Second, Dawkins v. Pacific Motor Trucking, supra, provides that one of the conditions in which claimant is deemed to be in the work force is when he "is engaged in regular gainful employment." Here, there is no indication that claimant has any ownership interest in the nutritional business. In fact, claimant's wife is the sole proprietor of that business. In addition, claimant provides no evidence of any earnings or wages paid to him. We do not find that claimant's occasional participation in training sessions for his wife's business without any indication of payment for his services amounts to "regular gainful employment."

Thus, on this record, we continue to find that claimant has not established that he was in the work force at the time of his compensable worsening. Accordingly, our prior orders are abated and withdrawn. As supplemented herein, we adhere to and republish our prior orders in their entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD M. JOHNSTON, Claimant
WCB Case No. 92-06585
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

The insurer requests review of those portions of Referee Daughtry's order that awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a neck and left shoulder injury, whereas an Order on Reconsideration had awarded no permanent disability. In his brief, claimant cross-requests review, seeking an award of scheduled permanent disability for loss of use or function of the left forearm. On review, the issues are extent of unscheduled and scheduled disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 15 percent loss of earning capacity as a result of his neck and left shoulder injury.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We affirm the Referee's opinion on the issue of unscheduled permanent disability, with the exception of the paragraph rejecting the medical arbiter report. We substitute the following.

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-35-007(9). After our review of the record, we conclude that the "Phase II Discharge Status" report by Dr. Holmes, with which Dr. Bernstein, claimant's attending physician, concurred, is more persuasive than the report by the medical arbiter for the following reasons.

Claimant participated in pain center treatment where it was noted that he did, indeed, have a pain syndrome, but his over-responsiveness to pain made it difficult for claimant to learn to manage his pain. (Exs. 27 and 31). Although Dr. Holmes noted in the Discharge Status report that claimant had discrepancies and inconsistencies in his cervical and left shoulder range of motion during the pain center program, and over-represented his pain, Holmes nevertheless provided objective measurements of range of motion, which indicate that claimant does have permanent impairment. Furthermore, Dr. Holmes concluded that claimant had greater physical capacities than shown in his testing and accordingly rated claimant as capable of light work. (Ex. 36-2). In contrast, Dr. Stanford, the medical arbiter, simply discounted his range of motion findings based on his conclusion that they were entirely negated by claimant's inconsistencies and did not evaluate claimant's work capacity, nor disagree with the other doctors' conclusion that claimant was capable of no more than light work.

We are more persuaded by the findings of Dr. Holmes who took into account claimant's personal characteristics and assessed claimant's impairment consistent with those characteristics. We accordingly conclude that a preponderance of medical opinion establishes a different level of impairment from that found by the medical arbiter. See OAR 436-35-007(9). Therefore, we rely on the impairment values concurred in by claimant's attending physician (Bernstein) as found in Dr. Holmes' Discharge Status report.

Scheduled Permanent Disability

We adopt the Referee's opinion on this issue.

Assessed Attorney Fee

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 $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 26, 1992 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

June 24, 1993 Cite as 45 Van Natta 1166 (1993)

In the Matter of the Compensation of
KATHERINE L. HUNT, Claimant
Own Motion No. 93-0145M
OWN MOTION ORDER ON RECONSIDERATION
Cash Perrine, Claimant Attorney
Saif Legal Department, Defense Attorney

The claimant requests reconsideration of our April 30, 1993 Own Motion Order in which we denied the reopening of her claim for temporary total disability benefits on the ground that she was not in the work force at the time of her disability. On June 1, 1993, we abated our order to allow the SAIF Corporation an opportunity to respond. SAIF's response has been received.

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 the work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof regarding the work force issue.

In January 1993, claimant's condition worsened requiring surgery. Therefore, the relevant question is whether claimant was in the work force as of January 1993, the time of her disability. Weyerhaeuser v. Kepford, supra. Claimant contends that she was in the work force at the time of her disability. In support of this contention, claimant submits a supplemental affidavit dated May 28, 1993 and several medical reports and chart notes.

Claimant has a compensabe cervical, lumbar spine and left knee condition. In her May 28, 1993 affidavit, claimant states that Drs. Maloney and Wigle indicated to her that it was impossible for her to return to gainful employment because of her back and knee conditions. However, claimant submits no evidence from either doctor to support her statement. Although she submits several medical reports and chart notes, none of these documents address her ability to work. The only mention of work in the evidence submitted by claimant is contained in a April 8, 1992 chart note signed with the initials "RPW," which might indicate that it was from Dr. Wigle. However, this chart note simply states that claimant "is presently not working." It does not discuss the reason for claimant's unemployment or indicate that claimant is physically unable to work due to the compensable injury. Therefore, we do not find that the record supports claimant's contention that Drs. Maloney and Wigle found that claimant was unable to work due to the compensable back and knee injury.

Furthermore, following a January 10, 1990 hearing, Referee Neal issued an order which found that Drs. Maloney and Carlson released claimant to sedentary work. There is no indication that Referee Neal's order was appealed. This is the last evidence in the record regarding claimant's ability to work. In her April 6, 1993 affidavit, claimant acknowledged that Dr. Maloney had released her to sedentary work, although claimant stated that she had been unable to find any work for which she was qualified. There is no evidence in the record that Drs. Maloney and Carlson changed their opinion regarding claimant's ability to do sedentary work.

In her May 28, 1993 affidavit, claimant lists several noncompensable conditions that she implies effect her ability to work. These include: anxiety, depression, asthma, allergies, bursitis in her left shoulder, diabetes, ulcers, and problems sleeping. She also notes that she has a compensable carpal tunnel syndrome claim with an earlier employer. However, pursuant to Dawkins, supra, "[a] claimant who is not employed, is not willing to be employed, or, although willing to be employed, is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force." Dawkins, supra, (emphasis added). Thus, claimant's non-compensable conditions are not relevant to the question of whether the work-related injury would make reasonable efforts to find employment futile. In any event, as noted above, the record does not establish that reasonable efforts to find work would be futile -- claimant was last released to sedentary work.

In her May 28, 1993 affidavit, claimant also states that, after she was released for sedentary work, she applied for work at several businesses without success. She also states that she contacted the Employment Service and was told that, because of her injuries, it would be difficult to find an employer who would give her an opportunity to work. However, claimant gives no dates regarding these applications for work other than to state that they were made "after [she] was released for sedentary work." Given the fact that a Referee Neal's order found that claimant was released to sedentary work as of the January 1990 hearing and had not looked for work since 1985, these applications could have been made any time after January 1990. As noted above, claimant must prove that she was in the work force at the time of her worsening in January 1993. Claimant presents no evidence that these applications occurred during the relevant time period.

Finally, claimant states that she would enjoy working if she were physically able to do so. However, Referee Neal's order found that claimant had shown little inclination to work since last working in 1984 and had not sought work since 1985. Also, in March 1990, claimant's return-to-work assistance was ended because she failed, after written warning, to cooperate in the development of a return-to-work plan. OAR 436-120-045(7). Given this history, claimant's statement that she was willing to work is inadequate to satisfy her burden of proof without corroborative evidence to demonstrate that her attitude toward returning to the labor market had changed since Referee Neal's January 24, 1990 Opinion and Order and the March 1990 termination of vocational assistance. Arthur R. Morris, 42 Van Natta 2820 (1990).

Accordingly, our April 30, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 30, 1993 order in its entirety effective this date. The parties rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS W. WILES, JR., Claimant
WCB Case Nos. 91-10073 & 91-07584
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Philip L. Nyburg, Defense Attorney
Gary Wallmark (Saif), Defense Attorney

Liberty Northwest Insurance Corporation has requested reconsideration of that portion of our March 4, 1993 order that directed it to pay claimant's attorney an assessed fee for services at hearing. Liberty contends that the fee should, instead, be assessed against the SAIF Corporation. In order to further consider Liberty's motion, we withdrew our order on April 1, 1993. Claimant has submitted a response to the motion. We now proceed with our reconsideration.

In our prior order, we affirmed that portion of the Referee's order that held that Liberty, which had accepted claimant's claim for a right knee injury in 1988, had carried its burden of proving that claimant sustained a new compensable injury with SAIF's insured in 1991 so that further responsibility for the knee condition had shifted to SAIF pursuant to ORS 656.308(1). We also awarded claimant's attorney an assessed fee payable by Liberty, reasoning that although SAIF was ultimately found responsible for claimant's condition, claimant had prevailed against Liberty's denial to the extent that it denied that his condition is compensable; i.e., work related.

Liberty contends that it did not deny that claimant's condition and need for treatment were work related, only that his condition had not worsened so as to prove an aggravation. We agree.

In response to claimant's aggravation claim, Liberty issued a denial letter on September 10, 1991, which provided, in relevant part:

> "To date, we have not received information indicating a worsening of your condition. Therefore, no aggravation claim has been established.
>
> "Any responsibility for your current condition and treatment would be expressly limited to medical treatment only.
>
> "Therefore, we must respectfully deny responsibility and compensability of your current condition and need for treatment as being related to your January 26, 1988 claim." (Ex. 25).

The language of the denial letter is slightly ambiguous. While the second paragraph suggests that Liberty is accepting responsibility for claimant's medical treatment, the third paragraph expressly denies the compensability of claimant's condition and need for treatment.

At hearing, Liberty's counsel clarified its denial by stating:

> "Our position, to try to make it as clear as I can, is that responsibility for medical care, [ORS] 656.245 benefits, is in issue; compensability of medical care is not in dispute, but compensability of an aggravation claim is in dispute, as against Liberty Northwest/Huffman & Wright; and entitlement to time-loss benefits is in dispute, and compensability is in issue there." (Tr. 3, emphasis added).

Thus, Liberty conceded prior to hearing that claimant's need for treatment (i.e., current condition) is compensable. Liberty denied only that it is responsible for that condition and that the condition had worsened so as to entitle claimant to temporary disability benefits.

Under these facts, this case is controlled by our decision in John L. Law, 44 Van Natta 1619 (1992) (on reconsideration). There, the claimant filed claims against two carriers for his condition. One carrier denied only responsibility for the claim; the other denied both compensability and responsibility, thereby preventing issuance of an order designating a paying agent pursuant to ORS 656.307. On the day of hearing, the latter carrier conceded that the claim was compensable, and the parties proceeded to hearing on the responsibility issue only. We held that the claimant was not entitled to an assessed attorney fee under ORS 656.386(1) for his attorney's services at hearing, because compensability of the claim was conceded prior to hearing, leaving responsibility as the sole issue, and because a hearing was held. John L. Law, supra, 44 Van Natta at 1620. See also International Paper Company v. Riggs, 114 Or App 203 (1992); Multnomah School District v. Tigner, 113 Or App 405 (1992).

Here, both Liberty and SAIF conceded prior to hearing that claimant's condition and need for treatment were compensable, and they proceeded to litigate responsibility for that condition and treatment. Although Liberty continued to deny the compensability of an aggravation (i.e., a worsening of his condition), claimant did not prevail against that aggravation denial and would, therefore, not be entitled to an assessed fee under ORS 656.386(1). Accordingly, because the compensability of claimant's condition was conceded prior to hearing by both SAIF and Liberty, and a hearing was held, claimant is not entitled to an assessed fee under ORS 656.386(1).

In this regard, we reject Liberty's contention that SAIF placed compensability at issue at hearing by arguing that claimant's condition was due, in major part, to a preexisting condition. (See Tr. 4). The "preexisting condition" to which SAIF referred is the 1987 compensable injury claimant sustained while working for Liberty's insured. Thus, SAIF was essentially asserting that Liberty, as the last insurer with an accepted injury claim, remained responsible for claimant's condition. SAIF did not assert that claimant's condition is not compensable. Accordingly, we do not find that SAIF placed claimant's compensation at risk.

On reconsideration, we affirm the Referee's order in its entirety. As modified herein, we adhere to and republish our March 4, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WARREN D. BATTLE, Claimant
WCB Case No. 92-00768
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband, Kinsley, and Hooton.

Claimant requests review of Referee Brazeau's order that: (1) upheld the insurer's unilateral termination of claimant's temporary disability compensation; and (2) declined to assess a penalty for the insurer's allegedly unreasonable refusal to pay compensation. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

Dr. Olson released claimant to light duty work on October 15, 1991, rather than October 14, 1991. (Ex. 9A).

Prior to surgery, claimant bought a non-refundable airline ticket to Texas to visit his mother, leaving November 21, 1991, the day after his right carpal tunnel release surgery, and returning Saturday, December 7, 1991. The ticket provided a $75 penalty in the event that it was used earlier than December 7, 1991. When he bought the ticket, claimant did not know of any specific day when he would be permitted to return to work. (Tr. 21). Claimant's post-surgery appointment with Dr. Ure was on Tuesday, December 10, 1991, after he returned from Texas. (Tr. 92).

On November 26, 1991, the employer tried to telephone claimant in Oregon regarding his return to work. The phone call was relayed to claimant in Texas by his domestic associate, Ms. Rhodes. Claimant called the employer, who discussed claimant's return to work after two weeks following surgery. (Tr. 22, 23 and 24). On December 3, 1991, claimant again called the employer, who told him that if he failed to return to light duty work that night (graveyard shift on December 4, 1991), it would be treated as a voluntary resignation. (Tr. 24 and 100). Claimant did not return to Oregon until December 7, 1991. He was fired and his temporary disability compensation was terminated effective December 4, 1991.

FINDINGS OF ULTIMATE FACT

Claimant did not return to regular or modified work. The attending physician did not give claimant a written release to return to regular work or modified work, nor did the employer offer such modified work to claimant in writing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's attending physician had approved his return to modified work, effective two weeks after his surgery, and concluded that the employer correctly terminated temporary disability payments because claimant failed to begin the work he was offered.

Claimant contends that he did not receive a written release from the attending physician to return to either regular or modified work. The insurer maintains that ORS 656.268(3) requires only that the attending physician prepare a written release, not deliver it to the worker. We disagree.

ORS 656.268(3) provides that an insurer may unilaterally terminate temporary total disability payments when one of the following events occurs: (a) the worker returns to regular or modified employment; (b) the attending physician gives the worker a written release to return to regular employment; or (c) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. We conclude that none of these conditions were met; therefore, the insurer unlawfully terminated claimant's temporary total disability benefits.

Here, claimant did not return to regular or modified work. Other than the release dated January 6, 1992, one month after claimant was terminated, there is no release contained in the record. Accordingly, there is insufficient evidence to prove that one existed prior to claimant's termination. Therefore, we cannot conclude that a release by Dr. Ure directed claimant to return to work on December 4, 1991.

Furthermore, claimant is not required to assume that he was to return to work after two weeks without either seeing or being read the written release. That release could have been relayed by a reliable third party, but there is no evidence that the employer (through Ms. Dobbins or Mr. Fuller), in fact, read the alleged complete attending physician's release, including his assessment that the offered modified work was within claimant's restrictions, when they spoke to claimant over the telephone. The only evidence regarding this matter refers merely to "a doctor's note." (Tr. 51 and 53).

In addition, there is no evidence that claimant's domestic associate, Ms. Rhodes, received a copy of the release at their house prior to claimant's termination and that she communicated the contents of the release to claimant if she got it. The only evidence in the file establishing that anything was mailed to claimant is a copy of a certified mail envelope dated December 3, 1991. (Ex. 12). Moreover, even if a copy of the release was in the envelope constructively received by claimant, by way of Ms. Rhodes, on December 4, 1991, that notice was not sufficient to trigger the insurer's cessation of temporary total disability payments allowed by ORS 656.268(3)(c), since, by that time, claimant had already been terminated and his opportunity to respond rendered meaningless. Furthermore, there is no evidence that claimant tried to avoid receiving a notice of any alleged work release by his physician. He initiated four or five calls to Ms. Dobbins and attempted to reach his physician once, but the doctor was unavailable. Moreover, there is no evidence that claimant missed the post-operative doctor's appointment to avoid getting a work release.

Inasmuch as the attending physician did not give the worker a written release to return to modified employment and the employer had not offered the modified work in writing to claimant, none of the requirements for unilateral termination of temporary total disability payments prior to claim closure have been met. Accordingly, we conclude that claimant is entitled to temporary disability benefits from December 4, 1991 until termination is authorized by law.

Penalty and Attorney Fees

Claimant is entitled to a penalty up to 25 percent of the amounts due if the insurer unreasonably refuses to pay compensation. ORS 656.262(10). Because there is no evidence in the record that any of the requirements for unilateral termination of temporary total disability prior to claim closure had been met, we conclude that the insurer's unilateral termination of temporary total disability payments was unreasonable. We, accordingly, assess a penalty of 25 percent of temporary disability benefits due through March 30, 1992, the date of hearing. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Of that amount, one-half shall be paid to claimant and one-half shall be paid to claimant's counsel, in lieu of an attorney fee. ORS 656.262(10)(a).

In assessing the penalty based on amounts of compensation due on the date of hearing, we are mindful of the Court of Appeals' recent decision in Conagra, Inc. v. Jeffries, 118 Or App 373 (1993). There, the employer denied the claim, and the claimant requested a hearing. Subsequent to the hearing, but before the referee had issued an order, the parties settled the claim and the employer agreed to process it. The parties stipulated that they would submit to the referee the question of whether a penalty should be assessed for an unreasonable denial. The referee found that the denial was unreasonable and assessed a penalty based on compensation due as of the date of the denial. On Board review, we affirmed the referee but stated that the penalty should be based on compensation due on the date of hearing.

The court reversed, holding that the penalty shall be based on compensation due on the date of the post-hearing stipulation withdrawing the denial. The court based its decision, in part, on the employer's concession that "amounts then due" for the purpose of assessing a penalty for an unreasonable denial are amounts due when the denial is set aside.[1] Id.

We find this case to be distinguishable from Jeffries. Here, the insurer did not recommence temporary disability benefits prior to issuance of the Referee's order, nor did it concede that a penalty, if assessed, should be based on compensation due if and when its termination of benefits was found to be improper.

Inasmuch as the insurer did not recommence the payment of benefits prior to hearing, we follow the same rule for assessing penalties that is applied in cases of unreasonable denials; that is, penalties are based on amounts due at the time of the hearing. See Wacker Siltronic Corporation v. Satcher, supra. That rule is consistent with the notions that the reasonableness of an insurer's conduct is judged on the basis of the evidence available at hearing and that the penalty must be proportionate to the wrong done. Insofar as the fact finder generally does not have evidence regarding the reasonableness of an insurer's post-hearing conduct, there is no factual basis to support a penalty based on amounts due after the hearing. For these reasons, as well as the fact that the Satcher rule has not been disavowed, we remain persuaded that a penalty for the insurer's unreasonable refusal to pay compensation is based on amounts due on the date of hearing.

ORDER

The Referee's order dated April 13, 1992, as reconsidered May 11, 1992, is reversed. The insurer is directed to commence payment of temporary disability benefits beginning December 4, 1991, until benefits may be terminated according to law. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The insurer is assessed a penalty of 25 percent of temporary disability benefits due through March 30, 1992, the date of hearing, to be equally divided between claimant and his attorney.

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[1] We note that the court in Jeffries cited to Weyerhaeuser v. Knapp, 100 Or App 615 (1990), as supporting authority for the employer's concession. However, we find the Knapp decision not to be controlling on the facts of this case. The issue in Knapp was not framed in terms of whether the penalty for an unreasonable denial should be based on compensation due on the date of hearing or the date of the order setting aside the denial (as is the issue in this case). Rather, the issue was whether the Board has the authority to base the penalty on compensation that will become due after the date of the order setting aside the denial. The court held that the Board did not have such authority. The court then went on to add that the penalty must be based on compensation due when the denial was set aside. Given the manner in which the issue was framed for the court, we find the court's latter statement distinguishes Jeffries from the present case. Further, in making that statement, the Knapp court cited to Wacker Siltronic Corporation v. Satcher, supra, in which the court stated, albeit indirectly, that a penalty for an unreasonable denial is based on amounts due at the time of the hearing. The citation to Satcher, therefore, supports the result in this case.

Board member Hooton concurring in part and dissenting in part.

I agree with the majority that the insurer's unilateral termination of temporary disability compensation was improper and unreasonable. I also agree with the assessment of a penalty for the conduct. I disagree, however, that the penalty is to be assessed as of the time of hearing. That conclusion thwarts the clear directive of the Court of Appeals to the contrary, and is inconsistent with the reasoning used by the majority to support its own conclusion. Instead, I would follow the courts' clear statement in Weyerhaeuser v. Knapp, 100 Or App 615 (1990), and in Conagra, Inc. v. Jeffries, 118 Or App 373 (1993), that a penalty for an unreasonable denial of benefits is to be assessed as of the time the denial is set aside.

I agree that the explanation of the court in Jeffries specifically indicates that the parties conceded that the penalty due in that case would be due as of the time that the denial was set aside. However, in light of the court's prior statement in Knapp, that concession is neither surprising nor unreasonable. It is simply an acknowledgement of what is, in fact, the law. In addition, the fact that the parties in Jeffries reached a stipulated agreement after the hearing but before the order has no discernable bearing on this issue, unless the majority means to suggest that an insurer who voluntarily rescinds a denial after a hearing but prior to the issuance of an order should be penalized to a greater degree than if they had awaited the issuance of the order. If anything, based on the voluntary attempt to right its own wrong, that penalty should be decreased.

I note that the majority argues that the date of hearing is the appropriate date for the assessment of the penalty, despite the clear language of Knapp to the contrary, because the denial is judged based on evidence presented at that time and the "penalty must be proportionate to the wrong done." I agree that the penalty must bear a reasonable relationship to the harm done. Kim S. Jeffries, 44 Van Natta

824, 826 (1992). However, if the insurer discovers new evidence to support its denial after the hearing is concluded, and the record closed, it is too late to present it. If the circumstances change so that there is a new basis for the termination of temporary disability after the date of the hearing, it would affect the "amounts due" upon which the penalty is based and would not distort the proportion to the wrong done.

As our reasoning in Jeffries would tend to indicate, an unreasonable denial is one which should never have issued in the first instance, or which should have been subsequently withdrawn at a determinable point in time. All of claimant's benefits withheld as a result of that denial are wrongfully withheld. The penalty is not reasonably related to the wrong done if it does not countenance all of the benefits withheld. By ignoring those benefits the entitlement to which accrued between the time of the hearing and the legal act which set aside the denial or affirmatively required payment, the majority does just that.

Here the legal act which affirmatively requires payment is the issuance of the Order on Review. While I am cognizant of the fact that reliance upon an incorrect order of a referee may have increased the amount of the penalty to be paid, by increasing the amounts due at the time of the order requiring payment, I direct the parties to a prior statement of the court which would appear to be precisely on point. "When an employer denies the compensability of a claim [or in this case unilaterally terminates temporary disability compensation], it takes the risk that that issue may be resolved against it. . . ." Vip's Restaurant v. Krause, 89 Or App 214, 217 (1988). (Emphasis added.)

June 28, 1993 Cite as 45 Van Natta 1172 (1993)

In the Matter of the Compensation of
TROY D. BJUGAN, Claimant
WCB Case No. 92-08461
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Lipton and Westerband.

Claimant requests review of Referee Peterson's order which upheld the SAIF Corporation's denial of claimant's right ankle injury. On review, the issue is compensability.

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

We agree with the Referee's determination that claimant's injury is not compensable because it occurred while he was engaged in a recreational activity primarily for his personal pleasure. ORS 656.005(7)(b)(B); Michael W. Hardenbrook, 44 Van Natta 529, aff'd mem 117 Or App 543 (1992).

Moreover, if we analyze claimant's injury under the unitary work connection test, we are persuaded that there was not a sufficient benefit to the employer to find a work connection between an injury occurring during a lunch break basketball game and claimant's employment. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985).

No one "Mellis factor" is dispositive. It is not dispositive that the injury occurred on the employer's premises during a paid lunch break. On the day of his injury, claimant participated in a training session, and he could have left the premises during his lunch break if he had chosen to. (Tr. 49). Although his superiors played in the game in which he was injured, claimant was neither required nor directed by his superiors to participate. (Id.) Claimant testified that he perceived that joining in the basketball game would help build rapport with his superiors. (Tr. 41-42). However, in order to constitute a benefit to the employer, the benefit must be beyond an improvement in employee health and morale. Steven M. Chambers, 42 Van Natta 2600 (1990). There is no evidence that the basketball game was part of the training session. Accordingly, we find that there was an insufficient work connection between claimant's employment and his injury in a basketball game during a lunch break. His claim is not compensable.

ORDER

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

In the Matter of the Compensation of
BETTY M. COOK, Claimant
WCB Case No. 92-09489
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Lipton and Gunn.

The SAIF Corporation requests review of Referee Neal's order that: (1) affirmed an Order on Reconsideration that increased claimant's unscheduled permanent disability award for a low back condition from 11 percent (35.2 degrees), as awarded by Determination Order, to 43 percent (137.6 degrees); and (2) awarded claimant an assessed attorney fee of $2,500 for prevailing against SAIF's hearing request. SAIF also requests that this matter be remanded to the Referee for cross-examination regarding the attorney fee request by claimant's counsel. On review, the issues are extent of unscheduled permanent disability, remand and attorney fees.

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

Extent

SAIF contends that claimant is not entitled to permanent disability benefits for the residuals of low back surgery performed on July 9, 1991, arguing that the surgery was required for noncompensable spinal stenosis. We disagree.

It is undisputed that claimant has preexisting spinal stenosis. When claimant experienced a severe onset of pain in the low back and legs following an April 23, 1991 work incident, she filed claims for her condition; one claim based on an occupational disease theory and the other based on an accidental injury theory. Both claims were denied. Claimant appealed the denials. A prior referee upheld the denial of an occupational disease claim, but set aside the denial of the injury claim. In so doing, the prior referee found that claimant sustained an industrial injury that was a material cause of her condition and need for treatment. The prior referee's order was not appealed and is final. (Ex. 5).

It is also undisputed that the preexisting spinal stenosis, which was asymptomatic prior to the compensable injury, combined with the injury to produce symptoms in claimant's low back and legs. The medical records show that the symptoms persisted until Dr. Smith recommended low back surgery. (Exs. 1, 3B). On July 9, 1991, Dr. Smith performed decompression lumbar laminectomy at L3-4 and L4-5, resulting in partial relief of symptoms. (Exs. 3, 3C).

The criteria for rating permanent disability is the permanent loss of earning capacity "due to" the compensable injury. ORS 656.214(5). Here, it is undisputed that claimant's surgery has resulted in a permanent loss of earning capacity. The dispute concerns whether the need for surgery was "due to" the compensable injury. Because claimant had a preexisting condition that combined with the compensable injury to cause a need for treatment, she must prove that the compensable injury was the major contributing cause of the resultant condition and need for surgery. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

The medical evidence is divided. Dr. Smith opined that the compensable injury was the major contributing cause of the need for surgery, reasoning that the injury caused the preexisting spinal stenosis to become symptomatic, ultimately requiring surgery. (Ex. 3B). Dr. Strukel, SAIF's medical advisor, opined that the preexisting spinal stenosis was the major contributing cause of the need for surgery, reasoning that the surgical findings were only of spinal stenosis without evidence of disc herniation. (Ex. 4).

After reviewing these opinions, we conclude that Dr. Smith's opinion is better reasoned. It is most consistent with claimant's uncontroverted testimony that she was asymptomatic prior to the compensable injury and, thereafter, had progressive symptoms requiring surgery. (Tr. 11-12). Accordingly, based on Dr. Smith's opinion, we conclude that claimant has sustained her burden of proving that the need for surgery was compensably related to the injury. It follows, therefore, that the permanently disabling residuals of that surgery are likewise "due to" the compensable injury.

Remand

SAIF requests remand, arguing that the Referee erred in declining to reopen the record for cross-examination regarding the amount of the attorney fee requested by claimant's counsel. We disagree.

A referee has discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(1). We review the referee's ruling for abuse of discretion. Dena M. Calise, 45 Van Natta 783 (April 16, 1993).

On the day that the record was closed, claimant's counsel submitted to the Referee a written request for an assessed attorney fee of $2,942.50, supported by an affidavit and itemized listing of time expended and services performed both before and after SAIF filed its hearing request from the Order on Reconsideration. SAIF objected to the attorney fee request, arguing that it was excessive.

The Referee issued her order on October 21, 1992, and awarded claimant an assessed fee of $2,500 pursuant to ORS 656.382(2) for prevailing against SAIF's appeal. SAIF requested reconsideration of the Referee's order, arguing that the assessed fee was excessive because it was based on attorney time rendered prior to the filing of SAIF's hearing request. SAIF requested that the record be reopened for a hearing on the attorney fee issue, noting that a primary reason for the rehearing was to explore the actual attorney time spent after its hearing request. The Referee denied the request for a rehearing, concluding that the written attorney fee request and SAIF's response were sufficient to decide the issue. Considering the factors set forth in OAR 438-15-010(4), the Referee declined to amend the assessed fee award.

The current record, which includes claimant's attorney fee request and SAIF's response, is not insufficiently developed to determine the appropriate amount of an assessed fee. See ORS 656.295(5). The record contains all of the information necessary to apply the factors under OAR 438-15-010(4) for determining a reasonable attorney fee. The amount of attorney time spent on the case is only one of several factors considered in determining a reasonable fee. Under these circumstances, we conclude that the Referee was within her discretion in declining to reopen the record. See Dena M. Calise, supra. Furthermore, SAIF's request for remand is denied.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable fee for claimant's attorney's services at hearing concerning SAIF's hearing request is $2,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue raised by SAIF's hearing request (as represented by the hearing record, claimant's counsel's affidavit/itemized statement, and SAIF's response), the complexity of the issue, and the value of the interest involved.

Attorney Fee On Review

Because claimant has prevailed against SAIF's request for Board review on the extent of unscheduled permanent disability issue, claimant would ordinarily be entitled to an assessed fee under ORS 656.382(2) for services rendered on review. However, claimant's respondent's brief was rejected as untimely and, therefore, not considered on review. Accordingly, claimant is not entitled to an assessed fee on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated October 21, 1992, as reconsidered November 17, 1992, is affirmed.

In the Matter of the Compensation of
DEBRA K. DONOVAN, Claimant
WCB Case No. 91-06516
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The insurer requests review of those portions of Referee Baker's order that: (1) found that claimant had established a compensable aggravation claim; and (2) awarded claimant's attorney an assessed fee of $5,000 for services at hearing. On review, the issues are aggravation and attorney fees. We affirm.

FINDINGS OF FACT

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

On July 1, 1991, claimant underwent an independent medical examination performed by Dr. Woolpert, orthopedist.

In addition to examining claimant and performing various tests, Dr. Johnson, treating orthopedist, talked with and listened to claimant over a period of 20 to 25 hours. (Ex. 70-14).

At the time of the January 11, 1990 Determination Order, claimant was at least released to sedentary work. (Exs. 14-2, 16-9). On April 16, 1991, Dr. Johnson, treating orthopedist, retroactively released claimant from work from March 18, 1991 through April 26, 1991. (Ex. 38). On May 31, 1991, Dr. Johnson again released claimant from work due to her treatment with a body brace. (Ex. 41A). During his deposition, Dr. Johnson stated that claimant was unable to work due to her worsened pain. (Ex. 70-13).

The January 11, 1990 Determination Order did not contemplate any waxing and waning of claimant's symptoms.

CONCLUSIONS OF LAW AND OPINION

Aggravation

To establish an aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, she has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991).

Claimant's claim was closed by Determination Order on January 11, 1990 which awarded 43 percent unscheduled permanent disability. This was the last arrangement of compensation. In October 1990, claimant began seeing Dr. Johnson, who became her treating orthopedist for her low back condition. Dr. Johnson opined that claimant had not suffered a pathological worsening in that her current low back condition involved problems that were either not addressed at the outset of her injuries or had arisen following, and as a result of, her two previous compensable low back surgeries. (Ex. 69). However, a pathological worsening is not required to establish an aggravation, a symptomatic worsening is sufficient.

At his March 19, 1992 deposition, Dr. Johnson opined that claimant had sustained a symptomatic worsening. (Ex. 70-28). He based this opinion on his examinations of claimant, various tests, and over 20 to 25 hours of talking and listening to claimant. (Ex. 70-14). Although Dr. Johnson acknowledged that claimant presented some pain behavior, he concluded that she had significant pain based on her relatively consistent examinations and relatively standardized test results. (Ex. 70-18 through -21). He also found that claimant's pain had increased to the point that she was unable to work and concluded that a spinal fusion was the only viable option for improvement of her symptoms, even though the surgical option presented only a 50 percent chance of significant improvement in her symptoms. (Ex. 70-29, -31).

Thus, Dr. Johnson diagnosed a symptomatic worsening of the compensable low back condition based on expert analysis of his examination findings, test results, and claimant's reported symptoms. We have held that such evidence meets the definition of "objective findings." See Georgia-Pacific v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991). Such findings may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that she is experiencing. Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991).

We do not agree with the insurer's argument that there are no objective findings of a worsening because the record presents only a recitation of claimant's complaints. Dr. Johnson did not simply recite claimant's complaints but clearly evaluated her symptoms over time and concluded that she had sustained a symptomatic worsening of her compensable condition.

The insurer also argues that claimant's low back condition has improved rather than worsened based on a comparison of a range of motion measurement for lumbar flexion taken on November 27, 1989 with one taken on June 21, 1991. We do not find this isolated measurement persuasive evidence of an absence of a worsening, especially in light of the treating orthopedist's opinion that claimant sustained a symptomatic worsening.

On July 1, 1991, claimant was examined by Dr. Woolpert, examining orthopedist. Although Dr. Woolpert noted nonorganic pain behavior, he did not address the issue of whether claimant had sustained a worsening of her back condition. (Ex. 54). As noted above, we find that Dr. Johnson was aware that claimant exhibited some nonorganic pain behavior and took that into account in his evaluation. In addition, although claimant underwent pain center treatment following her claim closure, the pain center physicians did not address the issue of worsening.

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, there are no persuasive reasons not to rely on the opinion of Dr. Johnson. Therefore, we find that claimant has established a symptomatic worsening of her compensable condition supported by objective findings.

Claimant's diminished earning capacity is demonstrated by Dr. Johnson's release of claimant from work from March 18, 1991, through April 26, 1991. (Ex. 38). On May 31, 1991, Dr. Johnson again released claimant from work due to her treatment with a body brace. (Ex. 41A). Furthermore, during his deposition Dr. Johnson stated that claimant was unable to work due to her worsened pain. (Ex. 70-13). We find that Dr. Johnson's releases from work and statements establish that claimant has sustained a diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

The insurer argues that, assuming that claimant sustained a worsening, it was simply a waxing and waning of her symptoms. We disagree.

The issue is whether claimant has sustained a worsening of her compensable condition that is more than a waxing and waning of symptoms as contemplated by the last award or arrangement of compensation. ORS 656.273(8). If there was medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra; see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988). Here, there is no evidence of any predictions of future flare-ups prior to the January 11, 1990 Determination Order which awarded 43

percent unscheduled permanent disability. Thus, there is no evidence that the Determination Order considered any waxing and waning of symptoms.

The insurer relies on Dr. Johnson's August 14, 1991 statement that claimant's condition "may simply be a 'waxing and waning' of her condition." (Ex. 69-1). However, this statement was made more than a year and a half after the Determination Order, so it could not have been considered at the time of the Determination Order. Also, Dr. Johnson explained in his deposition that he did not consider claimant's condition a flare-up because it had gone on over a period of several months. (Ex. 70-27).

Accordingly, based on the above reasoning, we find that claimant has established a compensable aggravation claim.

Attorney Fees

The Referee awarded claimant's attorney an assessed fee of $5,000 for services at hearing. The insurer argues that this is excessive because claimant prevailed on only two of the four issues at hearing, the case did not require extensive preparation, only claimant testified, the hearing was not adversarial, and claimant's counsel did not bear a significant risk of going uncompensated. We disagree.

First, the issues on which claimant prevailed, compensability of claimant's current right leg condition and compensability of the aggravation claim, are valuable to claimant. Second, the insurer offers no support to its contention that the hearing was not adversarial and claimant's attorney did not bear a significant risk of going uncompensated. To the contrary, the insurer's request for review illustrates the adversarial nature of the claim and claimant's attorney's risk of going uncompensated.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable fee for claimant's attorney's services at hearing concerning the compensability and aggravation issues is $5,000, 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 the deposition of Dr. Johnson), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney's efforts may have gone uncompensated.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After applying the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation issue is $1,150. In reaching this conclusion, we have particularly considered the the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated.

We note that, inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Benjamin G. Parker, 42 Van Natta 2476 (1990).

ORDER

The Referee's order dated June 18, 1992 is affirmed. For services on review, claimant's attorney is awarded $1,150, to be paid by the insurer directly to claimant's attorney.

In the Matter of the Compensation of
GEORGE FARAH, Claimant
WCB Case Nos. 91-16276, 91-16275 & 91-16274
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Beers, et al., Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Lipton and Westerband.

EBI Companies requests review of those portions of Referee Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claims for bilateral carpal tunnel syndrome and bilateral arthritic thumb conditions; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claims for the same conditions. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

Claimant first sought treatment for her bilateral carpal tunnel syndrome when SAIF was on the risk. Claimant's carpal tunnel condition pathologically worsened after EBI assumed coverage of the employer. Claimant first sought treatment for her bilateral arthritic thumbs when EBI was on the risk.

CONCLUSIONS OF LAW AND OPINION

The last injurious exposure rule governs the initial assignment of responsibility for an occupational disease when successive insurers of a single employer contest responsibility for a condition which has not been previously found compensable as to any particular insurer. UAC/KPTV Oregon TV, Inc. v. Hacke, 101 Or App 598, 602 n 2, rev den 310 Or 393 (1990). See also Eleanor G. Castrignano, 44 Van Natta 1134 (1992); Fred A. Nutter, 44 Van Natta 854 (1992). In this context, the rule assigns responsibility to the insurer on the risk either at the time when the condition becomes disabling or, if the condition does not become disabling, at the time when the worker first seeks medical treatment for the condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Progress Quarries v. Vaandering, 80 Or App 160, 163 (1986).

We find that claimant's condition, which was ultimately diagnosed as bilateral carpal tunnel syndrome (CTS) and arthritis of the thumbs, did not become disabling. We also find, contrary to the Referee's finding of fact, that claimant first sought treatment for his carpal tunnel condition when SAIF was on the risk, i.e., before July 1, 1989. Nerve conduction studies performed as early as September 1987 revealed moderate CTS on both sides. (Exs. 5, 11, 13). In April 1988, claimant was seeking treatment for pain and swelling in the right hand and for numbness and tingling of the thumb and fingers. (Ex. 8). In August 1988, he was seeking treatment for pain along the right thumb joint and numbness in the left thumb and index finger. (Ex. 12). By March 1989, approximately four months before EBI assumed coverage, claimant's main complaint was pain at the base of the right thumb, though he continued to have symptoms in both hands. (Ex. 17). Through this entire period, up through July 11, 1991, when osteoarthritis at the base of both thumbs was diagnosed, these symptoms were all considered symptoms of carpal tunnel syndrome, and medical treatment rendered accordingly. There is no evidence that claimant sought treatment for osteoarthritis, or even questioned whether thumb complaints were related to the previously diagnosed carpal tunnel condition before that date.

Because claimant first sought treatment for his bilateral osteoarthritis condition when EBI was on the risk, EBI is initially assigned responsibility for that condition. See id. Because claimant first sought treatment for his bilateral carpal tunnel condition when SAIF was on the risk, SAIF is initially assigned responsibility for that condition. See id. SAIF may shift responsibility to EBI, the later insurer, by proving that employment conditions while EBI was on the risk actually contributed to a pathological worsening of claimant's carpal tunnel syndrome. See Boise Cascade v. Starbuck, 296 Or 238, 243 (1984); Bracke v. Baza'r, 293 Or 239, 250 (1982); Oregon Boiler Works v. Lott, 115 Or App 70, 74-75 (1992). Because this issue presents a complex medical question, its resolution turns largely on 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).

Nerve conduction studies on August 29, 1988, revealed "moderate" CTS bilaterally. (Ex. 13). Nerve conduction studies on June 4, 1991, when EBI was on the risk, revealed "significantly" prolonged sensory latencies bilaterally. (Ex. 39). This is medical evidence, supported by objective findings, of a pathological worsening of claimant's condition. See ORS 656.802(2).

In addition, Dr. Layman opined that claimant's repetitive work activities of picking up full yogurt containers with a pinching action between the thumb and fingers and placing them on crates would be expected to cause bilateral CTS and bilateral osteoarthritis. (Ex. 58-3). He opined that such work over a number of years was the major contributing cause of claimant's condition. (Id.) Inasmuch as claimant continued to perform those work activities after EBI assumed coverage, we find that there is sufficient medical evidence that work activities while EBI was on the risk caused a progressive worsening of claimant's carpal tunnel condition. This evidence is further supported by claimant's testimony that his carpal tunnel symptoms have gotten worse since EBI assumed coverage on July 1, 1989. (Tr. 23-24).

We find that employment conditions while EBI was on the risk contributed to a pathological worsening of claimant's carpal tunnel syndrome. Therefore, SAIF has successfully shifted responsibility for claimant's carpal tunnel syndrome to EBI. See Boise Cascade v. Starbuck, supra; Bracke v. Baza'r, supra; Oregon Boiler Works v. Lott, supra. EBI can avoid responsibility by establishing that a prior employment exposure was the sole cause of claimant's condition or that it was impossible for claimant's employment exposure while EBI was on the risk to have caused his condition. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). We do not find that EBI has proved either fact. Accordingly, EBI is solely responsible for claimant's carpal tunnel syndrome and thumb arthritis conditions.

Inasmuch as claimant's compensation was at risk at hearing, it remained potentially at risk on Board review. Therefore, claimant is entitled to an assessed attorney fee for services performed on review. See ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252 (1992), mod on recon 119 Or App 447 (1993). 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 EBI, the party requesting Board review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 19, 1992, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by EBI Companies.

In the Matter of the Compensation of
ROSARIO FELIX, Claimant
WCB Case No. 92-05216
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

The insurer requests review of that portion of Referee Livesley's order that increased claimant's scheduled permanent disability award for loss of use or function of each arm from 5 percent (9.6 degrees), as awarded by an Order on Reconsideration which affirmed a Determination Order, to 11 percent (16.5 degrees) for each 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 following supplementation.

Claimant worked for the employer for 19 months as a chicken cutter, deboning chicken and raising cases of the product to shelf level.

On April 26, 1990, claimant sought treatment for numbness, tingling and pain in the left hand, pain in the left shoulder, nocturnal numbness in the right hand, and weakness in both hands. Dr. Morris diagnosed carpal tunnel syndrome and myofascial pain in the left shoulder and treated her conservatively. By June 28, 1990, her condition improved. Dr. Morris diagnosed tendinitis and fibromyalgia, but found no evidence for carpal tunnel syndrome. He released claimant from light to full duty on July 2, 1990. (Exs. 1 and 2).

On July 6, 1990, claimant was examined by Dr. Fry for the insurer. He noted complaints of pain and numbness in both wrists and hands, left greater than right, and neck pain. He reported tenderness over the paravertebral musculature and the trapezii and neck pain with compression of the cervical spine. He diagnosed overuse syndrome, both wrists, and recommended that she change to a less repetitive job. (Ex. 6).

On July 25, 1990, the insurer accepted claimant's hand and arm symptoms as bilateral tendonitis. (Ex. 7).

In 1991, claimant sought treatment from Dr. Brooks, who treated her conservatively. Claimant was changed to a lighter duty job. Her symptoms increased over time. (Ex. 10-1).

Claimant sustained a cervical injury on April 15, 1991, for which she treated with Dr. Kitchel. (Ex. 13-2).

On June 27, 1991, claimant was given a physical therapy evaluation in which Dr. Brooks concurred. (Exs. 10 and 11).

FINDINGS OF ULTIMATE FACT

Claimant has a 10 percent loss of use and function of each arm.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Determination Order awarded 5 percent (9.6 degrees) scheduled permanent disability for each whole arm, as contrasted with 5 percent (7.5 degrees) for each forearm. Neither the parties nor the Referee recognized the discrepancy. (See, e.g., claimant's respondent's brief at 4 and the O & O at 4 and 5). Consequently, even though the only issue raised by the insurer on review was the rating for loss of grip strength, we review the extent of scheduled permanent disability de novo. See Destael v. Nicolai Co., 80 Or App 596, 600-601 (1986).

After our review of the record, we adopt the Referee's opinion through the portion of the fifth paragraph on page 4 that ends: "which is then rounded to the nearest whole number, to wit: 6." We also supplement as follows.

The Referee found claimant's impairment due to loss of strength to be 6 percent for each forearm, which he then combined with a chronic condition award of 5 percent for each forearm, for a total of 11 percent (16.5 degrees) for each forearm.

Based on the findings by the physical therapist, in which Dr. Brooks concurred, claimant has continued weakness, tightness and pain bilaterally through the upper and lower arms, which continues to be worsened by any type of repetitive upper extremity work and which was not permanently improved by physical therapy. Accordingly, we conclude that the Order on Reconsideration, which affirmed the Determination Order, correctly rated claimant's chronic condition as 5 percent of the whole arm, rather than the forearm.

When two or more portions of the same body part are impaired, each is rated separately and each rating is converted to a value for the impaired portion which is closest to the body. These converted values are then combined (not added). Former OAR 436-35-120(4). According to the table provided in former OAR 436-35-090(1), 6 percent of the forearm converts to 5 percent of the arm. We then combine this 5 percent with the 5 percent chronic condition impairment for each arm for a total of 10 percent (19.2 degrees) scheduled permanent disability for each arm.

Generally, it is our policy not to increase a referee's award unless a claimant appeals the order seeking an increased award. See, Daniel M. Alire, 41 Van Natta 752 (1989). Here, claimant did not appeal the Referee's order. However, we find this case to present a rare exception to our policy because the Referee's awards for the forearm, rather than the arm, constituted a scrivener's error that was missed by all parties. We increase the Referee's award accordingly.

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 issue, and the value of the interest involved.

ORDER

The Referee's order dated August 6, 1992 is modified. In lieu of the Referee's award and in addition to the Order on Reconsideration award of 5 percent (9.6 degrees) for loss of use or function of each arm, we award 5 percent (9.6 degrees) scheduled permanent disability for each arm, for a total award for each arm of 10 percent (19.2 degrees) for the loss of use and function of each arm. Claimant's attorney is awarded 25 percent of any additional compensation created by this order, not to exceed $3,800. For services on Board review, claimant's attorney is awarded an attorney fee of $1,500, to be paid by the insurer.

June 28, 1993 Cite as 45 Van Natta 1181 (1993)

In the Matter of the Compensation of
GEORGE A. GODFREY, Claimant
WCB Case Nos. 92-10099, 92-06873, 92-10884, 92-11546, 92-10577, 92-06874, 92-10885 & 92-11547
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Lipton.

In WCB Case Nos. 92-06874 and 92-06873, Liberty Northwest Insurance Corporation (Liberty Northwest) requests, and claimant cross-requests review of Referee Myzak's August 28, 1992 order that: (1) found that claimant had timely filed an occupational disease claim for right carpal tunnel syndrome against Liberty Northwest; and (2) declined to award an assessed attorney fee for prevailing on the timeliness issue. Prior to conducting our review, Liberty Northwest has withdrawn its request for review.

In WCB Case Nos. 92-10099 and 92-10577, Liberty Northwest requests review of that portion of Referee Myzak's September 3, 1992 order which found that claimant had filed a claim for right carpal tunnel syndrome with Liberty Northwest in 1988. Claimant cross-requests review of those portions of the Referee's order which: (1) declined to award an assessed attorney fee for services rendered in connection with Liberty Northwest's pre-hearing concession of compensability; (2) awarded an assessed attorney fee of $1,500, payable by the SAIF Corporation (SAIF), for services rendered in connection with SAIF's concession of compensability at the close of the hearing; (3) declined to assess a penalty for Liberty Northwest's allegedly unreasonable claim processing; and (4) declined to assess a penalty for SAIF's allegedly unreasonable claim processing.

In WCB Case Nos. 92-11547, 92-11546, 92-10885 and 92-10884, Liberty Northwest requests review of those portions of Arbitrator Myzak's September 30, 1992 decision that: (1) set aside its responsibility denial of claimant's claim for right carpal tunnel syndrome; and (2) upheld SAIF's responsibility denial of claimant's claim for the same condition. Claimant cross-requests review of that portion of the Arbitrator's decision which declined to award an assessed attorney fee for prevailing over Liberty Northwest's responsibility denial.

At the parties' request and unanimous agreement, we have reviewed these cases in consolidation. We have taken this action because the issues are inter-related and the Referee/Arbitrator decisions issued within relatively the same time period. We dismiss in part, reverse in part and affirm in part.

ISSUES

WCB Case Nos. 92-06874 & 92-06873

(1) Timeliness of Hearing Request

(2) Entitlement to Attorney Fees

WCB Case Nos. 92-10099 & 92-10577

(1) Claim Filing

(2) Entitlement to Attorney Fees

(3) Amount of Attorney Fees

(4) Penalties

WCB Case Nos. 92-11547, 92-11546, 92-10885 & 92-10884

(1) Responsibility

(2) Attorney Fees

FINDINGS OF FACT

Claimant works for the employer as a carpenter. In December 1988, he experienced bilateral pain and numbness in his wrists. He sought treatment from Dr. Rosenbaum. Nerve conduction studies revealed motor and sensory latencies in the median nerves of both wrists. Diagnosing moderate bilateral carpal tunnel syndrome, Dr. Rosenbaum recommended surgery on the left side. Since the right side was asymptomatic, Rosenbaum declared that right side surgery was optional.

Thereafter, claimant underwent left carpal tunnel release surgery. Claimant was not treated for right carpal tunnel syndrome, nor was he temporarily disabled as a result of right carpal tunnel syndrome.

In January 1989 claimant filed a claim for left carpal tunnel syndrome. In March 1989, Liberty Northwest, the employer's insurer at that time, accepted claimant's claim for left carpal tunnel syndrome as nondisabling. In May 1989, Dr. Rosenbaum reported that claimant's left carpal tunnel condition was stationary with no loss of function.

On July 1, 1990, SAIF became the employer's insurer.

Between May 1989 and December 1991, claimant sought no medical treatment for either wrist. In December 1991, claimant returned to Dr. Rosenbaum with right wrist complaints. Dr. Rosenbaum recommended right carpal tunnel release surgery. Thereafter, claimant filed a claim for right carpal tunnel syndrome.

On January 28, 1992, SAIF issued a disclaimer of responsibility. On March 9, 1992, Liberty Northwest treated claimant's claim as a new occupational disease and issued a denial of responsibility. Thereafter, Liberty Northwest requested the issuance of a ".307" order. On March 16, 1992, SAIF issued a denial of compensability. On April 9, 1992, the Workers' Compensation Division (WCD) issued an Order Denying Designation of a Paying Agent Pursuant to ORS 656.307. WCD's order was based on SAIF's representation that compensability was at issue. Claimant requested a hearing protesting SAIF's and Liberty Northwest's denials.

On August 5, 1992, a hearing was convened before the Referee. (WCB Case Nos. 92-06874 and 92-06873). By order dated August 28, 1992, the Referee found that claimant had timely requested a hearing concerning Liberty Northwest's denial and deferred all other issues. Liberty Northwest and claimant both requested review of the Referee's order. Liberty Northwest subsequently withdrew its request for review.

On August 24, 1992, SAIF rescinded its denial of compensability and requested the designation of a paying agent pursuant to ORS 656.307.

On September 3, 1992, the Referee issued an order in WCB Case Nos. 92-10099 and 92-10577. In her order the Referee: (1) directed both SAIF and Liberty Northwest to process claimant's right carpal tunnel syndrome claim; (2) awarded claimant an assessed attorney fee of $1,500 for services rendered in connection with SAIF's concession of compensability; and (3) deferred resolution of the responsibility issue. Both Liberty Northwest and claimant appealed the Referee's order.

On September 4, 1992, WCD issued an order pursuant to ORS 656.307. SAIF was directed to process the claim.

On September 30, 1992, the Referee issued her decision in WCB Case Nos. 92-10884, 92-10885, 92-11547, and 92-11546. Inasmuch as a ".307" order had issued, the Referee issued her decision as an Arbitrator. In this capacity, she set aside Liberty Northwest's denial of responsibility and directed it to accept claimant's right carpal tunnel syndrome claim. Again, both Liberty Northwest and claimant appealed.

By letter of November 16, 1992, the Board consolidated all of the aforementioned cases for purposes of review.

CONCLUSIONS OF LAW AND OPINION

WCB Case Nos. 92-06874 & 92-06873

The Referee found that claimant had timely filed his claim as to Liberty Northwest. Liberty Northwest and claimant both appeal the Referee's order. Liberty Northwest subsequently withdrew its request for review. We dismiss both requests for review.

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the Referee's August 28, 1992 order neither finally disposed of, nor allowed the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order only found that claimant had timely filed his claim against Liberty Northwest. As a result of the Referee's decision, further proceedings were required to determine claimant's entitlement to, and/or the amount of compensation.

Inasmuch as further action before the Hearings Division was required as a result of the Referee's order, we conclude that it was not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Therefore, we lack jurisdiction to consider the parties' requests for Board review of the Referee's August 28, 1992 order. Accordingly, we dismiss the requests for review.

Normally, we would return this case to the Referee for further proceedings. However, those further proceedings have already taken place and the Referee's subsequent decisions are before us on appeal. Therefore, the substantive issues raised in these cases will be considered during our review of the Referee's subsequent decisions.

WCB Case Nos. 92-10099 & 92-10577

Attorney Fees in WCB Case Nos. 92-06874 & 92-06873

As noted above, we now address claimant's contention that his counsel is entitled to an attorney fee pursuant to ORS 656.386(1) against Liberty Northwest for prevailing on the timeliness issue.

In order to be entitled to an attorney fee under ORS 656.386(1), claimant must finally prevail over a denial of a claim for compensation. As discussed previously, a finding that a claim has been timely filed does not result in a conclusion that a claimant is entitled to compensation. Therefore, it would be premature to award an attorney fee for such services. However, should claimant ultimately prevail against Liberty Northwest's denial, such services will be considered when granting an attorney fee under ORS 656.386(1).

Claim Filing

The Referee found that claimant had filed a claim for right carpal tunnel syndrome in 1988, while Liberty Northwest was at risk. Liberty Northwest contends that the Referee erred in making this finding. We agree with Liberty Northwest.

Inasmuch as Liberty Northwest later conceded compensability, this finding is of importance only with regard to a possible attorney fee for a "de facto" denial and a possible penalty for an allegedly unreasonable failure to process a claim for compensation.

A "claim" is a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. ORS 656.005(6); Safeway Stores Inc. v. Smith, 117 Or App 224 (1992). ORS 656.005(8) defines "compensation" to include all benefits provided for a work-related injury, including medical services.

Although Dr. Rosenbaum diagnosed right carpal tunnel syndrome, in 1988, he reported that it was asymptomatic. There is no evidence that claimant was treated for right carpal tunnel syndrome, nor is there evidence that claimant was entitled to temporary disability benefits as a result of right carpal tunnel syndrome. Finally, on the 1989 801 form claimant indicated that his claim was only for the left hand.

Under these circumstances, we conclude that claimant did not file a claim with Liberty Northwest for right carpal tunnel syndrome in 1988. Accordingly, claimant is not entitled to an attorney fee for prevailing against a "de facto" denial or penalty.

Attorney Fees/Liberty Northwest

The Referee concluded that claimant's counsel was not entitled to an assessed attorney fee, payable by Liberty Northwest, for establishing compensability of claimant's claim against Liberty. The Referee based her conclusion on the finding that inasmuch as Liberty Northwest had conceded compensability prior to the time when claimant retained counsel, claimant's counsel was not instrumental in obtaining compensation for claimant.

We agree with and adopt the Referee's conclusions and reasoning with the following comment.

For the reasons discussed later in this order, we have found that Liberty Northwest's denial should be upheld. Accordingly, claimant has not finally prevailed against Liberty Northwest's denial.

Attorney Fees/SAIF

This issue shall be addressed in the "Attorney Fee" section of WCB Case Nos. 92-11547, 92-11546, 92-10885 and 92-10884.

Penalties/Liberty Northwest

The Referee found that claimant had filed a claim for right carpal tunnel syndrome in December 1988. She further found that Liberty Northwest's failure to accept or deny claimant's claim was unreasonable. However, the Referee declined to award a penalty or related attorney fee because she concluded that inasmuch as claimant did not receive any medical treatment or disability, Liberty Northwest's conduct did not result in an unreasonable resistance to the payment of compensation.

We have herein concluded that claimant did not file a claim for right carpal tunnel syndrome with Liberty Northwest in December 1988. Consequently, we do not find Liberty Northwest's conduct unreasonable. Accordingly, neither a penalty nor related attorney fee is warranted.

Penalties/SAIF

The Referee found that SAIF's denial of compensability was not unreasonable and therefore declined to assess a penalty. We agree with and adopt the Referee's conclusions and reasoning on this issue.

WCB Case Nos. 92-11547, 92-11546, 92-10885 & 92-10884

Scope of Review

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

Here, a ".307" order ultimately issued. However, the matter was not referred to the Board through the issuance of a ".307" order. Rather, the matter was already before the Board by virtue of the hearing requests in WCB Case Nos. 92-06784, 92-06783 and WCB Case Nos. 92-10099, 92-10577 which concerned the issues of timeliness, compensability, penalties and attorney fees. Moreover, the "hearing" on the above issues was the same "hearing" pursuant to ORS 656.307, as it involved the same parties and operative facts.

Since a ".307" order ultimately issued, responsibility for the claim should have been the sole issue. However, inasmuch as all of the aforementioned "non-responsibility" issues involved the same claimant and the same operative facts, resolution of all of these issues should have been contained in one order. Under such circumstances (particularly considering that all of these cases have been consolidated for review and some of them involve the "compensability" of claimant's claim), we conclude that our review of the Referee's order should be de novo. See Jeffrey W. Nelson, 44 Van Natta 1515 (1992); Linda A. Fuchs-Perrite, 43 Van Natta 926 (1991).

Responsibility

The Referee found that Liberty Northwest was responsible for claimant's right carpal tunnel condition. We disagree.

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which have not been previously accepted. Fred A. Nutter, 44 Van Natta 854 (1992). Under that 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 last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

The onset of disability is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date 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, 89 Or App 461, 465 (1987).

In order to shift responsibility to an earlier carrier, the carrier on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the prior carrier was on the risk were the sole cause of the disability or need for treatment or that it was impossible for work conditions during the period when the last carrier was on the risk to have caused the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984, clarified 73 Or App 223 (1985). In order to shift responsibility to a later carrier, the initially responsible carrier must show that a later employment actually contributed to a worsening of the condition. Spurlock v. International Paper Co., 89 Or App 461, 465 (1987).

The Referee concluded that claimant had first sought medical treatment for his right carpal tunnel syndrome in 1988 while Liberty Northwest was at risk. Therefore, the Referee initially assigned responsibility to Liberty Northwest. The Referee then concluded that Liberty Northwest had not carried its burden of proof and could not shift responsibility to SAIF. We disagree.

In this case, claimant has not been disabled due to his right carpal tunnel syndrome condition. As we have herein found, this condition was diagnosed in December 1988, however claimant did not

seek treatment for the condition until December 1991 when he returned to Dr. Rosenbaum who recommended that claimant undergo decompression surgery of the right carpal tunnel. In December 1991, SAIF was on the risk. Consequently, responsibility for claimant's right carpal tunnel syndrome is initially assigned to SAIF.

Moreover, since both Dr. Rosenbaum and Dr. Nathan attribute claimant's condition, at least in part, to claimant's work activities at SAIF's insured, SAIF has not established that the work exposure at its insured could not have caused the condition or that claimant's prior employment was the sole cause, responsibility remains with SAIF. FMC Corp. v. Liberty Mutual Ins Co., supra. Therefore, responsibility remains with SAIF.

Attorney Fees/SAIF

The Referee awarded claimant's counsel an assessed attorney fee of $1,500, payable by SAIF, for services rendered in connection with SAIF's rescission of its compensability denial. Claimant contends his counsel is entitled to a greater attorney fee. We agree that claimant's counsel is entitled to a greater fee, however we base our conclusion on the fact that claimant has "finally prevailed" against SAIF's denial on review. See ORS 656.386(1).

Claimant is entitled to an assessed attorney fee at hearing and on review pursuant to ORS 656.386(1) for prevailing against SAIF's denial. 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 the hearing level and on review concerning SAIF's denial is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

In lieu of the Referee's orders, we issue the following order. In WCB Case Nos. 92-06874 and 92-06873, claimant's and Liberty Northwest's requests for review are dismissed. In WCB Case Nos. 92-10099, 92-10677, 92-11547, 92-11546, 92-10885 and 92-10884, Liberty Northwest's denial is reinstated and upheld. 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 concerning the SAIF Corporation's denial, claimant's counsel is awarded an assessed attorney fee of $3,500, payable by the SAIF Corporation.

June 28, 1993 Cite as 45 Van Natta 1186 (1993)

In the Matter of the Compensation of
RICHARD J. GRIESENAUER, Claimant
WCB Case No. 91-03347
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Cohen & Wu, Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of Referee Hoguet's order that set aside its denial of claimant's injury claim for a cervical strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact, with the exception of his finding that claimant was "at lunch" at the time of the accident. The evidence is insufficient to determine what claimant was doing at the time of the accident, besides driving a car.

We do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

On October 17, 1990, claimant was injured in an automobile accident. He filed a claim relating to that accident, which SAIF denied. The Referee set aside SAIF's denial, because he concluded that the accident occurred within the course and scope of claimant's employment. We disagree.

To prove compensability, claimant must establish that his injury arose out of and in the course of his employment. ORS 656.005(7)(a). That is, he must prove that his injury was sufficiently work-related. Rogers v. SAIF, 289 Or 633, 642 (1985).

Traditionally, we have determined whether an activity is work-related by analyzing whether: (1) the activity was for the benefit of the employer; (2) the activity was contemplated by the employer and employee at the time of hiring or later; (3) the activity was an ordinary risk of, and incidental to, the employment; (4) the employee was paid for the activity; (5) the activity was on the employer's premises; (6) the activity was directed by or acquiesced in by the employer; and (7) the employee was on a personal mission of his or her own. Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985). Recently, however, the court has indicated that the question of work relationship is "best resolved by examining the contractual relationship of the parties." PP&L v. Jacobson, 117 Or App 280 (1992). We conclude that claimant has failed to prove a sufficient work relationship under either test.

To enable us to apply the seven-factor test, or assess whether claimant's activities at the time of the accident were contemplated by his employment contract, claimant must prove what he was doing at the time of the accident. Claimant failed to meet that burden.

On direct examination, claimant testified that, when the accident occurred, he was on route to a job site. (Tr. 16). However, he could not remember which job site, nor could he remember where he went after the accident. (Tr. 16). Moreover, on cross-examination, he related that he could not remember why he was at the location where the accident occurred. (Tr. 35). He testified:

> "Claimant: I don't really remember where I had been just prior to that. I know I had a job that I went to after that, and it was the same job I'd been to earlier. I might have went home and picked up molds. I'm not really sure if I did or not. I might have went to the store to get something. I might have went shopping. I really don't know. There's -- when you have the dead time, when you call in and they say, Okay, stay in the area, okay, and take care of this one, make sure you make your 1 O'clock, and that's what you do whether you're parked on the construction site or off the site or across the street or whatever, and that's --
>
> "Defendant: But the point is, you don't remember where you were coming from?
>
> "Claimant: No." (Tr. 144-45).

That testimony indicates that claimant's memory of the events surrounding his accident is not wholly reliable.

In contrast, SAIF's witnesses had no trouble recalling important events. One of claimant's co-workers testified that shortly after the accident, claimant reported that it had occurred during lunch. (Tr. 131). However, another co-worker reported that claimant had told her that the accident occurred on his own time. (Tr. 114).

Witness testimony that the accident occurred on claimant's "own time" is buttressed by other facts in the record. Of particular relevance is that the accident occurred at about 1 p.m., and that claimant was not in the vicinity of a job site, but was close to his home. Claimant sought to counter that evidence by suggesting that he might have gone home to get some work supplies. Again, however, he could only speculate and there is no evidence to corroborate that speculation. (Tr. 145).

SAIF's evidence, combined with claimant's inability to remember the details surrounding his injury, sufficiently discredits claimant's assertion that he was on route to a job when the accident occurred. Because that was the only evidence claimant offered concerning the work relationship of his

activity (driving a car) at the time of the accident, and we find that evidence unpersuasive, claimant failed to sustain his burden of proving that his accident occurred within the course and scope of his employment.

Claimant was not on the employer's premises at the time of the injury. Because we do not know why claimant was driving his car at the time of the accident, we do not find that claimant's activity was: (1) for the employer's benefit; (2) contemplated by the employer and claimant at the time of hiring or later; (3) an ordinary risk of, and incidental to, the employment; or (4) directed by or acquiesced in by the employer. We also do not find that claimant was paid for the activity. On the other hand, we find that it is just as probable as not that claimant was on a personal mission at the time of injury. Finally, we cannot determine if claimant's activities were contemplated by his employment contract. Consequently, SAIF properly denied the claim.

ORDER

The Referee's order dated March 12, 1992 is reversed. SAIF's denial is reinstated and upheld. The Referee's attorney fee award of $2,200 is reversed.

In the Matter of the Compensation of
BRIAN L. HIBMA, Claimant
WCB Case No. 92-09075
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The SAIF Corporation requests review of Referee Livesley's order which: (1) increased claimant's unscheduled permanent disability award for a neck injury from 20 percent (64 degrees), as awarded by an Order on Reconsideration, to 27 percent (86.4 degrees); and (2) increased claimant's scheduled permanent disability for loss of use or function of the right arm from no award made in the Order on Reconsideration, to 16 percent (30.72 degrees). On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. A physical capacities evaluation (PCE) was performed on April 23, 1992, not on March 23, 1992. (Ex. 16).

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We affirm and adopt that portion of the Referee's order which awarded claimant 27% unscheduled permanent disability, except for the first full paragraph on page 5 of the Opinion and Order on Reconsideration. England v. Thunderbird, 315 Or 633 (1993). We add the following supplementation to address SAIF's arguments on review. SAIF disputes only the Referee's determination of the adaptability factor.

First, SAIF contends that since claimant was released to regular work by his attending physician, the adaptability value should be zero. See OAR 436-35-310(2). We disagree that claimant was released to his regular work.

Claimant's attending physician released him to his "regular work" but with limitations on lifting and with instructions "to avoid activities which may be damaging or dangerous." (Ex. 17). Dr. Hacker limited claimant's lifting capacity to 0-15 pounds frequently, with a maximum lifting capacity of 35 pounds. (Id.) Claimant's job at injury, however, involved frequently lifting furniture weighing approximately 65-75 pounds, with maximum lifting of 100 pounds. (Tr. 9-10, 14). Thus, we do not find that Dr. Hacker released claimant to perform substantially the same job which he held at the time of

injury. OAR 436-35-270(3)(c). Claimant further testified that another employee had been hired to help with the heavy lifting, since claimant was unable to lift more than 35-40 pounds by himself. (Tr. 9, 16). Accordingly, after our review of the record, we agree with the Referee's finding that claimant did not return to his regular work, nor did he return to a job requiring greater strength than his job at injury. See OAR 436-35-310(2).

Second, SAIF contends that the Referee used the wrong DOT classification for claimant's job at injury. SAIF contends that claimant's job at injury should be classified as "retail store manager," which requires strength in the "light" category. (DOT 185.167.046). The Referee classified claimant's job as "furniture mover/driver," which requires strength in the "very heavy" category. (DOT 905.663-018).

After our review of the record, we agree with the Referee's determination that the "furniture mover/driver" job description more accurately describes claimant's job at the time of his injury. (See Tr. 9-14). In addition, we note that although claimant's job title at the time of injury was assistant manager, he had held this title only about one month, when the new owners took over the business. However, claimant testified that his job duties did not change, which included moving furniture. (Tr. 13-14, 21-22). See William L. Knox, 45 Van Natta 854 (1993) (although more than one DOT may arguably describe claimant's work, we consider the claimant's job duties and physical demands, rather than claimant's "title" at the time of injury).

Scheduled Permanent Disability

The Referee awarded claimant 16 percent scheduled permanent disability for loss of use or function of his right arm, based on diminished strength. SAIF contends the Referee erred. We agree.

The standards in effect on June 2, 1992, the date of the Notice of Closure, specify a percentage of impairment for "[i]njuries to unilateral spinal nerve roots with resultant loss of strength," as modified pursuant to OAR 436-35-007(14). OAR 436-35-110(7) (WCD Admin. Order 6-1992). OAR 436-35-007(14) provides that in order to determine impairment due to loss of strength, a 0-5 muscle grading system shall be used. Dr. Hacker, claimant's attending physician, apparently agreed with the physical capacities evaluation finding that claimant's strength was 5/5. (Ex. 17; see also Ex. 16). Since claimant's muscle strength is 5/5, his percentage of impairment is 0. OAR 436-35-007(14). We find no other evaluation of claimant's arm strength, that is consistent with the standards, that would support a scheduled permanent disability award.

Therefore, we reverse the Referee's scheduled permanent disability award. We reinstate and affirm that portion of the Order on Reconsideration which awarded claimant no scheduled permanent disability.

Attorney Fee on Review

Inasmuch as claimant's compensation has not been disallowed or reduced with respect to the extent of unscheduled permanent disability, claimant is entitled to an assessed attorney fee. ORS 656.382(2); Debra L. Cooksey, on recon, 44 Van Natta 2197 (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 concerning the unscheduled permanent disability is $500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 8, 1992, as reconsidered October 22, 1992, is affirmed in part and reversed in part. That portion of the Referee's order which awarded an additional 7% (22.4 degrees) unscheduled permanent partial disability, for a total award of 27% (86.4 degrees) unscheduled permanent disability for the neck, is affirmed. That portion of the Referee's order which awarded an additional 16% (30.72 degrees) scheduled permanent disability for loss of use or function of the right arm, as well as an out-of-compensation attorney fee based on that award, is reversed. Instead, that portion of the Order on Reconsideration which awarded no scheduled permanent disability is reinstated and affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DOUGLAS J. HIRTE, Claimant
WCB Case No. 91-03842
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Holtan's order that dismissed his request for hearing. On review, the issue is jurisdiction.

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

The insurer did not approve claimant's attending physician's request for palliative care under two statutes. First, the insurer contended that the palliative care is not "compensable" under ORS 656.245(1)(b), because it would not significantly improve the objective findings nor enable claimant to continue current employment. (See Exs. 61, 62-2). Second, the insurer contended that the palliative care is not permitted under ORS 656.327(1), because it is "excessive, inappropriate, ineffectual or in violation of any medical rules." (See Ex. 62-2).

The insurer requested Director review of the palliative care request pursuant to former OAR 436-10-041 and former 436-10-046(1). (WCD Admin. Order 32-1990). (Ex. 62). Former OAR 436-10-041 administers the provisions of ORS 656.245(1)(b) which authorize Director review of palliative care to determine whether the proposed palliative care is appropriate to enable the worker to continue current employment. Former OAR 436-10-046 administers the provisions of ORS 656.327 which authorize Director review of medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

By letter dated August 30, 1991, the Director, through the Medical Review and Abuse Section of the Workers' Compensation Division, responded to the insurer's request as follows:

> "The provisions of OAR 436-10-046 provide for director review of 'compensable' medical treatment that is believed to be excessive, inappropriate, ineffectual, or in violation of the rules. The types of palliative care that is subject to this review process includes treatment for workers who are Permanently Totally Disabled, the administration of prescription medications, and treatment regarding the monitoring of prosthetic devices. These three situations have been established by statute as being compensable care.
>
> "Your request is inappropriate, since palliative care to enable an injured worker to continue current employment is not a 'compensable' medical service, but rather treatment which the director may declare to be reimbursable in situations where it is appropriate. The process outlined in OAR 436-10-041 governs the manner in which palliative care is to be processed in cases such as this." (Ex. 63).

We have previously held that we lack original and review jurisdiction to consider whether requested palliative care is appropriate to enable a claimant to continue current employment. Mary S. Leon, 45 Van Natta 1023 (1993); Rexi L. Nicholson, 44 Van Natta 1546 (1992). The Director has exclusive jurisdiction of that question under ORS 656.245(1)(b). Id.

We do have jurisdiction to review a Director's order that is issued pursuant to ORS 656.327 declaring medical treatment to be "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." ORS 656.327(2); Iola W. Payne-Carr, 45 Van Natta 335 (1993) (on reconsideration). Here, however, the Director did not issue a formal order pursuant to ORS 656.327. Rather, the August 30, 1991 letter is more in the nature of an interim order that places the matter in a deferred status. It appears that the Director requires the parties to complete the determination of whether the treatment would be allowed under ORS 656.245(1)(b) and former OAR 436-10-041, before the Director will address whether the treatment would be allowed under ORS 656.327 and former OAR 436-10-046. Therefore, since the matter remains pending before the Director, as yet, the Board has no authority to act.

We recognize that the parties have been trying to resolve their dispute about medical benefits for some time and that this order still leaves the parties without any resolution. However, given the current state of the statutory and case law regarding which forum has jurisdiction to act in medical benefits matters, the Board is unable to act.

ORDER

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

In the Matter of the Compensation of
PAT JENNINGS, Claimant
WCB Case No. 91-04276
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Lipton and Westerband.

Claimant requests review of Referee Podnar's order which upheld the insurer's denial of claimant's condition resulting from a fall at work. On review, claimant moves to remand this case to the Referee for the taking of additional evidence regarding whether claimant's work conditions presented an increased risk of injury. On review, the issues are 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

Claimant moves to remand this case to the Referee for the taking of additional evidence on the issue of whether the work area where claimant fell presents an increased risk of injury. At hearing, the insurer objected to testimony which allegedly would have shown that the area where claimant fell was wet and strewn with trash, and that many other workers had fallen in that area as a result of such conditions. (Tr. 62-64). The Referee sustained the objection, based on the insurer's argument that since claimant could not remember how or why he fell, the evidence was irrelevant. (Tr. 63).

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We consider the proffered evidence only to determine whether remand is appropriate.

Here, claimant seeks to show that the workplace area where he fell presented an increased risk of injury. Under the "increased danger rule," claimant's injury will be found compensable, even though he fails to eliminate all idiopathic causes, if claimant proves there was a substantial employment contribution to the risk of injury or to the extent of harm. Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991); Emery A. Reber, 43 Van Natta 2373, 2375 (1991). However, we have held that merely walking or standing on a concrete floor does not present a sufficient "increase" in risk as to invoke the principles set forth in Marshall v. Bob Kimmel Trucking, supra. See Ruben G. Rothe, 43 Van Natta 369, 371 (1993).

In the present case, it is undisputed that claimant was standing at ground level on flat, asphalt-covered ground prior to his fall. See Opinion and Order at 1, 3. The proffered evidence allegedly would establish that the area was wet and strewn with trash, and that other workers had fallen there.

We find that even if claimant establishes the facts as alleged, such work conditions do not constitute a substantial danger, nor do they present inherent risks that are substantially different from those encountered by any person walking or standing on flat, asphalt-covered ground. Marshall v. Bob Kimmel Trucking, supra; Ruben G. Rothe, supra. Thus, we conclude that the proffered evidence would not establish that claimant's work conditions were such as to invoke the "increased danger rule." Accordingly, since the additional evidence is not reasonably likely to affect the outcome of this case, we conclude that the record is not improperly or insufficiently developed without the evidence. For these reasons, we deny claimant's motion to remand.

Compensability

We affirm and adopt the Referee's order which upheld the insurer's denial of claimant's condition resulting from a fall at work, with the following supplementation.

The Referee found that claimant failed to eliminate all potential idiopathic causes of his fall, and therefore, under Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), claimant failed to establish compensability of his claim.

However, subsequent to the Referee's decision, we held that the Russ rationale has been effectively overruled by ORS 656.266, which provides that claimant cannot establish compensability "merely by disproving other possible explanations." Ruben G. Rothe, supra, 45 Van Natta at 372. Therefore, even if claimant had eliminated all potential idiopathic causes of his fall, he still would have to affirmatively prove that his injury was, in fact, related to his working environment. Id. We find that claimant failed to prove by either direct or circumstantial evidence that his fall was, in fact, related to his work conditions or activities. Therefore, under ORS 656.266, his claim is not compensable.

Subsequent to the filing of Board briefs in this case, claimant, by letter, called our attention to the September 16, 1992 Court of Appeals decision in Boyd v. SAIF, 115 Or App 241 (1992). The insurer responded by a letter to the Board, arguing that the Boyd decision is inapplicable. Subsequently, the insurer by letter asked us to consider our February 26, 1993 decision in Ruben G. Rothe, supra.

It is permissible for any party to provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. Further argument, however, will not be considered. See Betty L. Juneau, 38 Van Natta 553, 556 (1986).

Here, the Boyd decision issued after claimant filed his reply brief on September 9, 1992. Likewise, our decision in Ruben G. Rothe issued after the conclusion of briefing in this case. Therefore, we allow both submissions, but only to the extent they advise us of recent developments in the law. We do not consider any supplemental submissions to the extent they contain additional argument. See Debra A. West, 43 Van Natta 2299 (1991). Therefore, we do not consider the insurer's letter in response to claimant's submission of supplemental authority.

We have already considered the Ruben G. Rothe case in our decision, and we found it to be controlling.

With respect to Boyd v. SAIF, we do not find that decision applicable to the facts in the present case. Here, claimant apparently fell at work; however, there is no evidence establishing how or why he fell. In Boyd, there was no question about the mechanism of injury. The issue in Boyd was whether the act of getting into a car after work in an employer-controlled parking lot was sufficiently work-related to be compensable. The Boyd decision did not address the central issue in the present case; that is, whether an unexplained fall at work, or a fall caused by idiopathic factors, is sufficiently work-related to be compensable. Accordingly, we find that the Boyd decision does not aid us in deciding the present case.

ORDER

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

In the Matter of the Compensation of
BEVERLY A. KIRK, Claimant
WCB Case No. 92-11018
ORDER ON RECONSIDERATION
Flaxel, et al., Claimant Attorneys
Randolph Harris (Saif), Defense Attorney

Claimant requests reconsideration of our June 18, 1993 Order on Review which awarded her a penalty pursuant to ORS 656.268(4)(g). Enclosing a statement of services, claimant's counsel seeks an "extraordinary" attorney fee for assisting claimant in obtaining the penalty.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v Western States Plywood, 297 Or 628 (1984). As noted in our prior order, unlike a "penalty" under ORS 656.262(10), the penalty under ORS 656.268(4)(g) does not provide for an equal distribution between a claimant and her attorney. Moreover, since we did not find the SAIF Corporation's conduct to have been unreasonable, an attorney fee award under ORS 656.382(1) is not warranted.

Claimant cites ORS 656.388 in support of her request for an attorney fee. ORS 656.388(1) provides, in relevant part:

> "No claim or payment for legal services by an attorney representing the worker or for any other services rendered before a referee or the board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the referee or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court."

ORS 656.388 envisions a claim for legal representation (i.e., a request for an attorney fee) based on an attorney fee granted pursuant to a specific statutory authority, e.g. ORS 656.382, 656.386, 656.388(1). The statute itself does not provide authorization for an attorney fee payable from a claimant to his or her counsel. Claimant has neither cited us to, nor have we uncovered, statutory authority which would allow for an attorney fee under these circumstances. Therefore, we are without authority to award the attorney fee sought by claimant. Forney, supra.

Accordingly, the motion for reconsideration is granted and our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
OSWALD F. KUZNIK, Claimant
WCB Case No. 91-14110
ORDER ON REVIEW (REMANDING)
Nancy F.A. Chapman, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of that portion of Referee McCullough's order which declined to assess an attorney fee for the self-insured employer's allegedly unreasonable refusal to provide discovery. Claimant requests that this matter be remanded for the Referee to make additional findings. Additionally, in its respondent's brief, the employer argues that litigation of the attorney fee issue is barred by res judicata. On review, the issues are res judicata, remand and attorney fees. We remand.

FINDINGS OF FACT

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

Claimant has an accepted 1984 claim for an injury to his right upper extremity. On August 20, 1991, following a prior hearing regarding claimant's entitlement to additional temporary disability and medical benefits, claimant requested that the employer provide copies of all medical bills and all summary sheets, payment ledger sheets and computer printouts concerning claimant's medical and temporary disability benefit payments.

On August 27, 1991, the employer replied by agreeing to provide claim-related documents generated after the August 20, 1991 hearing, but it refused to provide claim-related documents generated before that hearing.

On September 25, 1991, claimant requested a hearing on the employer's refusal to provide discovery. The next day, claimant made another request for discovery of all medical bills and the claim summary/payment ledger. At hearing on October 24, 1991, the employer agreed to provide claimant with copies of all claim-related documents not previously disclosed. The sole issue presented to the Referee is whether the employer should be assessed an attorney fee for its allegedly unreasonable refusal to provide discovery.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, even if the employer's conduct had been unreasonable, there is no evidence that it had resisted the payment of compensation so as to warrant the assessment of an attorney fee pursuant to ORS 656.382(1). On review, the employer agrees with the Referee's ruling. Alternatively, the employer contends that res judicata precludes claimant from litigating the attorney fee issue because it could have been raised at a previous hearing in November 1990 and March 1991.

Res Judicata

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

The hearing in November 1990, which was continued in March 1991, concerned the compensability of claimant's arthritic thumb condition. At that hearing, claimant also sought penalties against the employer for, among other reasons, its delay in disclosing claim-related documents. By Opinion and Order dated June 27, 1991, Referee Menashe held that the thumb condition was a compensable aggravation, but he declined to assess penalties, finding that the employer's conduct was not unreasonable.

The present proceeding, on the other hand, concerns the employer's refusal to provide discovery of claim-related documents pursuant to claimant's attorney's August 20, 1991 request. The discovery request was prompted by the August 16, 1991 deposition of the employer's claims examiner. Inasmuch as the discovery request and the employer's refusal occurred after the prior hearing, that issue was not actually litigated in the prior hearing, nor was it based on the same factual transaction that was at issue in the prior hearing. Accordingly, we conclude that claimant's attorney fee request is not barred by res judicata.

Remand

Claimant requests that this matter be remanded to the Referee for a finding that the employer's refusal to provide discovery was unreasonable.

Both the Board and the Director have rules regulating discovery of claim-related documents. The Board's rule, OAR 438-07-015(2), only applies after a hearing request is filed. See OAR 438-05-011; Dillard J. Graves, 42 Van Natta 2574 (1990); Lawrence A. Durette, 42 Van Natta 413, 414 (1990). The Director's rule, OAR 436-60-017, applies when a hearing request has not been filed. See OAR 436-60-017(1). Both rules require that claim-related documents be disclosed within 15 days after the discovery request. See OAR 438-07-015(2), 436-60-017(5).

Here, regardless of which rule applies, the employer did not timely disclose all claim-related documents requested by claimant. Claimant made the initial discovery request on August 20, 1991, filed the hearing request on September 25, 1991, and made another discovery request on September 26, 1991. (Exs. 3, 9, 9A). The employer did not agree to disclose the requested documents until October 24, 1991, the date of hearing. The employer explains that claimant's discovery request was procedurally barred, because he had not raised the discovery issue in prior hearings. We disagree.

The mere fact that claimant has had a prior hearing relating to the claim does not bar him from seeking disclosure of documents generated before that hearing. The discovery rules do not impose any such limitation. Rather, OAR 438-07-015(5) provides that "[i]t is the express policy of the Board to promote the full and complete disclosure of all facts and opinion pertaining to the claim being litigated before the Hearings Division." In the light of this policy, as well as the clear and unambiguous language of the discovery rules, we find that the employer did not have any legitimate doubt of its obligation to disclose all claim-related documents requested by claimant. Its refusal to do so, therefore, was unreasonable. See Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

We now turn to the issue of whether the employer resisted the payment of compensation so as to warrant assessment of an attorney fee pursuant to ORS 656.382(1). Claimant sought discovery to determine whether the employer properly paid claimant temporary disability and medical benefits. The employer responds that there is no evidence in this record to show that its refusal to provide full discovery actually interfered with claimant's receipt of compensation.

In order to determine whether the employer's unreasonable refusal to provide discovery constituted a resistance to the payment of compensation, there must be evidence in the record to show that the employer's conduct actually interfered with its obligation to pay compensation. See SAIF v. Condon, 119 Or App 194 (1993); Aetna Casualty Co. v. Jackson, 108 Or App 253, 257 (1991).

Because the documents which claimant sought are not in this record, we cannot determine whether the employer's failure to provide disclosure delayed claimant's recovery of compensation. Inasmuch as that determination is essential to the resolution of the attorney fee issue, we find that the record is insufficiently developed for our review. In this regard, we find that, because the requested documents were in the employer's possession at the time of hearing and the employer's refusal to disclose them, they were not obtainable by claimant at that time. Further, we find that the documents are reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Accordingly, we vacate the Referee's order. This matter is remanded to the Referee for the taking of evidence as to whether the employer's refusal to comply with claimant's discovery request delayed his receipt of compensation. The Referee shall then make findings as to whether or not an attorney fee may be assessed under ORS 656.382(1). The proceedings may be conducted in any manner that will achieve substantial justice. The Referee shall then issue a final, appealable order concerning the issues raised in this case.

ORDER

The Referee's order dated December 13, 1991 is vacated. This matter is remanded to Referee McCullough for further proceedings consistent with this order.

Board member Hooton specially concurring.

On the basis of the principles of judicial economy and expedience, I agree that it is appropriate to remand this claim to the Referee for the further receipt of evidence. However, I reach that conclusion based upon reasoning that differs from that presented by Member Kinsley.

In Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991), the court stated that "[w]e have held that failure to comply with discovery requirements may be unreasonable resistance to the payment of compensation and may justify attorney fees under ORS 656.382(1), even where there is no evidence that the noncompliance delayed acceptance of the claim." However, the court stated that the underlying claim must be compensable. The court specifically cited Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991) in support of its conclusion.

Here, the underlying claim is compensable. The discovery violation had not been cured at the time of hearing, so claimant could not possibly prove an entitlement to additional compensation, or a delay in the payment of past compensation. Consequently, the claim seems to fall squarely within Boehr, which would allow an assessed fee under ORS 656.382(1).

In the recent case of SAIF v. Condon, 119 Or App 194 (1993), the court reversed an award of penalty-related attorney fees under ORS 656.382(1) because the evidence demonstrated that all bills had been timely paid. It also cited Aetna Casualty Co. v. Jackson, supra.

I would conclude that Condon, Jackson and Boehr create apparently conflicting precedent on this issue. Any conflict can be resolved by construing Condon and Jackson to create a defense to a request for penalty related attorney fees if the insurer demonstrates that all bills have been timely paid. If the insurer does not so demonstrate the claimant is entitled to a penalty-related attorney fee under Boehr.

However, I acknowledge that I am unable to predict how the court will decide the next case which involves an award of attorney fees under ORS 656.382(1).

What is clear is that it is patently abusive to find that a claimant has failed to meet his burden of proof on an issue where the evidence necessary to meet that burden is in the hands of the insurer and remains undisclosed at the time of hearing. Whether the burden of proof is the insurer's or the claimant's, the hearing record ought to include the relevant evidence. Consequently, remand is appropriate.

However, I disagree with the statement of Member Kinsley that "there must be evidence in the record to show that the employer's conduct actually interfered with its obligation to pay compensation." When the basis for a request for attorney fees under ORS 656.382(1) derives from a failure to disclose documents properly requested in a request for discovery, the failure to disclose has no direct relationship with the payment of compensation. The refusal or delay in providing discovery is "considered" an unreasonable resistance to the payment of compensation because the failure to disclose "hides" the fact that claimant may be entitled to additional compensation, or a penalty for the late payment of compensation. Claimant is not, and can never be, entitled to additional compensation as a result of a disclosure of evidence held by the insurer. The obligation to pay benefits arises as a processing requirement under ORS 656.262, or ORS 656.245 upon receipt of a claim, not because the claimant forced an insurer to disclose that it had received the claim.

If the evidence reveals that the insurer inappropriately failed to pay compensation, or paid compensation due in an untimely manner, claimant is entitled to a penalty for that refusal or delay. The additional sanction for failure to disclose is assessment of an attorney fee under ORS 656.382(1), since two penalties cannot be assessed against the same amounts due. Consequently, claimant need not demonstrate a relationship between the non-disclosure and compensation due. Claimant should, however, provide evidence that there is compensation due, or that compensation was not timely paid, as well as that the insurer failed to disclose documents under the discovery rules.

In the Matter of the Compensation of
JOHN P. LAMBERT, Claimant
WCB Case Nos. 90-21305 & 90-21162
SECOND ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

The insurer requests reconsideration of that portion of our March 12, 1993 Order on Review, as reconsidered April 7, 1993, in which we concluded that Liberty Northwest Insurance Corporation, on behalf of West Coast Steel, is responsible for claimant's protruding discs and foraminal stenosis. In its brief, claimant contends that Liberty's request for reconsideration was untimely.

We address the timeliness issue first. In our Order on Reconsideration, we withdrew our March 12, 1993 Order on Review, which we republished, as supplemented, on April 7, 1993. The parties' appeal rights ran from April 7, 1993. Liberty requested reconsideration of the republished order on April 12, 1993, well within the 30 day appeal period established by the Order on Reconsideration. On May 5, 1993, within 30 days of our April 12, 1993 order, we withdrew our order for further consideration. Accordingly, we conclude that Liberty's request for reconsideration was timely and that we retain jurisdiction over this matter.

After review of the record, we modify page two of the March 12, 1993 Order on Review to note that it was Dr. Matteri, rather than Dr. Kitchel, who examined claimant in August 1990 and made diagnoses. We further modify the last sentence of our "Conclusions of Law and Opinion" on the issue of responsibility as follows. Because Liberty/West Coast was the insurer on the risk at the time of claimant's new injury, it is responsible for claimant's current disc condition and related medical treatment and disability.

Accordingly, our March 12, 1993 and April 7, 1993 orders are withdrawn. On reconsideration, as amended herein, we adhere to and republish our March 12, 1993 and April 7, 1993 orders in their 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
JOHN McCONNELL, Claimant
WCB Case No. 91-07586
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

The insurer requests review of Referee Black's order that awarded claimant temporary total disability benefits. On review, the issue is temporary total disability. We modify.

FINDINGS OF FACT

Claimant first worked as a route driver for United Parcel Service (UPS). That job required heavy lifting, and, in 1987, he began to experience left shoulder pain. Although the pain worsened to the point that it affected his job performance, he sought no medical treatment at that time. In August 1989, claimant left work at UPS for reasons unrelated to his condition and related to a violation of normal employment practices.

In January 1990, claimant began light duty work as a business agent with the Teamsters Union. In March 1990, he sought medical treatment for left shoulder pain and filed an occupational disease claim for the shoulder condition against UPS. UPS denied the claim on March 27, 1990. By Opinion and Order dated February 22, 1991, an earlier referee found the claim compensable, setting aside the denial and remanding the claim to UPS for processing. On review, we affirmed and adopted that order. John McConnell, WCB #90-12915 (September 23, 1991).

On October 26, 1990, claimant underwent surgery for left shoulder arthroscopic decompression. He was released from work for one week following surgery, though he apparently returned to work after a few days. He was subsequently released for light duty work. On December 13, 1990, claimant was discharged from his regular job with the Teamsters for reasons unrelated to his injury. He has not been declared medically stationary and is released for light duty work only.

CONCLUSIONS OF LAW AND REASONING

The Referee awarded claimant temporary total disability (TTD) benefits beginning October 26, 1990, subject to reduction for subsequent time worked. The Referee concluded that claimant is entitled to TTD benefits following his termination from the Teamsters job, reasoning that because claimant has not been released to the heavy work he was performing for UPS, his earning capacity has been reduced as a result of his compensable claim.

On review, the insurer argues that a worker's entitlement to TTD benefits must be determined with regard to the employment at the time the worker first seeks medical treatment or suffers disability. Because claimant was performing light duty work at the time of filing his claim, and because he remains physically capable of performing that work, the insurer contends that claimant is not disabled as a result of his compensable condition and, therefore, is not entitled to TTD benefits.

The calculation of TTD benefits is based on the partial replacement of wages lost as a result of a compensable injury or disease. See ORS 656.210(1); Cutright v. Weyerhaeuser, 299 Or 290, 298 (1985). For a worker who incurs an occupational disease, TTD benefits are based on the wage of the worker "at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease." ORS 656.210(2)(b)(B).

Here, although claimant had shoulder symptoms while working for UPS, the first "medical verification" of his inability to work due to the shoulder condition occurred on October 26, 1990, the surgery date. On that date, claimant was employed with the Teamsters, where his regular work was in the light category. Therefore, his TTD rate is based on the wage he earned in his Teamsters job.

It is undisputed that claimant was totally disabled from work on October 26, 1990, and for a few days thereafter, due to the compensable condition. He is entitled to TTD benefits for that period.

The dispute in this case turns on the issue of whether or not claimant's return to the light duty job with the Teamsters constituted a return to "regular employment" within the meaning of ORS 656.268(3)(a) so as to permit the termination of TTD benefits. The insurer argues that because claimant returned to the regular employment he had at the time of his disability, i.e., the Teamsters job, he has returned to "regular employment" within the meaning of ORS 656.268(3)(a) and, therefore, he is no longer entitled to further TTD benefits. We agree.

Inasmuch as claimant's TTD benefits for his occupational disease are based on his wage at the time there is medical verification of his inability to work, we are persuaded that a return to regular work which would permit termination of TTD benefits is a return to the job claimant was performing at the time of his medically verified disability. Here, claimant was performing regular work in light duty capacity for the Teamsters at the time of his medically verified disability. Because he returned to that job, we find that he returned to "regular employment" so as to permit the termination of TTD benefits.

Moreover, we note that, if claimant's return to the Teamsters job following surgery constituted a return to modified employment, claimant would only be entitled to temporary partial disability (TPD) benefits in accordance with ORS 656.212 and OAR 436-60-030. OAR 436-60-030(2) provides, in relevant, that "[t]emporary disability payments are not due if post-injury wages equal or are greater than the wages earned at the time of injury."

As we determined above, inasmuch as claimant sustained an occupational disease, rather than an injury, his "wages" for purposes of calculating TTD benefits are the wages he earned on the date he was disabled due to surgery in October 1990. Because claimant returned to that same job following surgery, earning the same wages he earned prior to surgery, no temporary disability payments are due following his return to work. See id.

Claimant was subsequently terminated from the Teamsters job for reasons unrelated to his compensable condition, as of December 14, 1990. Because he had already returned to work at the same wages he earned on the date of his disability due to surgery, he is not entitled to temporary disability benefits following his termination. See Dawes v. Summers, 118 Or App 15, 20 (1993); Stone v. Whittier Wood Products, 116 Or App 427 (1992); Safeway Stores v. Owsley, 91 Or App 475, 479-80 (1988). In addition, we note that none of the circumstances for recommencing TTD benefits occurred in this case. See former OAR 436-60-030(6) (WCD Admin. Order 8-1990).

Accordingly, we conclude that claimant is entitled to TTD benefits for the period of time he was totally disabled from work due to the surgery in October 1990. He is not entitled to any temporary disability benefits following his return to the Teamsters job.

Given our conclusion that claimant is not entitled to temporary disability payments following his termination from the Teamsters job, we need not address the issue of whether the insurer is entitled to an offset for unemployment compensation received by claimant following his termination.

ORDER

The Referee's order dated November 7, 1991 is modified. The Referee's temporary disability award is modified to award claimant temporary total disability benefits from October 26, 1990, to the date that claimant returned to the Teamsters job following surgery. In lieu of the Referee's attorney fee award, claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of any increased compensation created by this order, not to exceed $1,050, to be paid directly to claimant's attorney.

Board member Hooton dissenting.

Based on the reasoning of Safeway Stores v. Owsley, 91 Or App 475, 479-80 (1988), the majority concludes that claimant is not entitled to temporary disability compensation. I disagree.

The undisputed evidence in this record demonstrates that claimant obtained employment as a business agent with the Teamsters after his discharge from UPS. He was subsequently terminated from that employment because he was not suited, intellectually or by personality, to the requirements of the position.

While Owsley sought to protect the employer's interest in obtaining a speedy return to work, there is a presumption in Owsley and related cases that the employment to which the claimant returned was suitable employment. The rationale of Owsley, when applied to the present claim appears to protect the employer, and place claimant's compensation at risk, whenever the claimant seeks to better his work position by a change of employment. If claimant proves not to be suited to the new employment, for reasons unrelated to the injury, he will lose that employment through no fault of his own, and any entitlement to temporary disability compensation as well.

As a matter of public policy, there is at least as great an interest in furthering an injured worker's ability to obtain new employment, by protecting the injured worker's right to compensation should he prove not suited to the new employment for reasons unrelated to the injury, as there is in protecting the interest of the employer to the injured worker's speedy return to work.

Because I would conclude that the job of business agent was not a job to which claimant was otherwise suited, I would find that it is not regular or modified employment under the Workers' Compensation Law. Claimant remains unable to perform work to which he is suited, namely truck driving, as a consequence of the occupational disease. I would find that claimant's lost wages are, therefore, a result of the compensable condition, despite the termination of his employment as business agent for the Teamsters. I would, therefore, find claimant entitled to receive temporary disability compensation.

In the Matter of the Compensation of
DEWAIN J. MECHAM, Claimant
WCB Case No. 91-01184
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Myzak's order that upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for bilateral ulnar and radial neuropathies. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the last paragraph on Page 2, and with the following supplementation.

Industrial Indemnity denied responsibility for claimant's bilateral ulnar and radial neuropathies on October 8, 1990. (Ex. 19). On December 7, 1990, Industrial Indemnity denied both compensability and responsibility for the same condition. (Ex. 22).

On April 9, 1991, Liberty Northwest Insurance Corporation amended a January 25, 1991 denial of a different condition to include a denial of compensability and responsibility for claimant's bilateral ulnar and radial neuropathies. (Ex. 25).

On May 23, 1991, claimant and Industrial Indemnity entered into a disputed claim settlement (DCS), which provided:

> "1. Industrial Indemnity Co. shall pay to claimant the sum of $2,000 in full, final and complete settlement of claimant's disputed and denied bilateral ulnar and radial neuropathy conditions.
>
> "2. In consideration of the payment required in paragraph 1 above, the carrier's denial of December 7, 1990 is hereby approved and shall remain in full force and effect forever.
>
> "3. Claimant shall assume full responsibility for all medical and related expenses associated with his disputed and denied bilateral ulnar and radial neuropathies.
>
> "4. This is a full and complete settlement of any and all claims, whether mentioned specifically herein or not, for medical and temporary or permanent disability benefits or benefits of any other kind under the Workers' Compensation Law of the State of Oregon, with regard to claimant's disputed and denied bilateral ulnar and radial neuropathies." (Ex. 26).

FINDINGS OF ULTIMATE FACT

Work activities from May 18, 1989 through July 27, 1989 were not the major contributing cause of claimant's bilateral ulnar and radial nerve disability or to any worsening of it.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee, citing Garcia v. Boise Cascade Corp., 103 Or App 508 (1990), for the proposition that the last injurious exposure rule has no application when only one insurer is involved, found that claimant failed to prove actual causation against Liberty Northwest.

Claimant contends that the settlement with the prior insurer, Industrial Indemnity, has no effect on the outcome of the case and that the medical evidence is sufficient to establish a compensable claim against Liberty Northwest under the last injurious exposure rule of proof. We disagree.

Here, Industrial Indemnity denied compensability. In order to establish compensability under the last injurious exposure rule, claimant must prove that his work exposures generally contributed to his present condition.

However, by virtue of the DCS, claimant and Industrial Indemnity agreed that Industrial Indemnity's denial of compensability "remains in full force and effect." By doing so, they have agreed that there is no compensable relationship between claimant's work exposure at the employer prior to May 19, 1989 when Industrial Indemnity was on the risk[1] and claimant's bilateral ulnar and radial neuropathy condition. They are bound by that agreement, and the work exposure at the employer when Industrial Indemnity was on the risk cannot be regarded as having contributed to claimant's present condition. See Gilkey v. SAIF, 113 Or App 314 (1992). Accordingly, claimant must establish that employment conditions after Liberty Northwest was on the risk were the major contributing cause of the disease or its worsening. ORS 656.802(2).

We distinguish our analysis here from that in Meyer v. SAIF, 71 Or App 371 (1984), in which the court stated that the last injurious exposure rule applies to fix responsibility when an occupational disease could have been caused by work conditions at any one of several employments, even where only one insurer was a party to the case. In Meyer, the only issue was responsibility, whereas compensability is also at issue here, and Industrial Indemnity's employment cannot be considered by virtue of the DCS.

The medical evidence is unanimous that claimant's work for the employer while Liberty was on the risk was not the major contributing cause of either the onset or worsening of claimant's ulnar and radial neuropathies. Claimant has, therefore, failed to establish the compensability of his condition.

ORDER

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

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[1] Liberty Northwest came on the risk on May 19, 1989. Claimant last worked for the employer on July 27, 1989.

In the Matter of the Compensation of
TAMARA J. SIGLER, Claimant
WCB Case No. 91-14416
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Quillinan's order which: (1) affirmed an Order on Reconsideration affirming a Notice of Closure which awarded no permanent partial disability for claimant's cervical-thoracic strain; and (2) dismissed for lack of jurisdiction claimant's request for hearing regarding the insurer's denial of palliative medical treatment. On review, the issues are extent of unscheduled permanent disability and jurisdiction.

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

The Referee concluded that claimant is not entitled to an award of 5 percent impairment for a chronic condition limiting repetitive use of a body part because there is no medical evidence of any other impairment. The Referee interpreted former OAR 436-35-320(5) (WCD Admin. Order 2-1991, effective April 1, 1991) as allowing an award of 5 percent for a chronic condition only if claimant's measurable impairment is more than 0 but less than 5 percent. We agree with the Referee's conclusion that claimant is not entitled to an award for a chronic condition, but we do so based on the following reasoning.

We have previously held, interpreting former OAR 436-35-320(1) (WCD Admin. Order 7-1988, effective January 1, 1989), that nothing in that section indicated that a medically verified loss of repetitive use is not a measurable impairment. We concluded that loss of repetitive use is a "measurable impairment" within the meaning of former OAR 436-35-270(2). Robert L. Todd, 43 Van Natta 418, 419 (1991). We find nothing in the April 1, 1991 disability standards that requires a different result. See former OAR 436-35-005(5), 436-35-270(2), 436-35-320.

Impairment, including the presence of a chronic condition limiting repetitive use of a body area, must be established by medical evidence. Former OAR 436-35-320(1); see also, William K. Nesvold, 43 Van Natta 2767, 2768 (1991); James A. Hilary, 44 Van Natta 659, 660 (1992).

Here, the April 16, 1991 closing examination report of Dr. Takacs, attending physician, documented full cervical range of motion, "essentially no cervical, upper thoracic somatic dysfunction or associated muscle spasms," and no sensory, motor or reflex changes, muscle atrophy or loss of strength. (Ex. 17). At that time, Dr. Takacs concluded that claimant had no permanent impairment due to the cervicothoracic strain. Id.

To establish chronic condition impairment, claimant relies on a "check-the-box" report from Dr. Takacs generated more than two months after the Order on Reconsideration issued, which asserts that claimant has a chronic condition that limits repetitive use of the cervical-thoracic body area. We have previously held that medical evidence concerning a worker's impairment generated after the Order on Reconsideration cannot be considered. See ORS 656.268(7); Nancy A. Worth, 44 Van Natta 2345 (1992); Teresa L. Erp, 44 Van Natta 1728 (1992); Tor J. East, 44 Van Natta 1654 (1992). Inasmuch as Dr. Takacs' report was generated after issuance of the Order on Reconsideration, we decline to consider it. Accordingly, we conclude that claimant has failed to establish, based on medical evidence supported by objective findings, that she has a chronic condition that limited repetitive use of a body area.

ORDER

The Referee's order dated January 13, 1992 is affirmed.

In the Matter of the Compensation of
KEVIN P. SILVEIRA, Claimant
WCB Case No. 91-05623
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

The SAIF Corporation requests review of that portion of Referee Neal's order that set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception: There is no evidence that claimant missed work subsequent to an injury in November 1988.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that he has established a compensable claim for occupational disease with his employer. In order to do so, he must prove that his employment conditions were the major contributing cause of his disease or its worsening. The existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(2); Everett E. Newton, 43 Van Natta 1502 (1991).

Claimant's claim presents two issues for our review. The first is whether claimant's employment exposure in California can be considered in determining the major cause of his condition or its worsening. Assuming that it cannot, the second issue is whether claimant has proved that his Oregon employment exposure constituted the major cause of his condition or its worsening.

With regard to the first issue, the dissent asserts that no statute or case decision requires claimant to establish that his Oregon employment alone was the major cause of his condition. Rather, the dissent argues that claimant's entire exposure with this employer, both in California and in Oregon, must be considered in determining causation. The dissent then applies the last injurious exposure rule, Bracke v. Baza'r, 293 Or 239 (1982); Inkley v. Forest Fiber Products, 288 Or 337 (1980), to assign responsibility to the insurer on the risk at the time claimant became disabled.

We disagree with the dissent. Specifically, we conclude that claimant's California employment exposure cannot be considered in determining causation, because at the time of that exposure, claimant's employer was not a "subject employer" and claimant was not a "subject worker" under Oregon law. Thus, any exposure to which claimant was subjected while in California is not relevant to our review.

Pursuant to ORS 656.023, a "subject employer" is any employer "employing one or more subject workers in the state . . ." (emphasis added). We interpret the term "state," as used in ORS 656.023, to mean the state of Oregon. There is no evidence in this record that claimant's employer employed workers in Oregon at the time it operated its business in California. We conclude, therefore, that the employer was not subject to Oregon Workers' Compensation Law during that period.

It follows that claimant was not a "worker" subject to Oregon law at the time he was employed in California. Pursuant to ORS 656.005(26), a "subject worker" is a worker subject to Chapter 656. To be subject to Chapter 656, the "worker" must be employed by a "subject employer." See Lasiter v. SAIF, 109 Or App 464 (1991). If claimant was not employed by a "subject employer" while in California, he could not have been a "subject worker" during that period. Consequently, any injuries suffered during claimant's employment in California are not compensable under Oregon law.

From the foregoing analysis, we conclude that in order to establish the compensability of his claim for occupational disease, claimant must prove that his employment in Oregon was the major contributing cause of his condition or its worsening. From this record, we find that he has failed to sustain his burden of proof.

The only medical evidence in this case was provided by claimant's attending physician, Dr. Driver, who first examined claimant in February 1991. Two of Driver's reports are relevant with regard to the issue of causation. The first is his May 6, 1991 report, in which Driver opined that claimant's "work activities beginning in 1988 were the cause of his back condition." (Emphasis added) (Ex. 13.) We interpret this report to mean that claimant's entire employment exposure, including the period claimant worked in California, constituted the cause of his low back condition.

When asked to clarify his opinion, Dr. Driver reported on July 23, 1991:

> "I do agree that Mr. Silveira's heavy work driving skidder and tractor in October, November, December of 1990 and January 1991, certainly contributed to his seeking medical attention in February of 1991. In fact, this was probably a major contributor toward his need for medical attention." (Ex. 15). (Emphasis supplied).

This second report, on its face, suggests that claimant's work in Oregon represented the major cause of his "need for treatment" only. The report is silent, however, regarding whether that employment was the major cause of the condition itself. The report may mean that claimant's Oregon employment worsened the symptoms of the "condition" caused by his employment in both states. If it does, the report is insufficient to establish medical causation in a claim for occupational disease. See Weller v. Union Carbide, 288 Or 27 (1979). On this record, the precise meaning of the report cannot be discerned. Consequently, it cannot be determined whether claimant's Oregon employment was the major cause of his disease itself, or of its worsening. We conclude, therefore, that claimant has failed to establish a compensable claim for occupational disease. ORS 656.266; 656.802.

ORDER

The Referee's order dated August 9, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,200 assessed attorney fee is reversed.

Board member Hooton dissenting.

This is a relatively simple case that presents an interesting question of law. The resolution of the legal question is the sole issue presented by the parties. There is no disagreement between the parties regarding factual issues.

Claimant suffers from a severe degenerative disease of the lumbar spine. His treating physician has concluded that the disease is caused, in major part, by claimant's employment activities since 1988. However, claimant was employed in California in 1988, and remained employed in that state until the fall of 1990 when his employer, Larch Enterprises, moved its logging operations to Wallowa County in Oregon.

SAIF Corporation has taken the position that since employment in California is also identified as contributory, claimant's Oregon workers' compensation claim is not compensable unless claimant can demonstrate a pathological worsening of his "pre-existing" degenerative disc disease. Given their analysis based on the non-subjectivity of the employer for the period from 1988 through the fall of 1990, the majority has apparently adopted this reasoning. I disagree.

ORS 656.802 provides in pertinent part that:

> "...'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 exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death..."

This statute does not, on its face, limit employment exposures to those which occur in Oregon. The task which confronts the Board is to interpret and apply the statute in situations which the legislature may never have anticipated. A significant portion of the workforce in Oregon is comprised of transient or temporary forestry workers, migrant farm workers and other forms of temporary employment. In addition, the mobility of modern society assures a flow of labor into, and out of, Oregon on a regular basis. The question presented is how should we treat the compensability of occupational diseases for claimants who fall into one of these categories, and who have contributing exposures both within and without the state? That question is one of policy not specifically addressed by the legislature. The best sources for the development of an appropriate rule are the policy statements of the Workers' Compensation Law and the prior similar considerations, if any, that have developed in case law.

ORS 656.012(2) provides the statutory policy statements which help to guide our reasoning here. That statute provides in pertinent part as follows:

> ". . . [T]he 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;
>
> "(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable;
>
> "(c) To restore the injured worker physically and economically to a self sufficient status in an expeditious manner and to the greatest extent practicable;"

In Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), the Supreme Court adopted the last injurious exposure rule as a rule of proof in occupational disease cases. The court explained that the reason for adopting the rule lay in the difficulty of establishing causation as to successive employments, or between successive insurers for the same employment. This exposed claimant to a substantial risk of no recovery even though the disease process was known to be occupationally caused. Id. at 343. Under the rule claimant must prove that the claimed condition was caused by his employment generally. Thereafter, the application of the rule of proof would arbitrarily assign liability to the last insurer on the risk which could have been a contributory cause of the disease at the time of the onset of disability. Id. at 344. See also Bracke v. Baza'r, 293 Or 239, 247 (1982).

Inkley argues that, in those situations where the claimant has demonstrated that his occupational disease is, in fact, caused by his employment, the appropriate policy considerations would not support depriving claimant of compensation for his condition, or of placing that compensation substantially at risk, because of the inherent difficulty of proving the degree of contribution of each respective employer in successive employment or successive coverage cases. The last injurious exposure rule is consistent with the policy statement of the statute because it insures that a claimant who has demonstrated that his condition is caused by employment will receive compensation for any disability or need for medical treatment that results, even if he is unable to prove the contribution of a particular employer.

Here, claimant faces a similar problem. He has demonstrated that his employment exposure with Larch Enterprises actually caused his degenerative disk disease. His treating doctor, expressing the only medical opinion in the record, stated that "[m]y notes would suggest that Mr. Silveira's work activities beginning in 1988 were the cause of his back condition." He went on, specifically, to note that "[t]he degenerative condition is due to continuous work, not necessarily one specific injury." (Ex. 13.) The problem, however, is that it is very difficult to determine the extent of the disease process at the time claimant came to Oregon, or the contribution of the "Oregon" employment with this same employer to the causation of the condition. The condition was neither diagnosed nor treated in California, so far as the present record would indicate. Consequently, comparative medical evidence is a virtual impossibility.

To the extent that Inkley expresses a policy on this question, that policy is that claimant should not be required to show the actual contribution of the four months of exposure which occurred in this state to the causation of his condition, as distinct from the actual contribution of the period of employment with the same employer in California. Having shown that the employer, Larch Enterprises, caused the condition, claimant has done all that should be expected of him.

One of the virtues of the last injurious exposure rule in an occupational disease context is that it stabilizes a uniform burden of proof in all cases, whether or not responsibility issues are also present. Claimant must demonstrate that he suffers from a disease the major contributing cause of which is his employment environment generally. If he has had only one contributing employment, he will establish actual causation. If he has had multiple employment exposures, however, the rule allocates responsibility to the last employment exposure prior to the onset of disability. Consequently, to establish a compensable occupational disease, claimant must generally show only one thing - - that his employment environment is the major cause of his disease process.

The problem with applying this policy to the present claim was previously addressed by the court in Miville v. SAIF, 76 Or App 603 (1985). In that case the claimant had sustained a back injury in Oregon. The condition was accepted by the Oregon employer and benefits provided under the Oregon Workers' Compensation Law. Thereafter, the claimant left the state and experienced a worsening of his back condition while employed in Indiana. The claimant sought the application of the doctrine outlined in Grable v. Weyerhaeuser Co., 291 Or 387 (1982), to establish the continued liability of the Oregon employer. At the same time, the Oregon employer sought the application of the doctrine outlined in Smith v. Ed's Pancake House, 27 Or App 361 (1976), to relieve it of further responsibility. The court applied the Grable doctrine with some modifications in order to assure only a single recovery and to meet the concern that the claimant could potentially be deprived of any compensation whatsoever. The court explained its reasoning as follows:

> "The rules in Grable and Smith arose in a context in which Oregon has 'control' over the assignment of responsibility either to a subsequent employer, if there is one, regardless of whether that employer is a noncomplying one, or to the original employer, if there is not. Oregon can apply its own rules consistently between Oregon employers. Here, however, Oregon does not have that control, because three of the later injuries occurred out of the state. If, for example, we were to hold here that the Indiana incidents were new injuries, rather than aggravations of the Oregon injury, and were to apply the rule in Smith, claimant would have no means of enforcing that result against the Indiana employer. Similarly, if claimant filed a claim in Indiana, and Indiana had determined that the incidents were aggravations of the Oregon injury and . . . had a rule which required the first employer to remain responsible, claimant would have no means of enforcing that result against the Oregon employer. In either case, he would remain uncompensated for injuries which were clearly work related. That would be contrary to the policy of the workers' compensation system." 76 Or App at 606-607.

The problem here is similar. If we conclude that claimant has established a compensable occupational disease in Oregon, claimant may still be able to claim the employer contribution in California under the coverage and carrier appropriate for that state, thus obtaining a double recovery. On the other hand, if we find that claimant's degenerative disk disease was caused by his employment with Larch Enterprises, but that claimant has failed to establish compensability because he has not established that the condition has worsened from whatever it was at the time he left California, nothing prevents California from finding that the condition was caused by Larch Enterprises and apply a rule that would hold the subsequent Oregon employment period responsible for the condition. Despite the fact that both jurisdictions acknowledged the causal relationship, claimant would effectively be deprived of compensation entirely. Claimant is, therefore, at a substantial risk to remain uncompensated for a condition which the uncontroverted medical record indicates is caused by his employment with Larch Enterprises, solely because that employer moved his business across a state boundary during the development of the condition. "That would be contrary to the policy of the workers' compensation system." Id.

There are no doubt many different resolutions of this claim that conform to the prior policy statements of the statute and case law. Unfortunately, I am only able to think of two that make even a modicum of good sense. The majority resolution is not among them. That resolution ignores the underlying policy of the Workers' Compensation Law that led the court to adopt the last injurious exposure rule and the rule in Miville, and creates a technical defense to a claim for compensation even where all of the evidence indicates that the condition was caused by claimant's employment. The majority resolution permits this employer to point to the California exposure while before the Oregon Board, and the Oregon exposure while before the California Board, despite the fact that claimant has proved that the employment exposure with this employer actually caused the condition.

The two potential resolutions of this claim which make sense in light of the underlying policy issues is to treat the prior out-of-state exposure as a successive coverage situation and allow the claimant to establish his claim using the last injurious exposure rule, even though there is only one Oregon employer. This application of the rule would insure claimant the compensation to which he is entitled unless the employer can show that the Oregon employment exposure could not have contributed to the condition.

The alternate potential resolution is to adopt a rule similar to Miville to apply to prior potentially causal out-of-state employment exposures. Under such a rule, claimant would be required to file his claim with any prior out-of-state employer who could have contributed to the condition prior to litigating the claim in Oregon. If benefits are provided under the out-of-state claim, then, and only then, would claimant be required to show an actual contribution to a worsened condition as required for pre-existing conditions under Weller v. Union Carbide, 288 Or 27 (1979). If the claim for benefits in the out-of-state exposure was not allowed claimant's demonstration that his condition was caused by his employment would be sufficient to assign liability to the last potentially causal Oregon employer on the risk.

Despite the fact that these two alternatives have different proof requirements, I would find that claimant has successfully demonstrated compensability in this instance under either theory. His exposure with Larch Enterprises is the sole cause of claimant's degenerative disk disease. The Oregon exposure with Larch Enterprises is the last potentially causal employment exposure. In addition, by filing his claim with Larch Enterprises claimant effectively gave both his Oregon and his California employer notice of a claim. When the employer declined to remit the claim for processing in California, it effectively denied the claim for benefits under the California occupational disease law. I can find no persuasive reason to reward the employer for what is obviously an attempt to play both ends against the middle and deprive claimant of compensation on an otherwise compensable occupational disease claim.

It is interesting that Oregon adopted the last injurious exposure rule to prevent employers from escaping liability by pointing fingers at one another while claimant is required to prove actual causation. Because the present claim involves employment in two states, the majority has deprived the claimant of benefits of the policy that supports that rule of proof, even though all of the relevant employment exposure is with a single employer. The result is inconsistent with the purpose for which the Workers' Compensation Law was adopted. The only appropriate resolution of this claim is to find the employer, the only employer for whom claimant has worked since 1988, responsible for providing benefits under the Oregon Workers' Compensation Law. The majority does not do so. Therefore, I dissent.

In the Matter of the Compensation of
BARBARA SIMMONS, Claimant
WCB Case No. 91-05148
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Lipton, Brazeau, and Hooton.

Claimant requests review of Referee Herman's order which upheld the insurer's partial denial of claimant's right shoulder rotator cuff tear condition. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated June 19, 1992 is affirmed.

Board member Hooton dissenting.

The insurer contends that claimant's rotator cuff tear is a consequential condition, the compensability of which must be independently established by a preponderance of the evidence showing that the original low back injury is the major cause of disability or the need for treatment. The Referee, and the majority here, by adopting that reasoning, appear to agree. Even claimant, whose only argument on review is that the low back injury is the major cause of an impingement syndrome, and the impingement syndrome the major cause of the rotator cuff tear, appears to have adopted the reasoning presented by the insurer. I disagree, and write primarily for the purpose of educating the courts, insurers and the bar.

It is arguable that the Board, either in the majority opinion, or the dissent, ought to consider the theory of the case presented by the parties, and stop its analysis at that point. I acknowledge the dangers of deciding a case on grounds other than those presented and argued by the parties. See Boise Cascade Corp. v. Katzenbach, 307 Or 391, 394 (1989). Nevertheless, ORS 656.295(6) would appear to require the Board to consider arguments not made by the parties if those arguments determine the "appropriate" resolution of the claim. Indeed, in many instances since the passage of SB 1197 we have decided cases based on case precedent which was not in effect on the date the case was heard or argued to the Board, and consequently, have frequently decided cases based on considerations not raised or argued by any party.

In this case, claimant sustained an injury to her low back in January of 1987. In January of 1988 claimant began to receive treatment for a right shoulder condition subsequently diagnosed as impingement syndrome. Claimant received regular treatment for that condition from December 7, 1988 through March 30, 1990. The condition was never formally accepted or denied. Based on medical evidence submitted in the present hearing, however, the Referee found that "the impingement syndrome was a result of the 1987 injury" (O & O p. 4), based on the analysis of Dr. Chamberlain that "due to the compensable back injury claimant began to rely more on her arms leading to increased shoulder difficulties." (O & O p. 3.) Those findings and conclusions are adopted by the majority.

In January of 1991 claimant returned to Dr. Chamberlain with increased shoulder difficulties subsequently diagnosed as a rotator cuff tear. While everyone appears to accept that this is a new condition, the medical evidence, which for all intents and purposes is limited to the chart notes, reports and deposition of a single physician, Dr. Chamberlain, does not support that conclusion.

Dr. Chamberlain describes the onset of the rotator cuff tear as a function of the impingement syndrome, using two analogies both of which are very instructive on this point. First, Dr. Chamberlain explains that the supraspinatus tendon (the rotator cuff) becomes inflamed, or develops a tendonitis, from overuse. He likens this condition to a rope that becomes frayed. Continued use of the frayed rope causes more fibers to fray until, ultimately, the rope breaks. The broken rope is the torn rotator cuff. (Ex. 28-6 through 28-7.).

Later, in his deposition, Dr. Chamberlain likened the impingement syndrome to a bunch of sand that gets into a set of ball bearing.

> ". . . Now, if you immediately take this thing apart, clean it all out and regrease it, it will probably do well for a long, long time. But if you don't, you just leave the sand in there, don't change the grease, and just keep going, its going to lead to the destruction of that set of ball bearings." (Ex. 28-22 through 28-23.)

Both of these analogies explain that the rotator cuff tear is not really a new condition. Rather, it is the natural expected worsening of the uncorrected impingement syndrome. A natural worsening of a compensable condition is compensable under ORS 656.273(1) unless the insurer can demonstrate that the major cause of the worsening is an injury not occurring in the course and scope of employment. Here, the insurer has not done so. Consequently, I would find the rotator cuff tear to be a compensable aggravation of the compensable impingement syndrome under ORS 656.273(1).

In the Matter of the Compensation of
TERRY R. SURRATT, Claimant
WCB Case No. 92-07568
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The insurer requests review of Referee Peterson's order that: (1) set aside its partial denial of claimant's claim for an upper back condition; (2) concluded that claimant was entitled to temporary disability benefits beginning March 3, 1992; and (3) assessed a penalty of 25 percent of all amounts then due for its unreasonable failure to pay temporary disability benefits. On review, the issues are compensability, temporary disability benefits, 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

On March 12, 1992, claimant filed a claim for a March 2, 1992 injury to his upper back. On June 1, 1992, the insurer accepted that claim as a temporary symptomatic flare-up of a thoracic strain, but denied the compensability of claimant's condition as of that date. At hearing on August 24, 1992, the insurer verbally amended its June 1 denial to deny claimant's current condition as of June 23, 1992. (Tr. 12). That is, the insurer conceded that claimant's condition was compensable as it existed between March 2 and June 23, 1992, but denied the compensability of claimant's condition as it existed thereafter.

The Referee refused to consider the insurer's oral amendment of its denial. Moreover, because he concluded that the medical evidence did not support the insurer's denial as of June 1, 1992, the Referee set aside that denial. The insurer contends that its June 1, 1992 denial, as orally amended on August 24, 1992, was proper. We agree.

Initially we note that the insurer's oral amendment of the effective date of its prior denial was valid. Claimant did not object to that amendment, nor did he assert surprise or request a continuance. See Lloyd L. Crockett, 43 Van Natta 1767 (1991). Consequently, we must evaluate the substantive validity of the insurer's denial as of June 23, 1992.

Claimant contends that his upper back condition, as it existed on June 23, 1992, resulted from the combination of his March 2, 1992 industrial injury and his preexisting upper back condition. Consequently, to prove compensability, claimant must show that the March 2, 1992, injury is and remains the major contributing cause of the denied condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409, 412 (1992), on recon 120 Or App 590 (1993). Because of the various possible causes of claimant's current upper back condition, including his prior noncompensable injury, we conclude that the issue of medical causation is a complex one requiring expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Anderson opines that, as of June 23, 1992, claimant's disability or need for treatment is more likely than not related to claimant's preexisting injury. (Ex. 51). There is no contrary medical opinion. Consequently, we conclude that claimant failed to prove the compensability of the denied upper back condition, and that the insurer's June 23, 1992 denial is valid.

Temporary Disability

We affirm and adopt the Referee's conclusions of law and opinion concerning claimant's entitlement to temporary disability benefits.

Penalties and Attorney Fees

Unreasonable Failure to Pay Temporary Disability

We affirm and adopt the Referee's conclusions of law and opinion concerning the insurer's unreasonable failure to pay temporary disability benefits.

Attorney Fees at Hearing and On Review

For prevailing over the insurer's denial at hearing, the Referee awarded claimant an assessed attorney fee of $2,500. In the light of our conclusion that the insurer's amended denial is valid, claimant did not prevail over the insurer's denial at hearing. Consequently, we set aside that award. Nevertheless, the insurer's amendment of its June 1, 1992 denial constituted a pre-hearing concession of the compensability of claimant's condition from June 1, 1992 until June 23, 1992. Inasmuch as the insurer had initially denied the compensability of claimant's condition during that period, claimant prevailed on a denied claim without a hearing. Because claimant's counsel filed a request for hearing challenging the insurer's June 1, 1992 denial, we conclude that claimant's counsel was instrumental in obtaining that denied compensation. ORS 656.386(1); Kimberly Wayne, 44 Van Natta 328, 330 (1992). Moreover, we note that claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review on the temporary disability benefits issue. ORS 656.382(2); see Marlin L. Samms, 44 Van Natta 1568, 1571 (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 for prevailing on a denied claim without a hearing is $300, to be paid by the insurer. We find that a reasonable fee for claimant's attorney's services on review concerning the temporary disability issue is $750, to be paid by the insurer. In reaching those conclusions, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and the hearing record), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631, 634 (1986).

ORDER

The Referee's order dated September 10, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's partial denial is reversed. The insurer's partial denial is reinstated and upheld. In lieu of the Referee's attorney fee award, for being instrumental in obtaining claimant compensation without a hearing, claimant's counsel is awarded an assessed fee of $300, to be paid by the insurer. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
BUDDY W. VAUGHN, Claimant
WCB Case Nos. 92-01764 & 91-14595
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lester R. Huntsinger (Saif), Defense Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Lipton and Brazeau.

Claimant requests review of those portions of Referee T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's denial, issued on behalf of Hage Brothers Farm, of claimant's aggravation claim for a low back condition; (2) upheld SAIF's denial, issued on behalf of Sherwood Park Nursing Home, of claimant's occupational disease claim for the same condition; and (3) declined to award claimant an assessed attorney fee for his attorney's services at hearing. On review, the issues are responsibility, aggravation and attorney fees.

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

Dr. Hubbard opined that claimant's worsened condition "was consistent with a waxing/waning of symptoms in someone who has received 71% unscheduled permanent disability for his back." (Ex. 56). However, claimant had actually been awarded only 56 percent unscheduled permanent disability. Notwithstanding Dr. Hubbard's erroneous assumption, there is no reliable basis in the record for concluding that Hubbard would have changed his opinion, even had he known the correct award. Accordingly, claimant has not sustained his burden of proof.

ORDER

The Referee's order dated June 29, 1992, as reconsidered August 10, 1992, is affirmed.

In the Matter of the Compensation of
DIANA M. COOPER, Claimant
WCB Case No. 92-10550
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton, Westerband, and Gunn.

Claimant requests review of Referee Spangler's order which held that the insurer's termination of temporary total disability compensation was proper under ORS 656.268(3)(c). On review, the issue is entitlement to temporary disability benefits.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated September 17, 1992 is affirmed.

Board Member Gunn dissenting.

In December 1991, claimant sustained a compensable disabling injury to her left shoulder while working at the employer's Dallas, Oregon plant. That plant is approximately 1 mile from claimant's home. In July 1992, the employer offered claimant physician approved modified work to be performed at its Salem office. That office is approximately 15 to 25 miles from claimant's home. Because claimant is not licensed to drive, has no access to a car and no public transportation is available between Dallas and Salem, she declined the employer's offer.

ORS 656.268(3)(c) permits an insurer to terminate a worker's temporary total disability benefits (TTD) if:

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

Relying on that statute, the insurer construed claimant's refusal of the physician approved modified work as authorizing it to terminate claimant's TTD. Claimant requested a hearing challenging that termination. The Referee concluded that, because the employer's work offer was "reasonable," the insurer properly terminated claimant's TTD. The majority affirms and adopts the Referee's order. Because I disagree with the Referee's conclusion that the "reasonableness" of an offer of modified work determines the worker's obligation to comply with that offer, I dissent.

The parties do not dispute that claimant had the physical capacity to perform the offered work. Claimant's only objection to the work was that it was to be performed at a location different from the location of her work at injury. In short, she objected to one of the terms and conditions of the modified employment. Thus, the issue here is what, if any, limits does ORS 656.268(3)(c) place on an employer's ability to offer modified work that provides terms and conditions of employment that differ from those of the worker's employment at injury.

When construing a statute, our task is simply to ascertain the intent of the legislature. ORS 174.010. We begin that assessment with an examination of the text and context of the statute. State v. Trenary, 316 Or 172, 175 (1993). If that examination does not reveal the intended meaning of a statute, then it is appropriate to consult the legislative history. Id.

An examination of the text and context of ORS 656.268(3)(c) reveals that the legislature has not imposed any express limitations on the terms and conditions of an offer of modified work. On its face, that statute would not preclude an employer from offering a worker modified work at a geographically inconvenient location or at markedly different wages or hours. Nor would it preclude an employer from offering work that it had agreed not to require the worker to do before the injury. Nevertheless, the legislature's failure to preclude an activity cannot be construed as an expression of its intent to permit that activity. City of Portland v. Jackson, 316 Or 143, 149 (1993). Consequently, I turn to the legislative history for further insight concerning the legislature's intent.

The legislative history of ORS 656.268(3)(c) is no more revealing than the text and context of that provision. What little discussion of that provision that I could find does not concern the limits, if any, that that statute imposes on an offer of modified work. See Minutes, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B at 348. In sum, it appears that the legislature failed to consider the problem. Under such circumstances, we must consider how the legislature would have intended the statute to be applied had it considered the problem. Security State Bank v. Luebke, 303 Or 418, 423 (1987). To do that, we must "look to the language used, the statutory objective and any other evidence of the intended meaning." Liberty Northwest Ins. Corp. v. Short, 102 Or App 495, 499 (1990). Our overriding objective, however, must be to give the statute an interpretation that is consistent with or tends to advance a more generally expressed legislative policy. See Springfield Education Assn. v. School Dist., 290 Or 217, 226 (1980).

One of the paramount policies underlying the workers' compensation laws is to "restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c). The specific policy underlying ORS 656.268(3)(c) is to encourage employers to provide work for injured workers who are not yet able to perform their customary work and to preclude workers, who are physically able to do modified work, from continuing to draw full benefits when remunerative work is available to them.

Both the general and specific policy underlying ORS 656.268(3)(c) would be frustrated if an employer could terminate a claimant's TTD by offering a make-work position at a geographically inconvenient location with the expectation that the claimant would refuse that offer. Under such circumstances, employers would not be motivated to truly facilitate an injured worker's return to work, because it would be cheaper to establish a sham position that a worker would never accept. Moreover, the injured worker would not be resorted to self-sufficiency, because his or her TTD would be prematurely terminated. Consequently, I agree with the Referee and the majority that ORS 656.268(3)(c) implicity limits an employer's ability to alter the terms and conditions of modified work. Nevertheless, I cannot accept the "reasonableness" limitation recognized by the Referee and the majority.

One of the other paramount policies of the workers' compensation laws is to "provide a fair and just administrative system * * * that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable." ORS 656.017(2)(b). Any time that a "reasonableness" standard is injected into a legal dispute, adversity and litigation increase. Adverse parties virtually never agree about what is "reasonable." Consequently, if the majority's view prevails, we shall see more cases arise as employer's and claimant's attempt to divine our view of reasonableness on a case-by-case, Board-by-Board basis. I see no reason to offend an overarching policy of the worker's compensation laws when a much more sensible approach is available.

An employment relationship is based on contract. That contract typically defines the terms and conditions of a worker's job, and specifies the terms and conditions of any alternative jobs that the worker may be required perform. Nothing in the text or policy of the workers' compensation laws suggests that employers should be permitted to capitalize on a worker's injury by imposing terms and conditions of employment that it could not have imposed before the injury. Consequently, the employment contract, whether express or implied, should limit an employer's ability to alter the terms and conditions of modified work. In short, a worker need only comply with an offer of modified work if the employer could have imposed the terms and conditions of that work prior to the injury.

In my view, requiring an offer of modified work to conform to the pre-injury contract between the employer and the employee will reduce adversity and litigation. It is much more likely that an employer and employee will agree on the terms of a contract, where they would otherwise disagree about the "reasonableness" of the terms and conditions of modified work. Moreover, if litigation does result, the factfinder's role will be more traditional. That is, the factfinder will be required to find facts concerning the terms of a contract rather than having to make a "reasonableness" value judgment.

Shortly after the employer offered claimant physician approved modified work, it closed its Dallas plant for the season. That closure, however, did not terminate claimant's entitlement to TTD. See International Paper Co. v. Huntley, 106 Or App 107, 109 (1991). Claimant was entitled to TTD until one of the conditions listed in ORS 656.268(3) was satisfied.

In my view, the condition established by ORS 656.268(3)(c) would not be satisfied unless the pre-injury employment agreement between claimant and the employer contemplated that claimant might work in Salem when the Dallas plant closed. If it did, the insurer properly terminated claimant's TTD. If it did not, claimant was entitled to reject the offer of modified work and continue to receive TTD, just as she would if the employer did not have another plant. International Paper Co. v. Huntley, supra. Because the record is not sufficiently developed for us to resolve that factual determination, I would remand this case for the receipt and consideration of additional evidence.

I dissent.

In the Matter of the Compensation of
MAXINE HEADLEY, Claimant
WCB Case No. 89-01834
ORDER ON REVIEW
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of that portion of Referee Tenenbaum's order that declined to authorize an offset of an alleged overpayment of claimant's prior permanent disability award. On review, the issue is offset. We modify.

FINDINGS OF FACT

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

Pursuant to an August 5, 1986 referee's order, claimant's unscheduled permanent disability award was increased from 30 percent (as granted by a January 1986 Determination Order) to 50 percent. On September 5, 1986, the insurer sent claimant a letter detailing the manner in which claimant's award would be fully paid. (Ex. 64A). The letter notified claimant that her award would be paid in 33 monthly installments, with the final payment to be made in June 1989. Claimant acknowledged that she received payment checks "to the place where they said it was paid off." (Tr. 36).

In October 1989, claimant entered a vocational training program. Following its conclusion, a November 1990 Determination Order issued. Claimant's unscheduled permanent disability award was reduced to 13 percent. According to the insurer's audit sheet, this reduction resulted in an overpayment of $11,840 ($16,000 - $4,160). (Ex. 123). The Referee subsequently increased claimant's award from 13 percent to 29 percent.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to award the insurer an offset for allegedly previously paid unscheduled permanent disability, reasoning that the insurer failed to prove the amount of its alleged overpayment. We disagree.

In Metro Machinery Rigging v. Tallent, 94 Or App 245, 248 (1988), the court held that an insurer must prove its "entitlement to a particular amount of overpayment" by a preponderance of the evidence. In the absence of rebuttal evidence, an insurer satisfies that burden by submitting evidence that shows "how the payments of the various awards of compensation were made and details the method of calculating the claimed overpayment." Allen L. Frink, 42 Van Natta 2666 (1990).

Here, the insurer submitted a letter detailing the manner in which claimant's August 1986 50 percent unscheduled permanent disability award would be paid. (Ex 64A). That letter further notified claimant that the award would be fully paid by June 1986. Claimant acknowledged that she received checks from the insurer until the time the insurer said the award was "paid off." Moreover, following the November 1990 Determination Order reduction of claimant's 50 percent award to 13 percent, the insurer also provided an audit sheet calculating its overpayment.

In light of such circumstances, we are persuaded that the insurer paid the entire 50 percent unscheduled permanent disability award prior to claimant's October 1989 entrance into a vocational training program and the subsequent November 1990 Determination Order. That award totalled $16,000 (160 degrees @ $100 per degree). Thereafter, as a result of the Referee's order, claimant's total unscheduled permanent disability award has been increased from 13 percent (41.6 degrees) (as granted by the Determination Order) to 29 percent (92.8 degrees). Thus, the total dollar amount of claimant's award to date equals $9,280.

Inasmuch as the insurer has previously paid $16,000 (160 degrees), the Referee's "increased" award (16 percent - 51.2 degrees) shall be offset against the insurer's overpayment. In addition, the insurer is authorized to offset the remainder of its overpayment ($6,720 - 67.2 degrees - 21 percent) against any future permanent disability awards granted on this claim.

ORDER

The Referee's order dated August 21, 1992, as reconsidered on October 5, 1992, is modified in part and affirmed in part. The insurer is authorized to offset claimant's 29 percent (92.8 degree) unscheduled permanent disability award as granted by the Referee's order against its previously paid 50 percent (160 degrees) unscheduled permanent disability benefits. The insurer is further authorized to offset the remainder of this overpayment (21 percent - 67.2 degrees - $6,720) against claimant's future permanent disability awards granted on this claim. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DENNIS B. KRALL, Claimant
WCB Case No. 91-06038
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of those portions of Referee Garaventa's order that: (1) upheld the insurer's denial of claimant's current condition; (2) found that claimant was entitled to temporary disability for a certain period; and (3) calculated that the proper rate of temporary disability was $339.44 per week. On review, the issues are compensability, entitlement to temporary disability and rate of temporary 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

Compensability - Temporary Disability

We affirm and adopt that portion of the Referee's order regarding these issues, with a supplemental response to claimant's arguments on review concerning compensability.

The insurer previously accepted a claim for a low back injury based on an alleged July 27, 1989 work event. In January 1991, claimant returned to work in a modified position, then left work two days later, reporting an exacerbation of symptoms. After an MRI showed evidence of a herniated disc at L4-5, the insurer denied compensability of claimant's current condition.

As noted by the Referee, the only medical opinion supporting compensability of claimant's current low back condition is provided by claimant's current treating physician, Dr. Rosenbaum, orthopedic surgeon. However, Dr. Rosenbaum expressly premised his opinion on the Referee finding claimant credible, thus supporting claimant's history that he was asymptomatic from 1986 until July 1989. Finding claimant not credible, the Referee concluded that Dr. Rosenbaum's report did not support a finding of compensability and that claimant, therefore, failed to carry his burden.

We agree with claimant that the Referee, for the most part, based her credibility finding on the substance of the evidence and not demeanor, and, therefore, that finding is not necessarily entitled to deference on review. See Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984). Nevertheless, for the reasons cited by the Referee, we also find that claimant is neither credible nor reliable.

The only remaining evidence supporting claimant's assertion that he was asymptomatic is testimony from a coworker regarding the physical demands of claimant's job and claimant's lack of complaints. In light of Dr. Rosenbaum's reports, however, we are not persuaded by this testimony. Dr. Rosenbaum stated that it would be "uncommon" for someone exhibiting the severity of symptoms that claimant showed in 1986 to experience similar symptoms in 1989, yet be asymptomatic during the interim. (Ex. 64-48, 64-49, 64-50). For this reason, Dr. Rosenbaum had "trouble believing the credibility" of claimant's history. (Id. at 48). Therefore, we agree with the Referee that the coworker's testimony was not sufficient to prove that claimant was asymptomatic between 1986 and July 1989.

Rate of Temporary Disability

Claimant contends that the Referee miscalculated claimant's temporary disability when she concluded that he was entitled to a rate of $339.44. We agree. Claimant earned $15,961.38 for 30 weeks of work in 1989. Therefore, his average weekley rate is $532.05 (15,961.38 divided by 30) and his temporary disability rate is $356.66 (532.05 multiplied by .6666). See ORS 656.210(1).

Attorney Fees on Review

We have affirmed the Referee's order except with regard to the issue of the proper rate of temporary disability, which was modified. The modification concerns only the amount of compensation rather than the issue of causation. Therefore, claimant is not entitled to an assessed fee under ORS 656.386(1). See Gloria J. Shelton, 44 Van Natta 2232 (1992). Claimant is entitled to a fee of 25 percent of the increased compensation created by this order, not to exceed $3,800. See ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated September 30, 1992 is affirmed in part and modified in part. In lieu of the Referee's finding that claimant was entitled to a temporary disability rate of $339.44, we conclude that he is entitled to a rate of $356.66. Claimant's attorney is awarded a fee of 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

June 29, 1993 Cite as 45 Van Natta 1215 (1993)

In the Matter of the Compensation of
ROSE MILLS, Claimant
WCB Case No. 91-13731
ORDER ON REVIEW
Allard J. Heitkemper, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Bethlahmy's order that: (1) dismissed claimant's request for hearing from the insurer's "back-up" denial of a left thumb claim; and (2) alternatively, upheld the insurer's "back-up" denial. In her brief, claimant renews her objection to the Referee's admission of Exhibits 19 and 20, medical evidence solicited by the insurer. On review, the issues are evidence, timeliness, propriety of the "back-up" denial and compensability. We affirm the Referee's evidentiary ruling and reverse the remainder of the Referee's order.

FINDINGS OF FACT

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

We do not adopt the Referee's finding that claimant's work activities were not the major contributing cause of her left thumb condition or her need for treatment for that condition. We do not adopt the finding that claimant did not timely request a hearing from the October 24, 1991 and December 20, 1991 denials.

We supplement as follows:

Claimant's September 24, 1991 request for hearing, from the September 6, 1991 denial of the previously accepted claim for a left thumb condition, was timely.

The medical evidence at the time of claim acceptance indicated that claimant's work activities for the insured caused her preexisting osteoarthritic thumb condition to become symptomatic. Thereafter, the insurer obtained no "new evidence" supporting its "back-up" denial.

CONCLUSIONS OF LAW AND OPINION

Evidentiary issue

Claimant objects to the Referee's admission of Exhibits 19 and 20, "check-the-box" and "one-word" opinions from Drs. Baum and Button, respectively. Claimant contends that this evidence is objectionable because the doctors' responses are conclusory and it is not clear that they understood counsel's use of legal terms. Claimant further argues that Exhibit 19 should have been excluded because the insurer solicited Baum's responses without claimant's attorney's knowledge and with no opportunity for "cross-examination."

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).

In this case, we find that the Referee did not abuse her discretion in admitting Exhibits 19 and 20, for two reasons. First, nothing prevented claimant's attorney from requesting further explanations from either physician after Exhibits 19 and 20 were solicited by the insurer. Under these circumstances, we are not persuaded that counsel was deprived of an opportunity to examine or cross-examine either witness. Second, insofar as the doctors' opinions are conclusory, that evaluation goes to the weight accorded the evidence, not to their admissibility. Accordingly, claimant's motion to exclude Exhibits 19 and 20 is denied and we review the record as developed by the Referee. See ORS 656.295(5).

Jurisdiction/"back-up" denial

The Referee dismissed claimant's request for hearing regarding the compensability of claimant's left thumb condition. In so doing, the Referee found that the request for hearing from the insurer's September 6, 1991 denial was timely filed. However, because claimant failed to separately request hearings from two subsequent denials, the Referee concluded that she lacked jurisdiction to consider the compensability of claimant's left thumb condition. We disagree.

It is undisputed that claimant's September 24, 1991 request for hearing was timely as it was filed within 60 days of her notice of the September 6, 1991 denial. See ORS 656.319. Thus, the question is whether claimant's request invoked the Referee's jurisdiction regarding the denied claim. We are persuaded that the answer to that question is yes.

On February 21, 1990, the insurer accepted claimant's claim for a disabling basilar arthritis of both thumbs. Following claimant's right thumb surgery, a December 6, 1990 Determination Order closed the right thumb claim and awarded 23 percent scheduled permanent partial disability for loss of use of the right hand. In July 1991, Dr. Baum, treating surgeon recommended left thumb surgery. The insurer issued three denials concerning claimant's left thumb claim. The first, dated September 6, 1991 states, in pertinent part:

> "[Y]ou originally submitted this claim in 1989 and it was accepted. * * * There is no doubt that if you have an arthritic condition, any activity of the hand including working [for the employer], will cause you to experience symptoms. However, under present workers' compensation law, an occupational disease is not compensable unless the work is the major contributing cause of the condition." (Ex. 15).

The above-quoted denial refers to the accepted claim, then states that, "under present workers' compensation law," the occupational disease claim is not compensable unless work is its major contributing cause. Thus, the insurer attempted to revoke its prior acceptance. Such an action constitutes a "back-up" denial. See ORS 656.262(6); Bauman v. SAIF, 295 Or 788 (1983).

It is undisputed that claimant's request for hearing from the September 6, 1991 "back-up" denial was timely. Under such circumstances, no further request for hearing was necessary to invoke the Referee's jurisdiction over the issue of the compensability of claimant's left thumb condition from the inception of the claim. See Kevin C. O'Brien, 44 Van Natta 2587 (1992); Tom E. Dobbs, 35 Van Natta 1332 (1983).

Claimant did not separately request hearings from the October 24, 1991 and December 20, 1991 denials, which purport to "supplement" the September 6, 1991 denial. However, because the first denial was a "back-up" denial from which claimant had timely appealed, claimant's failure to request a hearing within 60 days from the subsequent supplemental denials could not preclude her from contesting the insurer's attempt to retroactively retract its prior acceptance of the left thumb claim.

Accordingly, we reinstate claimant's hearing request. Inasmuch as the parties were permitted to fully develop the record, we proceed to consider the insurer's argument that, assuming the Referee had jurisdiction to reach the merits, the denial of the left thumb claim should be upheld because the medical evidence unequivocally establishes that claimant's arthritis condition is not work-related. We disagree.

In CNA Insurance Companies v. Magnuson, 119 Or App 282 (April 12, 1993), the court held that a "back-up" denial under ORS 656.262(6) must be based on "later obtain[ed] evidence," rather than a reevaluation of existing evidence. In Magnuson, the carrier based its "back-up" denial of an occupational disease claim on a "post-acceptance" report from a physician (who merely repeated a "pre-acceptance" opinion that he could not state that claimant's work was the major contributing cause of claimant's condition) and a new interpretation of occupational disease law. In affirming a Board order which rejected the carrier's denial, the court reasoned as follows:

> "Employer's argument is, essentially, that it properly accepted the claim on the basis of the medical reports under then existing interpretations of the burden of proving an occupational disease. When that interpretation was changed, the existing medical reports take on new significance. However, a reevaluation of known evidence, for whatever reason, is not "later obtain[ed] evidence" under 656.262(6)." 119 Or App at 286.

Here, as in Magnuson, the insurer's "back-up" denial was not based on "later obtained evidence" as required by ORS 656.262(6). The insurer knew, at the time of claim acceptance, that the core of claimant's thumb problem was a preexisting degenerative arthritis condition which became symptomatic due to her work activities. (See Ex. 4). No evidence indicated that claimant's work activities caused or worsened her arthritis condition. See ORS 656.802(2); Scarratt v. H. A. Anderson Construction Co., 108 Or App 554 (1991). Nonetheless, the claim was accepted.

Approximately six months later, the insurer issued its September 6, 1991 "back-up" denial, asserting that claimant's accepted occupational disease claim was not compensable under current law. We have previously reasoned that such a basis is not appropriate under ORS 656.262(6). Nevertheless, although not mentioned in the denial, we note that the insurer had received a report from Dr. Button, independent medical examiner, prior to its "back-up" denial. In that report, Button, opined, as Baum had previously, that claimant had a preexisting degenerative arthritis condition and that hand activities, including work activities, caused claimant's symptoms, but did not worsen her underlying condition. (Ex. 15).

Dr. Button's report does not provide the "later obtain[ed] evidence" required by the statute. In our view, Button merely repeated the one legally significant statement that Dr. Baum had already made, i.e., that claimant's work activities caused her thumb symptoms but not her arthritis condition. Here, as in Magnuson, the post-acceptance evidence merely repeats the earlier medical reports. 119 Or App at 286. Such evidence does not constitute "later obtained evidence," as required by ORS 656.262(6). See id. Consequently, the insurer's denial of claimant's left thumb condition is not permissible under the statute and the denial must be set aside. See id., Ralph E. Murphy, 45 Van Natta 725 (1993). Finally, because the insurer's denial is set aside on procedural grounds, we do not address the compensability issue.

Claimant is entitled to an assessed attorney fee for prevailing on the back-up denial 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 "back-up" denial is $3,900, 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, statements of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated August 3, 1992 is reversed. Claimant's request for hearing is reinstated. The insurer's back-up denial is set aside. The claim is remanded to the insurer for further processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,900, payable by the insurer.

In the Matter of the Compensation of
ANGELA M. MOON-MEYER, Claimant
WCB Case No. 92-01155
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Westerband, Neidig, and Gunn.

Claimant requests review of that portion of Referee Davis' order that upheld the SAIF Corporation's "de facto" denial of her current low back condition and need for treatment. SAIF cross-requests review of that portion of the Referee's order that set aside its "de facto" denial of a January 31, 1991 injury. 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

Relying on our decision in Bahman N. Nazari, 43 Van Natta 2368 (1991), the Referee found that claimant had established the occurrence of a compensable injury under ORS 656.005(7)(a), but had failed to establish that the compensable injury, rather than claimant's preexisting low back condition, was the major contributing cause of her disability and need for treatment. In accordance with our decision in Nazari, the Referee set aside SAIF's "de facto" denial of compensability of the January 31, 1991 injury and upheld SAIF's "de facto" denial of responsibility for the resultant condition. In addition, the Referee awarded claimant a $1,500 assessed attorney fee for prevailing over SAIF's "de facto" denial of the January 31, 1991 incident.

Subsequent to the date of the Referee's order, the Court of Appeals affirmed our decision in Nazari, but rejected our two-step analysis. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992). Instead, the court held that a work-related injury which combines with a preexisting condition to cause disability or a need for treatment is compensable only if it is the major contributing cause of the disability or need for treatment.

The court has recently reconsidered its Nazari decision. Tektronix, Inc. v. Nazari, supra, on recon 120 Or App 590 (1993). On reconsideration, the Nazari court modified its earlier decision and concluded that ORS 656.005(7)(a)(B) was applicable in the context of an initial injury claim if the injury combines with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment. The court explained that if, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of

the disability or need for treatment. However, if the disability or need for treatment in an initial claim is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment.

Here, the persuasive medical evidence supports the Referee's finding that the January 31, 1991 injury combined with claimant's preexisting, noncompensable back condition to cause or prolong disability or a need for treatment. (Exs. 34; 37). On this record, we agree with and adopt the Referee's reasoning and conclusion that claimant did not establish that the work-related injury is the major contributing cause of her low back disability and need for medical treatment. ORS 656.005(7)(a)(B). Therefore, SAIF's "de facto" denial of a January 31, 1991 compensable injury is reinstated in its entirety and upheld.

ORDER

The Referee's order dated August 31, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that set aside SAIF's "de facto" denial of a January 31, 1991 compensable injury is reversed. SAIF's denial is reinstated and upheld. The Referee's assessed attorney fee award is reversed. The remainder of the order is affirmed.

Board Member Gunn dissenting.

Because I believe that claimant does not have a "preexisting condition" as contemplated by ORS 656.005(7)(a)(B), I dissent.

I would find that claimant's chronic low back pain does not amount to a preexisting condition. No physician whose opinion appears in the record has diagnosed a specific condition which affects claimant's lumbar spine. Rather, the only causative factor which the medical experts allude to is obesity. Claimant's overweight condition is better analyzed as a predisposing factor rather than a "cause" of her back condition. This view is supported by the medical evidence. In their report, Drs. Fuller and Peterson noted that claimant had postural hyperlordosis of the lumbar spine, or swayback. Fuller and Peterson further noted that this condition produces abnormal pressure on the facet joints at L4 and L5, and predisposes to low back pain, particularly in combination with obesity.

Based upon the medical opinion summarized above, I would find that claimant's overweight condition and her hyperlordosis of the lumbar spine are predisposing factors, which create a special susceptibility to low back pain, but do not amount to a preexisting disease or condition within the meaning of ORS 656.005(7)(a)(B). See John E. Perkins, 44 Van Natta 1020 (1992); see also Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991).

Because I do not believe that claimant suffers from a preexisting low back condition, I would rely on the opinions of Drs. Isaacs and Thompson to find that claimant has met her burden to prove that the January 31, 1991 injury was a material contributing cause of her low back condition.

In the Matter of the Compensation of
VIRGINIA G. PARTRIDGE, Claimant
WCB Case No. 92-00687
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Lipton and Gunn.

Claimant requests review of that portion of Referee Howell's order which upheld the insurer's denial of claimant's low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed claimant's back condition as an occupational disease claim and found that claimant had a preexisting low back disease which had worsened symptomatically, but not pathologically. Therefore, the Referee found claimant's low back condition not compensable. We agree that the claim should be analyzed as an occupational disease. See Valtinson v. SAIF, 56 Or App 184 (1982). However, we disagree that claimant failed to prove the compensability of her low back condition.

In order to prove the compensability of an occupational disease claim, claimant must show that "employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2). To establish worsening of a preexisting disease, claimant must show that the underlying disease has worsened; proving merely an increase in symptoms is not sufficient. Weller v. Union Carbide, 288 Or 27 (1979); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). In addition, existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

First, we determine whether claimant had a preexisting disease. Claimant sustained a compensable injury to her coccyx in 1983, following which she received treatment for low back pain. (Exs. 2, 3). This claim was closed in October 1984 with no permanent disability. (Ex. 14). In the spring of 1985, claimant again treated for low back pain. (Ex. 17). At that time, a lumbosacral spine myelogram revealed only minimal extrinsic pressure at the L4-5 level, which was considered to be of questionable significance. (Ex. 19).

Thereafter, claimant had no treatment for back problems until August 1988 when she sustained back and neck strains as a result of an off-work vehicle accident. (Ex. 23B). By January 1990, Dr. Cross, claimant's treating physician, found that she was stable following the motor vehicle accident although still exhibiting tenderness, muscle spasm and limited range of motion due to "chronic back pain and tension from MVA." (Ex. 23F).

From January 1990 to August 1991, there is no medical evidence that claimant received treatment for back problems. In May 1991 claimant completed a job application for the employer in which she indicated that she had recovered from the 1988 motor vehicle accident and previous back injuries. (Ex. 23G-4; Tr. 20). Claimant's supervisor and a co-worker testified that claimant had no back problems at work prior to the back pain which developed in August 1991. (Tr. 94, 125). Claimant credibly testified that she experienced increased low back pain in late July and early August 1991 due to heavy lifting at work. (Tr. 18-19; see also Ex. 25-1).

Dr. Cross noted that claimant has a history of back injuries and that she periodically suffers chronic back pain. (See Exs. 23F, 25). However, he has not opined that claimant suffers from an underlying back disease whose symptoms increased in August 1991.

Under these circumstances, we find that the medical evidence does not establish that claimant has a preexisting back disease. We find that claimant was asymptomatic and her prior back injuries had essentially resolved before August 1991. We further find that claimant had no preexisting back "disease" apart from her prior injuries. Although Dr. Cross referenced her prior back injuries, he did not report that claimant's current back condition was a symptomatic flare-up of a preexisting back condition. Rather, he diagnosed an acute low back strain related to her recent work activities. Accordingly, we conclude that claimant did not have a preexisting disease at the time of the onset of her current back problem. See Theresa A. Adams, 45 Van Natta 28 (1993)(A history of pain and stiffness prior to the claim does not establish that a claimant has a preexisting condition). Therefore, claimant must prove that work conditions were the major contributing cause of her August 1991 back condition. Id.

Dr. Cross examined claimant on August 5, 1991 and found her range of motion "markedly limited," noting that she was "barely able to stand" and had to push on her leg muscles in order to straighten up. (Ex. 25-1). He diagnosed "acute back strain" and prescribed physical therapy. (Id). On the basis of Dr. Cross' examination, we find that claimant established the existence of her disease by medical evidence supported by objective findings.

Dr. Cross offers the only medical opinion on causation. He opined that claimant's August and September 1991 back treatments resulted from her work activities involving heavy repetitive lifting. (Ex. 29). He further opined that the major reason for claimant's August 1991 back treatment was these work activities. (Id.; see also Ex. 25-3). Based on Dr. Cross' opinion, we find that claimant has established that work activities were the major contributing cause of her current back condition.

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the 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 20, 1992 is reversed in part and affirmed in part. That portion of the order which upheld the insurer's denial is reversed. The insurer's January 7, 1992 denial is set aside, and the claim is remanded to the insurer for processing in accordance with 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 insurer.

In the Matter of the Compensation of
PASCUAL ZARAGOZA, Claimant
WCB Case No. 92-05615
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Howell's order that awarded claimant additional temporary disability benefits. Claimant cross-requests review of that portion of the Referee's order that found his claim had not been prematurely closed. On review, the issues are premature closure and temporary 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

Premature Claim Closure

We affirm and adopt the portion of the Referee's order which found that the claim was not prematurely closed by the November 27, 1991 Notice of Closure.

Temporary Total Disability

The Referee found that because the April 2, 1992 Order on Reconsideration set aside the insurer's Notice of Closure and declared that the claim remained in open status, the insurer was obligated to continue paying temporary disability compensation until claim closure or until unilateral termination was authorized by law. Relying on OAR 436-60-150(4)(e), the Referee further found that the insurer was required to make such payments within 14 days of the April 2, 1992 Order on Reconsideration. Consequently, the Referee ordered the insurer to pay temporary disability compensation from the date claimant's condition was medically stationary, July 24, 1991, through May 7, 1992.[1] Finding the insurer's conduct to have been unreasonable, the Referee also assessed a 25 percent penalty based on this compensation. We modify the Referee's order.

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[1] Because OAR 436-60-150(5) allows TTD payments to be paid in 7 day arrearage, the Referee determined that, on May 14, 1992, the date of hearing, payment was due for the period through May 7, 1992.

We recently addressed a similar issue in John R. Heath, 45 Van Natta 840 (1993). In Heath, the insurer appealed a May 17, 1991 Order on Reconsideration, which rescinded a January 3, 1991 Determination Order as premature. The referee reinstated the Determination Order, finding that the claim had not been prematurely closed. We held that an "administrative" overpayment was not created, but rather the insurer was statutorily obligated, under ORS 656.313(1)(a)(A), to pay compensation accruing from the date of the order on reconsideration until the referee reversed and set aside the Order on Reconsideration.

However, in Heath, we did not address the issue of when the insurer must file a request for hearing on an Order on Reconsideration in order to stay payment of retroactive temporary disability benefits under ORS 656.313. This case presents that issue.

In Walden J. Beebe, 43 Van Natta 2430 (1991), we held that amended ORS 656.313 authorized the insurer to stay payment of retroactive temporary disability benefits upon filing a request for review within 30 days of the date of the Referee's order awarding such compensation. We held that amended ORS 656.313, in conjunction with ORS 656.289(3), superceded former OAR 436-60-150(3)(e),[2] which required payment of temporary disability benefits within 14 days of the referee's order.

Subsequent to Beebe, the administrative rule has been amended to distinguish between a department order and a litigation order. OAR 436-60-150(4)(e) now requires payment of temporary disability benefits be made no later than the 14th day of any department order awarding such compensation; whereas, subsection (4)(f) requires payment within 14 days after a litigation order becomes final. This distinction is consistent with our holding in Beebe.

This distinction is also consistent with our holding in Lydia L. Kent, 44 Van Natta 2438 (1992). There, we assessed a penalty for the insurer's unreasonable resistance to the payment of compensation, where the insurer failed to pay a permanent disability award within 30 days of the reconsideration order as required by department rules.

In Kent, we distinguished Beebe based on the difference between a referee's order and a department order and the disparate time limitations for appealing each. We stated that "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." Id. at 2441. Consistent with that policy and with OAR 436-60-150(4)(e), we hold that, for the insurer to stay payment of temporary disability benefits that accrued from claimant's medically stationary date (July 24, 1991) to the Order on Reconsideration (April 2, 1992), the insurer was required to appeal the reconsideration order no later than the 14th day after the date of the order.

Here, the insurer did not appeal the Order on Reconsideration until May 11, 1992 (39 days after the order). Consequently, payment of the compensation was not lawfully stayed. Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the insurer contends that claimant was not substantively entitled to temporary disability compensation past his medically stationary date and therefore the Referee could not order an "administrative" overpayment.

In light of Seiber, we will not order the insurer to pay temporary disability benefits that accrued from July 24, 1991 to April 1, 1992, ("pre-reconsideration order" temporary disability), for to do so would create an "administrative" overpayment which otherwise, would not exist. However, the insurer is required to pay temporary disability benefits that accrued from the date of the April 2, 1992 Order on Reconsideration until the Referee's July 9, 1992 order reversing that order. ORS 656.313(1)(a)(A); John R. Heath, 45 Van Natta at 842. Therefore, the Referee's temporary disability award is modified.

Penalty

The Referee also assessed a penalty for the insurer's unreasonable refusal to pay temporary disability benefits. We agree, with the following supplementation.

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[2] Former OAR 436-60-150(3)(e) provided that temporary disability benefits must be paid no later than the 14th day after "the date of any determination or litigation order which orders payment of temporary disability, unless the order has been appealed by the insurer."

In light of our prior conclusion that we are precluded from creating an "administrative overpayment," an argument could be advanced that we are likewise unable to assess a penalty based on the unpaid "pre-reconsideration order" temporary disability (July 24, 1991 to April 1, 1992). We disagree with that argument for the following reasons.

In Seiber, the court acknowledged that imposition of penalties was the appropriate sanction where the insurer unreasonably delayed or refused to pay temporary disability benefits. Seiber, 113 Or App at 654. Considering the court's acknowledgment of the existence of a penalty, we are persuaded that the assessment of such a sanction is possible, irrespective of the mandate against the creation of an administrative overpayment.

ORS 656.262(10)(a) provides, in pertinent part, that "[i]f the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, ... the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due." In light of the clear directive contained in OAR 436-60-150(4)(e), we conclude that the insurer's failure to pay claimant temporary disability within 14 days in the absence of filing its request for hearing was unreasonable. Thus, the issue becomes whether the unpaid "pre-reconsideration order" temporary disability were "amounts then due."

We have previously determined that the delay period can be the "then" with regard to the term "amounts then due" under ORS 656.262(10). George Violett, 42 Van Natta 2647 (1990); Harold L. Lester, 37 Van Natta 745, 747 (1985). In Lester, we concluded that the reasoning behind the "amounts then due" language of ORS 656.262(10) was to provide a means by which to make the "punishment fit the crime" by focusing on what conduct was being penalized in deciding whether amounts were then due. We stated that to arrive at any other result would render the penalty provision "utterly toothless," considering that the conduct being penalized was the delay in performance. Harold L. Lester, 37 Van Natta at 747.

In this case, the delay period was the time between the date the payment became untimely (the 14th day after the Order on Reconsideration) (April 16, 1992) and the filing of the request for hearing (May 11, 1992). See Jeffrey D. Dennis, 43 Van Natta 857 (1991)(period between the date when a denial became untimely and the denial date was the delay period upon which to base a penalty for an untimely denial). During this delay period, claimant was due temporary disability that was not timely paid.

In Dennis, we also reasoned that an insurer could not cure its unreasonable delay by "paying up" just before issuing an untimely denial. Id. at 858. Here, the insurer could not cure its delay (i.e., unilaterally staying time loss owing from July 24, 1991 through April 1, 1992) by virtue of filing a request for hearing after the 14 day time limitation. Therefore, at the time of the insurer's unreasonable conduct, the temporary disability benefits that accrued from July 24, 1991 through May 11, 1992 were "then due" upon which a penalty is appropriately assessed under ORS 656.262(10). See Lydia L. Kent, 44 Van Natta at 2441. To reach any other result would permit the insurer to profit by its refusal to comply with clear statutory and administrative obligations.

Finally, in clear contravention of ORS 656.313, the insurer unreasonably failed to pay temporary disability benefits that accrued from the date of the April 2, 1992 Order on Reconsideration until reversed by the Referee. Since we have found that the insurer was required to pay temporary disability benefits through July 9, 1992, (the date of the Referee's order reversing the Order on Reconsideration) and considering our prior conclusion that the insurer unreasonably failed to pay the "pre-reconsideration order" temporary disability, we modify the Referee's order to assess a 25 percent penalty based on the amount of temporary disability benefits for the period July 24, 1991 through July 9, 1992. One-half of the penalty shall be payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10).

Attorney Fee on Board Review

The Referee awarded temporary disability from July 24, 1991 through May 7, 1992. We have found claimant entitled to temporary disability from April 2, 1992 through July 9, 1992. Thus, claimant's temporary disability has been reduced as a result of our decision. Therefore, claimant's counsel is not entitled to an attorney fee for services on review. ORS 656.382(2).

ORDER

The Referee's order dated July 9, 1992 is affirmed in part and modified in part. In lieu of the Referee's temporary disability award, claimant is awarded temporary disability from April 2, 1992 through July 9, 1992. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $1,050. The Referee's assessed penalty is modified to assess a penalty equal to 25 percent of temporary disability benefits which were paid or should have been paid from July 23, 1991 through July 9, 1992, to be equally divided between claimant and his attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
STELLA D. BALES, Claimant
WCB Case Nos. 92-09854 & 91-17672
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of that portion of Referee McCullough's order that upheld the self-insured employer's denial of her occupational disease claim for a right carpal tunnel syndrome. The employer cross-requests review of that portion of the order that set aside its denial of claimant's occupational disease claim for a right arm/shoulder overuse syndrome. On review, the issue is compensability.

We affirm and adopt the Referee's order, with the following supplementation regarding the employer's cross-request for review.

Claimant filed a claim for a right arm/shoulder overuse syndrome based on independent hand specialist Dr. Jewell's report that claimant has a forearm/shoulder overuse problem which requires "a fairly aggressive program of physical therapy for stretching, strengthening, and conditioning." The employer denied the claim, asserting that claimant's overuse syndrome "is not compensable because it does not require any treatment and is not causing any disability."

Claimant requested a hearing concerning the employer's denial. At the hearing, the employer did not raise any new basis for its denial of claimant's right arm/shoulder overuse syndrome.

The Referee considered the evidence in light of ORS 656.802(1) which provides that an occupational disease must require medical services or result in disability to be compensable. Finding that claimant's right arm/shoulder overuse syndrome requires medical services, the Referee concluded that the claim is compensable.

On review, the employer now contends that claimant has not proved that her work activities were the major contributing cause of the right arm/shoulder overuse syndrome. We decline to address the employer's causation challenge.

Until the submission of its cross-appellant's brief, the employer's sole defense to the claim has been its contention that claimant's overuse syndrome has not required any treatment or caused any disability. Since it has not previously questioned the causation of claimant's overuse syndrome, it would be fundamentally unfair to permit the employer to raise this issue at this late date. See Greg S. Meier, 45 Van Natta 922 (1993), on recon 45 Van Natta 1015 (1993) (Board declined to consider a carrier's challenge to a compensability claim based on insufficiency of medical evidence when the carrier had only contested the claim on "not arising out of employment" grounds at the hearing); Karen K. Malsom, 42 Van Natta 503 (1990) (Board declined to consider a carrier's challenge to an aggravation claim based on no worsening when the carrier had only contested the claim on causation grounds at the hearing).

Although claimant's attorney is not entitled to an assessed fee for her services on review concerning the carpal tunnel syndrome claim, she is entitled to an assessed fee for prevailing over the employer's cross-request for review concerning the overuse syndrome claim. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this issue, 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 issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 22, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, payable by the self-insured employer.

June 30, 1993 Cite as 45 Van Natta 1225 (1993)

In the Matter of the Compensation of
TONY N. BARD, Claimant
WCB Case No. 91-10900
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Nichols' order that set aside its "back-up" denial of claimant's left knee injury claim. Claimant cross-requests review of that portion of the order that awarded claimant a $3,500 assessed attorney fee for counsel's services at hearing. On review, the issues are propriety of the "back-up" denial, compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

In January 1990, claimant sustained a severe, noncompensable, injury to his left knee, that occurred when he stepped off of a ladder. That injury resulted in the dislocation of his left patella. Approximately 4 months later, claimant obtained a job with the present employer. As a condition of employment, claimant was required to, and did, pass a physical examination conducted by a nurse practitioner. On the medical history questionnaire he filled out as part of that examination, claimant indicated that he had no prior injury to, or problems with, his left knee.

On May 6, 1990, claimant reported an unwitnessed, work-related injury to his left knee, for which he filed a claim. As part of its investigation of that claim, SAIF's claims adjuster asked claimant if he had any prior injury to, or problems with, his left knee. Claimant indicated that he had not. He also did not inform his treating orthopedist, Dr. Galt, of his prior injury, nor did he indicate that he had a prior left knee injury on the claim forms.

CONCLUSIONS OF LAW AND OPINION

Propriety of Back-up Denial

On May 15, 1990, SAIF accepted claimant's disabling occupational injury claim for his left knee. However, on August 9, 1991, after claimant's step-mother reported that claimant had previously injured his left knee, SAIF issued a back-up denial of that claim, claiming that its acceptance was fraudulently induced. The Referee concluded that that denial was proper, thus shifting the burden to claimant to prove the compensability of his left knee condition. We agree.

In Bauman v. SAIF, 295 Or 788, 794 (1983), the Court concluded that, generally, an insurer cannot revoke an acceptance, because no provision of the workers' compensation laws authorized such revocations. Nevertheless, the Court recognized that a revocation of an acceptance, i.e., a "back-up" denial, is permissible if the insurer proved that its acceptance was induced by fraud, misrepresentation or other illegal activity. 295 Or at 794. If the insurer meets that burden, then it becomes the claimant's burden to establish that the claim is, in fact, compensable. Parker v. North Pacific Ins. Co., 73 Or App 790, 793 (1985); John K. French, 43 Van Natta 836, 839 (1991).

In short, under Bauman, an insurer is entitled to be restored to the position it would have been in, but for the claimant's fraud, misrepresentation or other illegal activity. It is entitled to revoke its acceptance, thus placing the claim in a denied status. However, concluding that an insurer has properly revoked an acceptance has no bearing on the merits, i.e., compensability, of the claimant's claim. See Skinner v. SAIF, 66 Or App 467, 470 (1984).

Subsequent to Bauman, the legislature amended ORS 656.262(6) to provide, in relevant part:

> "* * * if the insurer * * * accepts a claim in good faith, but later obtains evidence that the claim is not compensable * * * the insurer * * * at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable * * *."

Under the express terms of that statute, a "back-up" denial is valid only if the insurer subsequently obtains evidence that shows that the claim is not compensable. In short, under ORS 656.262(6), a "back-up" denial is valid only if the insurer proves by clear and convincing evidence that the claim is noncompensable on the merits. Claimant contends that the Referee erred in following Bauman, because the rule of that case was abrogated by ORS 656.262(6). We disagree.

Because ORS 656.262(6) authorizes a "back-up" denial only if the claim is subsequently found to be noncompensable on the merits, an insurer that was fraudulently induced into accepting an otherwise compensable claim cannot rely on ORS 656.262(6) to support the revocation of its acceptance. Nevertheless, under Bauman, an insurer can revoke a fraudulently-induced acceptance of an otherwise compensable claim. Consequently, if, as claimant contends, the legislature abrogated Bauman when it enacted ORS 656.262(6), an insurer could never revoke a fraudulently-induced acceptance. The insurer would always have to prove noncompensability to support a "back-up" denial. That would virtually immunize fraudulent conduct that induces an acceptance of a compensable claim. In our view, the legislature did not intend for the amendments to ORS 656.262(6) to immunize such conduct.

In enacting legislation, the legislature is presumably aware of existing case law. In the light of that knowledge, "the failure of the legislature to expressly change the law is evidence of a legislative intention not to change it." U.S. National Bank v. Heggemeier, 106 Or App 693, 699 (1991). Prior to the amendments to ORS 656.262(6), an insurer could revoke a fraudulently-induced acceptance. Although the legislature was presumably aware of that, no part of the amendments to ORS 656.262(6) expressly prohibits such revocations. In the absence of clear legislative direction, we are unwilling to infer that the legislature intended to preclude such revocations, solely because the claimant's fraud results in an acceptance of a compensable claim. We take that view, especially in the light of the fact that we have already concluded that ORS 656.262(6) does not preclude an insurer from revoking a fraudulently-induced acceptance more than two years after that acceptance.

In Anthony G. Ford, 44 Van Natta 239, 243 (1992), the insurer sought to revoke its acceptance, based on its conclusion that that acceptance had been fraudulently induced. The insurer discovered the purported fraud more than two years after it had accepted the claim. Because ORS 656.262(6) only authorizes back-up denials within two years of claim acceptance, the insurer sought to rely on Bauman. After examining the text, context and history of ORS 656.262(6), we concluded that it could, because "the legislature did not intend to prohibit denials of fraudulent claims more than two years after claim acceptance." Anthony G. Ford, 44 Van Natta at 243.

Because the issue was not presented in Anthony G. Ford, we did not expressly decide whether the legislature intended to prohibit insurers from revoking fraudulently-induced acceptances within two years of claim acceptance. Nevertheless, our decision in that case resolved that issue by implication, because nothing in the text or history of ORS 656.262(6) indicates that the legislature intended that statute to preclude insurers from revoking a fraudulently-induced acceptance within two years of that acceptance, but to permit such revocations after two years. Moreover, we find additional support for our conclusion, considering the policy implications of our decision.

Had the legislature intended to prohibit insurers from revoking fraudulently-induced acceptances, claimants could use fraud to shift the burden of proving noncompensability, by clear and convincing evidence, to the insurers. That would represent a dramatic change in the procedures established for obtaining compensation. See ORS 656.266. Moreover, rewarding fraud in that manner would contradict the policy supporting ORS 656.990(1), which criminalizes making a false statement to obtain worker's compensation benefits, and ORS 656.268(14), which provides an offset for benefits obtained by fraud and which was added to the worker's compensation laws at the same time as the amendments to ORS 656.262(6). See Or Laws 1990 (Special Session), ch 2, §§ 15, 16. It would be absurd to suggest that the legislature would enact new provisions to deter fraudulent conduct, but immunize, and thereby encourage, fraudulent conduct under a different statutory provision.

In addition, we have already concluded that an insurer can revoke a fraudulently-induced acceptance more than two years after that acceptance. Anthony G. Ford, supra. If such revocations were prohibited within two years of claim acceptance, but allowed after two years, insurers would wait two years before revoking an acceptance. If anything, the express terms of ORS 656.262(6) indicate that the legislature would rather have a back-up denial occur within two years, not after. In the absence of an express statutory provision, which we do not have, or indisputable legislative history, which is also absent, we are unwilling to infer that the legislature intended to permit such manipulations.

Consequently, we conclude that an insurer that can prove that it was induced to accept a claim through fraud, misrepresentation or other illegal conduct can still revoke its acceptance at any time pursuant to Bauman, thereby requiring the claimant to prove the compensability of the claim. If, on the other hand, an insurer issues a back-up denial within two years from the date of acceptance, without proof that its acceptance was induced by fraud, misrepresentation or other illegal activity, and that denial is appealed, it is the insurer's burden under ORS 656.262(6) to prove by clear and convincing evidence that the claim is not compensable. In short, we conclude that ORS 656.262(6) was intended to supplement the Bauman rule, not supplant it.[1]

In concluding that the legislature did not intend for the 1990 amendments to ORS 656.262(6) to preclude Bauman-type denials, we recognize that the court recently said that "[t]he amendment allowing back-up denials specifically sought to change the law articulated in Bauman * * *." CNA Insurance Companies v. Magnuson, 119 Or App 282, 285 (1993). That statement appeared in the context of a discussion concerning that portion of Bauman that held that "back-up" denials are generally not permissible. The court did not consider whether the legislature intended to abrogate that part of Bauman that permits an insurer to revoke a fraudulently-induced acceptance. Consequently, we view that statement to mean only that the legislature intended to change that part of Bauman that precludes "back-up" denials based on newly discovered evidence when there is no evidence of fraud, misrepresentation or other illegality.

We agree with the Referee that SAIF proved that its acceptance was fraudulently induced. Consequently, under Bauman, SAIF properly revoked its acceptance and claimant must prove the compensability of his left knee condition by a preponderance of the evidence. See Parker, supra; Skinner, supra.

Compensability

Because the Referee concluded that claimant's May 6, 1990 industrial injury was a material contributing cause of claimant's disability or need for treatment, she found claimant's left knee condition to be compensable. We disagree.

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[1] In Walter D. Vail, 44 Van Natta 548 (1992), the insurer issued a back-up denial of a previously accepted claim, within two years from acceptance, on the basis that the claim was fraudulent. Assuming, without expressly deciding, that ORS 656.262(6) applied in that context, we upheld the insurer's back-up denial, because the evidence of noncompensability was clear and convincing.

Vail stands for the proposition that, if the evidence clearly and convincingly shows that a claim is not compensable, the claimant cannot prove by a preponderance of the evidence that the claim is compensable. Nevertheless, we recognize that that case could be viewed as holding that an insurer that issues a back-up denial, within two years from acceptance, on the basis of fraud, misrepresentation or other illegal conduct bears the burden of proving noncompensability by clear and convincing evidence. To the extent that Vail suggests that holding, it is disavowed.

The medical evidence establishes that claimant's left knee condition is a result of the combination of his alleged May 6, 1990 work injury with his preexisting left knee condition. Subsequent to the Referee's order, the court decided that, under such circumstances, a claim is not compensable unless the claimant proves that the compensable injury is and remains the major contributing cause of his disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409, 413 (1992). Considering the possible causative influence of claimant's preexisting left knee condition, we conclude that the medical causation issue is a complex one requiring expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Assuming that claimant suffered an on-the-job injury involving his left knee, a fact that SAIF contests, the only medical opinion concerning the causative influence of that injury is provided by Dr. Galt. Dr. Galt first saw claimant on May 7, 1990. At that time, he noted that claimant reported having had no prior problems with his left knee, and he diagnosed a patellofemoral dislocation. (Ex. 9). On May 16, 1990, Dr. Galt performed arthroscopic surgery on claimant's knee and discovered evidence of the January 1990 knee injury.

In various chart notes and letters, Dr. Galt indicates that claimant's May 6, 1990 injury was probably the major cause of claimant's left knee condition. (Exs. 19, 26). However, in response to a letter from SAIF, asking Dr. Galt whether the major contributing cause of claimant's disability and need for treatment was the January 1990 injury, Dr. Galt said:

> "Clearly, the description of the injury back in January 1990 could very well be the contributing cause of his disability. I do not know for sure whether he sustained subsequent injury May 6, 1991 [sic], or whether he had symptoms related solely to the previous injury with no subsequent injury in May. (Ex 25).
>
> "As we have talked before, either scenario is certainly feasible and given the discrepancies we have reviewed, it would be possible if he did not sustain an injury on May 6, 1991, but again I specifically speak to that, as I do not have the facts."

Moreover, in his sworn deposition, Dr. Galt testified that the major contributing cause of claimant's disability and need for surgery was the noncompensable January 1990 injury. (Ex. 30).

In our view, Dr. Galt's opinion is inconsistent over time and lacks a reliable factual basis on which to judge its validity. See Randy L. Dare, 44 Van Natta 1868, 1869 (1992). Consequently, it is unpersuasive and we do not rely on it. Somers v. SAIF, 77 Or App 259, 263 (1986). In any event, Dr. Galt eventually attributed the major contributing cause of claimant's left knee disability to claimant's noncompensable January 1990 injury. Because claimant offered no other medical opinions, he failed to establish the compensability of his claim.

ORDER

The Referee's order dated July 28, 1992, as reconsidered August 26, 1992, is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award of $3,500 is also reversed.

Board Members Lipton and Gunn specially concurring.

Although we agree with the result, we do not agree with Anthony G. Ford, 44 Van Natta 239 (1992),[1] and do not vote to extend its realm. Rather, we find that SAIF's denial withstands review under ORS 656.262(6).

In order to prevail on a "back-up" denial under ORS 656.262(6), SAIF must demonstrate that it came into possession of evidence subsequent to its acceptance and prove by clear and convincing evidence that the claim is not compensable. We find that SAIF could meet that burden in this case.

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[1] Member Gunn agrees with Ford, but would not extend it to permit "back-up" denials issued within two years of claim acceptance, except as provided by ORS 656.262(6).

First, there is no question that SAIF, post-acceptance, came into possession of evidence of an earlier left knee injury which claimant had not disclosed, even under direct questioning.

Second, given the Referee's credibility finding concerning claimant's testimony and the various dates of injury identified, we do not accept the Referee's conclusion that an acute left knee injury in early May necessarily occurred at work.

Third, and finally, we agree with the majority's characterization of the evidence from Dr. Galt.

Therefore, rather than extend the rule of Anthony G. Ford, supra, we would affirm SAIF's denial pursuant to ORS 656.262(6).

Board Member Hooton dissenting.

The majority concludes that the exception for fraud, misrepresentation or other illegal activity to the rule expressed in Bauman v. SAIF, 295 Or 788, 794 (1983), that back-up denials are not within the contemplation of the Workers' Compensation Law, continues to apply during the two year period covered by the statute, despite the express language of ORS 656.262(6). I disagree.

In January 1990, claimant sustained a severe, noncompensable, injury to his left knee when he stepped off of a ladder. That injury resulted in the dislocation of his left patella. At the time of that injury, however, and for the period of the subsequent treatment, claimant was advised that he had sustained a strain to the medial collateral ligament, a potentially much less serious condition than the patellar dislocation subsequently diagnosed. (Exs. 1, 3, 6.) A January 16, 1990 chart note of Dr. Hughes indicates the additional diagnosis of probable subluxation of the patella. (Ex. 6.) However, it is not clear from the chart note, or from any subsequent report or testimony that claimant was advised of the nature of the additional diagnosis or of the future ramifications of that condition. Approximately four months later, claimant obtained a job with the employer. As a condition of employment, claimant was required to, and did, pass a physical examination conducted by a nurse practitioner. On the medical history questionnaire he filled out as part of that examination, claimant indicated that he had no prior injury to, or problems with, his left knee.

On May 6, 1990, claimant reported an unwitnessed, work-related injury to his left knee. The form 801 was completed by the employer, and the employer provided no testimony regarding whether it had sought to determine whether there was a prior injury to the knee. (Ex. 12, Tr. 30.) As part of its investigation of that claim, SAIF's claims adjuster contacted claimant. At hearing, the adjustor testified that he must have asked claimant if he had any prior injury to, or problems with, his left knee, but also indicated by his testimony that he had no independent recollection of having done so. (Tr. 27.) Claimant apparently did inform his treating orthopedist, Dr. Galt, that he had experienced no prior injury to the knee. In addition, a form 827 completed by claimant also indicates that claimant had no prior injury to the knee. (Ex. 11). Claimant explained that the January 1990 incident was of relatively short duration and seemed less serious than the subsequent, work-related injury of May 1990.

In Bauman v. SAIF, supra, the Court concluded that, generally, an insurer could not revoke an acceptance, because no provision of the Workers' Compensation Law authorized such revocations. Nevertheless, the Court recognized that a revocation of an acceptance, i.e., a "back-up" denial, was permissible if the insurer proved that its acceptance was induced by fraud, misrepresentation or other illegal activity. 295 Or at 794. A review of Bauman indicates that the question of fraud, misrepresentation or other illegal activity was never presented in that case. The expression of the court on that issue, therefore, amounted to dicta only. In addition, the court offered no explanation for the exception, and no supporting authority, either in the law or public policy. Nevertheless, the courts have subsequently applied the dicta, made rule by application, with the same fervor as it would apply a legislative enactment.

As developed in subsequent case law, the Bauman "rule" required the insurer to carry the burden of proving fraud, misrepresentation or other illegal activity. If the insurer met that burden, then it became the claimant's burden to establish that the claim was, in fact, compensable. Parker v. North Pacific Ins. Co., 73 Or App 790, 793 (1985); John K. French, 43 Van Natta 836, 839 (1991).

Subsequent to Bauman, the legislature amended ORS 656.262(6) to provide, in relevant part:

> "* * * if the insurer * * * accepts a claim in good faith, but later obtains evidence that the claim is not compensable * * * the insurer * * * at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable * * *."

Under the express terms of that statute, a "back-up" denial is valid only if the insurer subsequently obtains evidence that shows, clearly and convincingly, that the claim is not compensable. In contrast, under Bauman, the insurer need only prove that the claimant's fraud reasonably could have affected its decision to accept the claim. It then becomes the claimant's burden to prove compensability by a preponderance of the evidence. Claimant contends that the Referee erred in following Bauman, because the rule of that case was abrogated by ORS 656.262(6). I agree.[1]

In construing a statute, we must effectuate the intent of the legislature. England v. Thunderbird, 315 Or 633, 638 (1993). To determine that intent, we begin by examining the statute's text and context. Boone v. Wright, 314 Or 135, 138 (1992). We need not look beyond those, if that examination provides sufficient insight to the legislature's intent. Sullivan v. Kizer, 115 Or App 206, 210, rev den 315 Or 313 (1992). Nevertheless, we note that the court, in deciding an unrelated issue, has concluded that the amendment to ORS 656.262(6) "allowing back-up denials specifically sought to change the law articulated in Bauman * * *." CNA Insurance Companies v. Magnuson, 119 Or App 282, 285 (1993).

When enacting legislation, the legislature is presumably aware of earlier related case law. State ex rel Frohnmayer v. Low, 105 Or App 357, 361 n 5 (1991). Consequently, the legislature's failure to expressly change that law is evidence of its intent not to change it. State v. Waterhouse, 209 Or 424, 436 (1957). Conversely, the court has suggested that, if a subsequent enactment conflicts with prior law, that conflict is evidence of a legislative intention to change the prior law by the new enactment. See U.S. National Bank v. Heggemeier, 106 Or App 693, 699 (1991).

ORS 656.262(6) applies whenever the insurer obtains information after claim acceptance which suggests that the claim is not, or may not be, compensable. The statute does not require clear and convincing evidence at the time the denial issues, but only requires the insurer to show noncompensability by clear and convincing evidence if the claimant challenges the "back-up" denial. Because the statute contains no language of inclusion or exclusion for any potential causes for a "back-up" denial, the statute, on its face, permits an insurer to deny a claim, after a good faith acceptance, for any reason whatsoever, subject to the limitation that it prove noncompensability by clear and convincing evidence. Because the statute is broad enough to include any reason whatsoever, it must apply when an insurer issues a fraud-based denial within two years of claim acceptance. That was our implicit conclusion in Walter D. Vail, 44 Van Natta 548 (1992), where we applied ORS 656.262(6) to uphold the insurer's fraud-based "back-up" denial of the claimant's claim. Moreover, that statute requires the insurer to prove noncompensability by clear and convincing evidence. That requirement conflicts with the Bauman rule, that shifted the burden of proving compensability to the claimant after the insurer proved fraud by a mere preponderance of the evidence. Because of that conflict, and because the legislature clearly intended to change the law articulated in Bauman, I conclude that the legislature intended that statute to provide the sole basis for issuing a "back-up" denial, and limited the application of that statute to a period within two years of claim acceptance.

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[1] It is not my intention to suggest that claimants ought to be rewarded for deceitful and fraudulent activity in presenting or pursuing a claim for compensation. Indeed, such conduct is reprehensible whether it is carried out by the claimant, the employer, a medical doctor or even the insurer. Over my period of service as a Board member it has been patently clear that fraud may come from each of these sources, and the system suffers from its presence, regardless of who the proponent of the deceitful conduct may be, or the motivation which compels the party to promote it. Nevertheless, I find it even more destructive to the aim and purpose of the Workers' Compensation Law to permit this Board to place its own judgment regarding sound public policy ahead of that of the legislature, and to rewrite legislation to conform to our own view of a sound administrative system.

While the statute alone, by its clear and unambiguous language, is sufficient to support that conclusion, additional support is available in the legislative history. Senator Brenneman of the Joint Interim Committee on Workers' Compensation, in his explanation of the amendments to ORS 656.262(6) to the Senate, and Ross Dwinnell, member of the Governor's Workers' Compensation Labor-Management Advisory Committee, in addressing the Joint Interim Committee, of which Senator Brenneman was a member, both specifically referenced the impact of the amendments to ORS 656.262(6) on the Bauman exception. Ross Dwinnell stated, in pertinent part, as follows:

> "This allows for insurers and self-insured employers to back up and deny a claim that was first denied [sic] in good faith.
>
> "* * * *
>
> "[T]his caps at two years, incidentally, where Bauman was unrestricted as far as fraud is concerned it could go out twenty years. * * * We're saying in those situations, if the evidence comes about within the two years after the claim's been accepted, and we've shifted the burden to the insurer to prove the claim is not compensable, then we're saying those back-up denials will be sustained in those types of circumstances." Minutes, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B at 221

In addressing the full Senate, Senator Brenneman noted:

> "What this section of the Bill does is that it reverses the Bauman decision. Under old law, an insurer had 60 days from the claim to accept or deny the claim. Under new law the insurer now has 90 days. Under the old law, once an insurer accepted a claim, the 60 days elapsed, the decision was final no matter whether or not evidence of fraud or mistake was later discovered. Now the insurer has two years to discover such evidence and issue a retrospective denial." Special Session, Senate Floor Debates, May 7, 1990, Tape 4, Side A.

I recognize and acknowledge that this legislative history was considered by the Board in reaching the conclusion that the Bauman exception was not overruled in Anthony G. Ford, 44 Van Natta 240, 242 (1992). However, a review of the discussion in that case reveals that the Board reached its conclusion based on a misconception of the limits of its authority. The Board reasoned as follows:

> "We now turn to the legislative history of the 1990 amendments. The Bauman rule is well established and supported by public policy that disfavors fraudulent claims. See ORS 656.990(1) (imposes a prison term and/or fine for intentional misrepresentation regarding a claim for compensation); ORS 656.268(14) (allows insurers an offset against future compensation for prior, fruadulently-obtained benefits). Therefore, we believe there must be clear and unambiguous legislative intent to overturn the rule." Id.

This statement evidences the Board's willingness to place itself in the position of the legislature, despite acknowledged legislative action. Rather than focus on the amendments to ORS 656.262(6) which it was the responsibility of the Board to construe, the Board concluded that the public policy involved in the Bauman exception was so significant that it would continue to apply it, regardless of the terms of the statute and the legislative history, unless it could find "clear and unambiguous" evidence that the legislature intended to prohibit it from doing so. That is not within the Board's authority.

Where the legislature has declined to act, or where the statute deals with an area of law incompletely, the Board and the courts, have authority to fill the interstices. In doing so, it may consider public policy together with other resources to devise an appropriate rule. Where the legislature has acted, however, the Board "may not, under the pretext of construing a statute, supply an essential element omitted, by mistake or design, by the legislature. Salahub v. Montgomery Ward, 41 Or App 775, 785 (1979). In a case construing the state's liquor laws, the Supreme Court stated this principle even more strongly:

> "We have no legislative power and, therefore, cannot rewrite the act. Nor can we overcome our lack of legislative power by resort to misconstruction of the plain language of the act." Gouge v. David, 185 Or 437, 463 (1949).

It is the express duty of this Board, in construing the statute, to determine and declare the intent of the legislature, either from the language of the statute, or if the statute is ambiguous, with the use of legislative history and other parol evidence. In completing that function we must make two determinations. First, we must establish whether the statute, as written, is sufficiently broad to include the circumstances of the present claim. If it is, we must include the present claim, unless there is clear indication of a legislative intent to exclude it.

The clear and unambiguous language of the statute is broad enough to include the present claim. Indeed, it permits a "back-up" denial for any reason whatsoever, subject only to the precondition that the denial be based on evidence acquired after an acceptance, made in good faith. The statute contains no exceptions, and absolutely no indication that any exceptions were intended. The legislative history fails to indicate that the legislature intended to except any claim from the operation of the statute except as specifically provided. Indeed, the testimony of Ross Dwinnell and Senator Brenneman supports the conclusion that ORS 656.262(6) was intended to apply to all claims, and all "back-up" denials, without exception. Both individuals discussed the Bauman rule at the time the bill was presented. Neither excluded the exception to the Bauman reasoning from the operation of the statute.

The court in Bauman prohibited "back-up" denials, both because they were not permitted by the language of the statute, and because the statute itself was supported by strong policy considerations in favor of finality and the orderly processing of claims. Bauman v. SAIF, supra at 794. The Board has concluded that the exception to the Bauman rule prohibiting "back-up" denials for claims involving fraud, misrepresentation or other illegal activity is supported by public policy disfavoring fraudulent claims. Though the court did not state its reasoning, it is likely that the Bauman court was cognizant of those same policy considerations when it adopted the exception to the Bauman rule.

Nevertheless, the legislature is the appropriate forum for consideration and balancing of policy issues. Where, as here, there is legislative history which suggests that the legislature, in fact, considered the very policy issues that bear on the matter, it is not appropriate for this Board, or the courts, to supplant the language of the statute with our own view of the proper balance to be given to competing policies. Neither can I conclude, as the majority apparently does, that because the public policy against fraudulent claims is codified at ORS 656.990(1) and 656.268(14), that an equally strong embodiment of the public policy in favor of finality and the orderly processing of claims in ORS 656.262(6) is "absurd."

In the civil law, in areas other than workers' compensation claims, there remains a public policy against fraud, and damages that result are generally compensated. However, the court also recognizes the seriousness of the implication of criminal wrongdoing in an allegation of fraud. Consequently, the civil law has developed a presumption against the finding of fraud, which must be overcome by clear and convincing evidence. Galego v. Knudsen, 282 Or 155, 165 (1978); Briggs v. Morgan, 262 Or 17, 24 (1972); Cays v. McDaniel, 204 Or 449, 452 (1955). Consequently, it is arguable that the legislature merely placed allegations of fraud in the workers' compensation system on a par with all other areas of civil litigation.

Following extensive analysis, the majority states its holding in a single sentence. "In short, we conclude that ORS 656.262(6) was intended to supplement the Bauman rule, not supplant it." In light of Senator Brenneman's clear statement that "this section of the Bill * * * reverses the Bauman decision," this conclusion is somewhat surprising. I confess that, upon first reading, I presumed that the majority had placed the cart before the horse, and had committed obvious and gross error. The construction of the statute, or the adoption of court-made rules to fill the interstices of legislation, is properly viewed as supplemental to the legislative act. Given their relative constitutional authority, however, it is difficult to imagine legislative action as supplemental to case decision.

However, on further examination, there is authority to support the majority holding if it falls within a limited class of cases. Where a legislative enactment is intended to codify the provisions of the common law, the failure to include specific provisions of the common law, or to address them in the act does not indicate an intent to overrule or supplant the common law on which the statute is based. Rather, in that case, the actions of the legislature are viewed as cumulative of the law so codified. See Brown v. Transcom Lines, 284 Or 597 (1978). I have been unable to find any support for the proposition that the same reasoning can be applied to case decisions in purely statutory law, such as the Workers'

Compensation Law, which construe or explain the law, or fill the interstices not considered by the legislature. Even if the principle applies by analogy, however, the amendments to ORS 656.262(6) were not intended to codify existing case law, but to reverse that law.

I recognize that my reasoning here conflicts with our holding in Anthony G. Ford, 44 Van Natta 239 (1992), where the Board concluded that an insurer could rely on Bauman to deny a claim more than two years after acceptance. The Board reached that conclusion, because it concluded that the legislature did not clearly and unambiguously declare its intent to impose a two-year cap on "back-up" denials, or that it intended to overrule Bauman in its entirety. 44 Van Natta at 242. Because such a result is not supported by the text, context or history of ORS 656.262(6), I would disavow our decision in Anthony G. Ford, supra.

Even if the exception to the Bauman rule prohibiting back-up denials survives the reversal of Bauman, I would conclude that the insurer has failed to demonstrate an essential element of that conduct. To prove fraud, the complainant must show, not only that a statement made by the speaker was false, but must also show that the speaker knew it to be false at the time of speaking, and his intent that the falsehood be acted upon to the detriment of the complainant. South Seattle Auto Auction, Inc. v. Western Cas. & Sur. Co., 41 Or App 707, 713 (1979); Cays v. McDaniel, supra at 453. Here, SAIF has failed to establish the requisite intent.

I acknowledge that the claimant completed that portion of a form 827 indicating that he had no prior injury to the knee. I also acknowledge that he denied injury to the knee when questioned by the treating physician and may have done so to the claims examiner. Nevertheless, I cannot find that the acts of the claimant, in this instance, establish the intent to deceive. In virtually every case of injury in the course and scope of employment the statement that claimant has no prior injury to the affected body part is false. In developing from infancy to adulthood, each of us goes through one or more periods where motor control is less than satisfactory. Falls and minor injuries are common during these periods and affect virtually every part of the body. During childhood, most of us learned to run on uneven ground, or ride a bicycle, only after several scraped and bruised knees, hands, shoulders and buttocks. As adults the vast majority of individuals experience the symptoms of muscle strain related to periods of overexertion. Each of these are "injuries" as that term is strictly defined. However, it is unlikely that even this Board would find that the failure to disclose a complete history of such minor injuries from childhood through adulthood would constitute a misrepresentation sufficiently material to support a fraud-based "back-up" denial, simply because those injuries are not sufficiently severe to provide any indication that they are significant in determining the causation of a condition arising subsequent to a work-related injury.

Here, claimant was advised that his January 1990 injury was a strain. It is not clear that Dr. Hughes ever advised him that he had suffered a "probable" dislocation injury, or that the injury he experienced was likely to have long-term consequences. Claimant recovered from the effects of the January 1990 injury, so far as he was aware, in an expeditious manner, supporting claimant's belief that the injury was relatively minor, and bore no relationship to the subsequent injury in May 1990.

It is always easy to find evidence of fraud if we believe that claimant is a liar. If, however, claimant is presumed to be honest and without evil intent, actions that appear to imply dishonesty may be susceptible of easy explanation. I would find that this is such a case.

Because I am forced to conclude that the legislature intended to include fraud, misrepresentation and other illegal activity within the back-up denial provisions of ORS 656.262(6), I would disavow Ford and require the insurer to prove the claim not compensable by clear and convincing evidence. I would also find that, on this record, the insurer has failed to do so. Further, if the exception for fraud remains, I would find that SAIF has failed to show an essential element of its proof in this claim. Therefore, I dissent.

In the Matter of the Compensation of
FADOL H. FADOUL, Claimant
WCB Case Nos. 91-08217, 90-20683, 90-16598 & 90-16994
ORDER ON REVIEW
Julene M. Quinn (Saif), Defense Attorney
VavRosky, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig, Brazeau, and Hooton.

The United Employers Insurance Company (UEI) requests review of Referee Leahy's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; (2) upheld Kemper National Insurance Companies' (Kemper) denial of a claim for the same condition; (3) upheld United Pacific Insurance Company's (UPI) denial of a claim for the same condition; and (4) upheld the SAIF Corporation's (SAIF) denial of a claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

In March 1988, claimant began working as a full-time cook for Kosta's Family Restaurant, which at that time was insured by UPI. This job required repetitive use of his hands and wrists when chopping vegetables, cooking food and washing dishes. From April 1988 to September 1988, he concurrently worked as a part-time cook at the Greek Village, which was insured by SAIF. This job also required repetitive use of his wrists.

In June 1988, claimant injured his neck in an off-the-job motor vehicle accident and he sought treatment from Dr. Mack. During treatment on June 8, 1988, claimant also reported right wrist numbness. Nerve conduction studies in July 1988 revealed that claimant had bilateral carpal tunnel syndrome (CTS), more advanced on the right. Dr. Mack referred claimant to Dr. Gill, orthopedic surgeon, for evaluation. Claimant declined to have surgery. He was advised to wear a wrist splint on the right. Claimant missed no time from work due to the wrist condition and filed no workers' compensation claim for medical services at that time.

By September 1989, claimant had fully recovered from his neck injury and was performing his regular work at Kosta's, which was then insured by Kemper. By March 13, 1990, claimant's wrist complaints became noticeably worse when he was unable to hold onto objects with his right hand. On March 15, 1990, he returned to Dr. Mack who again referred him to Dr. Gill. On April 4, 1990, Dr. Gill diagnosed bilateral CTS and related the condition to claimant's repetitive work activities as a cook. He recommended a surgical release of the right carpal tunnel. Claimant continued to work, performing the same activities with his wrists.

On April 11, 1990, UEI began providing workers' compensation insurance for Kosta's, which had been renamed Gourmet Broiler. Claimant first left work on June 1, 1990 due to his wrist condition. On July 15, 1990, claimant returned to part-time work at Kosta's Gourmet Broiler while his condition remained symptomatic, but again left work on September 15, 1990 due to his wrist condition.

Claimant filed claims against UPI, SAIF, Kemper and UEI, all of which were denied. He subsequently requested hearings on the denials, and the four claims were consolidated for hearing.

CONCLUSIONS OF LAW AND OPINION

Finding claimant's carpal tunnel syndrome condition to be compensable as an occupational disease claim, the Referee applied the last injurious exposure rule to determine responsibility for the claim. The Referee held that UEI was responsible. We agree.

Under the last injurious exposure rule, if a worker establishes that an occupational disease was caused by work conditions in existence when more than one insurer is on the risk, the insurer on the risk during the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially

causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The "onset of disability" is the date on which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date she first seeks medical treatment for the condition.[1] Progress Quarries v. Vaandering, 80 Or App 160, 163 (1986); SAIF v. Carey, 63 Or App 68, 70 (1983).

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[1] UEI contends that the triggering date for the determination of which carrier is the "last potentially causal employer" should be the date surgery was recommended, not the date claimant actually left work due to his wrist condition. Under such an analysis, UEI argues that responsibility for the claim would rest with a prior carrier. UEI's assertions are not consistent with application of the last injurious exposure rule.

It is well-settled that the date a worker first seeks medical treatment is the "triggering event" for initial assignment of responsibility for an occupational disease, provided that the worker is not disabled by the disease. See Oregon Boiler Works v. Lott, supra, at page 74; Progress Quarries v. Vaandering, supra, at page 163. In making such a statement, we note that the dissent argues that the Vaandering court has recognized the "triggering event" for application of the last injurious exposure rule to be the earlier of the first date of medical treatment or the onset of disability. The dissent misunderstands the findings and holding of Vaandering.

In Vaandering, the court addressed the issue of responsibility among several employers for an occupational disease claim for hearing loss / tinnitus. Although the claimant experienced progressive hearing loss and discomfort from tinnitus, the court specifically found that he continued to work. Thus, in determining the "triggering event" for purposes of assigning responsibility under the last injurious exposure rule, the court reasoned as follows:

> "When, as here, a claimant is not actually disabled from work, the "triggering event" for assignment of responsibility is the date when claimant first seeks medical treatment for the condition. SAIF v. Carey, 63 Or App 68, 662 P2d 781 (1983)." Progress Quarries v. Vaandering, supra, at page 163.

In other words, the court found, as fact, that the claimant did not suffer disability. In light of such circumstances, the court expressly turned to the date the claimant first sought medical treatment as the "triggering event" for application of the last injurious exposure rule.

In support of its reasoning that the Vaandering court "rejected" the date of disability, rather than the date of first medical treatment, as the "triggering event," the dissent refers to the court's footnote. Progress Quarries v. Vaandering, supra, at page 167, n. 1. In that footnote, the court acknowledged one of the later employer's disagreements with a referee's findings that the claimant had become disabled while working for that employer. Id. Yet, the court found it unnecessary to resolve this "date of disability" issue because it had already concluded that the date of the claimant's first medical treatment was the "triggering event" for application of the last injurious exposure rule and that responsibility had shifted under the rule to that later employer. Id.

Thus, the Vaandering court did not hold that the "triggering event" for application of the last injurious exposure rule is the earlier of the first medical treatment date and the disability date. To the contrary, the court expressly found that the claimant was not actually disabled from work and, thereafter, followed the established principle of turning to the date of first medical treatment as the "triggering event." Progress Quarries v. Vaandering, supra, at page 163.

By declining to address the later employer's "disability date" issue, the Vaandering court was not concurring with the referee's findings that the claimant had actually been disabled from work. Such an interpretation would directly contradict the court's express finding of fact that the claimant was not actually disabled. Instead, the most reasonable interpretation of the court's footnote is that, in light of its previous finding of fact that the claimant did not suffer disability and that the later employer was responsible for the claim under the last injurious exposure rule using the date of first medical treatment as the "triggering event," the court considered it unnecessary to address the later employer's contentions regarding the referee's "disability date" findings.

Any question regarding the court's understanding of the Vaandering holding was answered in Oregon Boiler Works v. Lott, supra. In Lott, the issue was responsibility among several employers for an occupational disease claim for hearing loss. The claimant did not lose any time from work as a result of his hearing loss. 115 Or App at p. 73. Applying the last injurious exposure rule, the court stated as follows:

> "Ordinarily, responsibility for an occupational disease is assigned to the claimant's employer at the time that the disease results in disability. However, when the worker is not disabled by the disease, the "triggering event" for assignment of responsibility is the time when the worker first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160, 163, 722 P2d 19 (1986)." Oregon Boiler Works v. Lott, supra, at page 74. (Emphasis supplied).

Inasmuch as the claimant had not lost time from work, the Lott court determined that the employer for which the claimant was working when he first sought medical treatment was initially responsible. Id. Furthermore, since the Board had found that the claimant's subsequent work exposures for other employers had not actually contributed to a worsening of his hearing loss and because that finding was supported by substantial evidence, the Lott court affirmed the Board's holding that responsibility for the claim did not shift to a later employer. Id.

Contending that claimant's need for surgery preexisted its April 1990 coverage and that claimant's condition did not subsequently worsen, UEI argues that the last injurious exposure rule is not applicable. We recognize that application of the rule might be unnecessary provided that a claimant establishes actual causation against a particular carrier. See Bracke v. Baza'r, supra at page 249. Nevertheless, claimant has not proven compensability against a particular carrier. Instead, the record establishes that his employment in general caused his condition. Under such circumstances, the last injurious exposure rule is applicable.

Here, claimant left work due to his wrist condition shortly after UEI came on the risk. Inasmuch as claimant's occupational disease resulted in disability, responsibility for the claim is initially assigned to the carrier on the risk during the last employment providing potentially causal conditions. See Bracke v. Baza'r, supra; Oregon Boiler Works v. Lott, 115 Or App 70 (1992). Our review of the record establishes that UEI satisfies the aforementioned criteria.

Dr. Gill, the orthopedic surgeon, noted that claimant's condition did not dramatically or appreciably change since the April 1990 surgery recommendation. Nevertheless, Dr. Gill opined that claimant's continued repetitive work activities after April 1990 contributed somewhat to the condition. Moreover, Dr. Button, hand surgeon, concluded that claimant's condition deteriorated between April 1990 and July 1990. In light of this medical evidence, we are persuaded that claimant's work activities while UEI was on the risk were of a type which could have potentially caused his disability.

UEI can avoid responsibility by establishing that a prior employment exposure was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while UEI was on the risk to have caused her disability. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). Based on the reasoning expressed above, we are neither persuaded that a prior exposure while another carrier was on the risk was the sole cause of claimant's disability nor that it was impossible for UEI to have caused the disability. Consequently, we hold that responsibility for the claim rests with UEI.

Although compensability was not raised as an issue on review, it was an issue at hearing. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (April 21, 1993). Accordingly, claimant's attorney is entitled to a reasonable assessed attorney fee under ORS 656.382(2) for legal representation on review.

For purposes of determining a reasonable assessed fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee for claimant's counsel's services on review is $750, to be paid by UEI. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by claimant's respondent's brief), the value of the interest involved, and the complexity of the issues.

Thus, as demonstrated by our review of the Vaandering and Lott holdings, the court does not subscribe to the dissent's view that the "triggering event" for application of the last injurious exposure rule is the earlier of the first date of medical treatment or the onset of disability. Rather, the first date of medical treatment is used only where the claimant has not lost time from work as a result of the claimed condition.

In addition, under the last injurious exposure rule, full responsibility for the disease may fall on a carrier, even if that carrier's exposure was very brief. See Runft v. SAIF, 303 Or 493 (1987); UAC v. Hacke, 101 Or App 598, 604 (1990).

We proceed to apply the Vaandering and Runft principles to the present case. It is undisputed that claimant left work as a result of his wrist condition. Since claimant became disabled on that date, UEI, as the insurer on the risk at that "triggering event," is initially assigned responsibility for the claim regardless of when claimant first sought medical treatment or acceded to a surgery recommendation. Furthermore, its relatively brief exposure does not alter UEI's full responsibility for the claim under the last injurious exposure rule.

Finally, even if we were to consider the surgery recommendation as the "triggering event," we would continue to find UEI responsible for the claim. We would reach such a conclusion because claimant's "post-surgery request" work activities while UEI was on the risk continued to contribute to a deterioration of his condition. See Warren J. Kucera, 43 Van Natta 2782 (1991). (Date of first medical treatment used as "disability date" where the claimant's condition remained unchanged until his eventual surgery).

ORDER

The Referee's order dated November 21, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by UEI.

Board member Hooton dissenting.[1]

The issue is responsibility for claimant's compensable occupational disease as between the four insurers, UPI, SAIF, Kemper and UEI. Applying the last injurious exposure rule against all four insurers as a group, the majority holds UEI responsible for the entire claim. The majority concludes that UEI is responsible for the totality of claimant's CTS, because claimant did not lose any time from work due to the condition until after UEI assumed the risk on April 11, 1990. I disagree.

In an occupational disease case involving successive insurers, the last injurious exposure rule assigns initial responsibility to the last carrier on the risk whose employment exposure could have contributed to causation as of the date of a specific event sufficient to fix liability. In Mathis v. SAIF, 10 Or App 139, 144 (1972), the Court of Appeals adopted the explanation of the last injurious exposure rule presented by Professor Larson, and described the date fixing liability as follows:

> "In the case of occupational disease, liability is most frequently assigned to the carrier who was on the risk when the disease resulted in disability, if the employment at the time of disability was of a kind contributing to the disease."

The rule as outlined in Mathis was adopted by the Supreme Court in Inkley v. Forest Fiber Products, 288 Or 337, 342 (1980). Based on the reasoning in those two cases, the court adopted the date of disability as the date on which liability for an occupational disease is fixed. In Bracke v. Baza'r, 293 Or 239, 247-48 (1982), the Supreme Court, quoting Professor Larson, explained the reasoning for selecting the date of disability as follows:

> "...In the search for an identifiable instant in time which can perform such necessary functions as to start claim periods running, establish claimant's right to benefits, determine which year's statute applies, and fix the employer and insurer liable for compensation, the date of disability has been found the most satisfactory. Legally, it is the moment at which the right to benefits accrues; as to limitations, it is the moment at which in most instances the claimant ought to know he has a compensable claim; and, as to successive insurers, it has the one cardinal merit of being definite, while such other possible dates as that of the actual contraction of the disease are usually not susceptible to positive demonstration." 4 Larson, Workmen's Compensation Law, § 95.21, 17-79 through 17-86. (Emphasis added).

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[1] On June 9, 1993 the Board received a Motion for Recusal and Abatement directed toward my continued participation in this case, and any other case in which the office of moving counsel represented one of the parties. The motion was based on contact which occurred on June 4, 1993, and which allegedly involved a prohibited ex parte communication on this pending case, as well as an indication that a letter dated April 16, 1993 from counsel for Kemper Insurance had adversely affected my substantive decision in this case. I decline to voluntarily recuse myself.

I acknowledge that on June 4, 1993 I had a conversation with Mr. Keene, who is counsel for Kemper in the present claim. The purpose of the conversation was not to discuss the substantive issues of the case, its facts, or the law related to the decision. Indeed, no such discussion occurred. It was my purpose to discuss the contents of a letter written on April 16, 1993, and our discussion was limited to the content and wisdom of that letter.

The letter of April 16, 1993 contained language that could have been construed as a personal attack on the capability of individual Board members to complete the responsibilities of their positions. As such the letter was potentially inflammatory and its author could or should have reasonably anticipated that it would evoke some response. Nevertheless, the letter was not of a type which would be expected to produce a reaction so severe that it would be expected to permanently affect any Board member to which it impliedly applied, or to change the outcome of the case, nor did it.

While I regret any misunderstanding that may have occurred as a result of that discussion, a misunderstanding is all that the present episode amounts to. It is not a basis for recusal.

Despite this extensive discussion, however, the Court qualified what might have been a clear cut rule by noting that:

> "...given the wording of ORS 656.005(8) [now ORS 656.005(7)]. . . the date when symptoms necessitate medical treatment could also be deemed a triggering date for liability or a substitute for proof of causation. Because claimant suffered disabling symptoms when she first sought medical treatment, we need not examine the effect to be given to the date of first treatment." Bracke v. Baza'r, supra 293 Or at 248 n 4.

In Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), the Supreme Court again expressed the possibility that, Larson's characterization of the last injurious exposure rule notwithstanding, the date of first treatment might be an appropriate triggering date for fixing the initial liability of the potentially causal employers. It stated that "[w]e use the term 'disability' throughout the remainder of this opinion because almost all cases applying the last injurious exposure rule are claims for a disability award. The doctrine also might be applicable to claims for medical benefits. ORS 656.245." 296 Or at 243 n 2.

In SAIF v. Carey, 63 Or App 68 (1983), and Progress Quarries v. Vaandering, 80 Or App 160 (1986), the Court of Appeals took up the question left unanswered by the Supreme Court. In Vaandering, the initial event was a claim for medical services related to hearing loss and tinnitus. Despite the fact that the court permitted claimant to file additional evidence of disability prior to its de novo review, the Court rejected the date of disability as the appropriate date for fixing liability and relied instead on the date of first medical treatment. On the basis of that date, it assigned initial liability to Progress Quarries. Thereafter, however, on the basis of a showing of actual contribution to a worsened condition, the court shifted responsibility for the tinnitus to Todd Building. In explaining its result the court noted that claimant had submitted evidence of disability arising at Todd Building but stated:

> "We need not reach the matter because we have concluded that claimant's medical treatment was the triggering event for purposes of the last injurious exposure rule and that, pursuant to Boise Cascade Corp. v. Starbuck, supra, responsibility shifts to Todd as a subsequent employer where employment conditions exacerbated claimant's underlying disease." 80 Or App at 167 n 1. (Emphasis added).

With the reasoning of Progress Quarries v. Vaandering, supra, application of the last injurious exposure rule in Oregon is triggered either by the first date of medical treatment or the onset of disability, whichever event first occurred.[2] That has remained the law in Oregon since the Vaandering decision. See Oregon Boiler Works v. Lott, 115 Or App 70 (1992). To the extent that the Board has held otherwise in Fred A. Nutter, 44 Van Natta 854 (1992), and Eleanor G. Castrignano, 44 Van Natta 1134 (1992), those cases must be disavowed.

In addition, the Court has made clear that the question of liability only arises between employers and their insurers who were in a position to have contributed to the disability or need for medical treatment on the date liability is fixed. Bracke v. Baza'r, supra, 293 Or at 245. This would exclude any insurer from the initial assignment of liability who came on the risk after the triggering event.

The evidence establishes that claimant's work activities while all four insurers were on the risk were of the kind that could have caused the disease. Meyer v. SAIF, 71 Or App 371 (1984). However, when claimant's condition worsened on March 13, 1990 (which resulted in a claim being filed for the first time by way of Dr. Gill's April 4, 1990 letter and report), UEI was not yet on the risk and claimant had not yet been disabled by his bilateral CTS. Therefore, we must first examine who was responsible for claimant's compensable condition as it existed when the first claim was filed, and only UPI, SAIF

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[2] The majority's construction of the rule as it is explained in Progress Quarries v. Vaandering, 80 Or App 160 (1986), depends upon the conclusion that "disability" and "disabled from work" are the same thing. They are not. Disability includes temporary and permanent disability, both total and partial. It has never been necessary for a worker to be disabled from actually performing his regular work, in order to be disabled. See, Inkley v. Forest Fiber Products, 288 Or 337 (1980); Oregon Boiler Works v. Lott, 115 Or App 70 (1992). The court's decision not to inquire into whether claimant had become permanently disabled during his employment with a later employer in Vaandering, is therefore, inconsistent with the majority interpretation of the rule.

and Kemper were on the risk. At that time, claimant had never been disabled, but had sought medical treatment. Therefore, the date claimant first sought medical treatment is the triggering date for determining responsibility. SAIF v. Carey, supra. Dr. Mack's chart notes show that claimant first received medical treatment for his carpal tunnel symptoms on June 8, 1988. At that time, UPI was on the risk for Kosta's and SAIF was on the risk for Greek Village. Claimant's concurrent employment with Kosta's and Greek Village requires that we find both UPI and SAIF to be responsible for a portion of claimant's benefits.[3]

We must next determine whether responsibility has shifted from UPI and SAIF to either Kemper or UEI. In order to shift responsibility for an occupational disease, UPI and SAIF must prove that the later employment activities caused claimant to sustain a new compensable disease involving the same condition. ORS 656.308; ORS 656.802(2); Oregon Boiler Works v. Lott, supra; Donald C. Moon, 43 Van Natta 2595 (1991). In order to show a new compensable disease, UPI and SAIF must prove that subsequent employment activities were the major contributing cause of a material, pathological worsening of the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979).

After my review of the record, I would conclude that UPI and SAIF have met that burden. Dr. Gill's reports show that, while the underlying disease did not dramatically change, claimant's continued repetitive work activities after June 1988 contributed to a progressive and material worsening of his underlying condition. (Exs. 50, 55 and 57). Specifically, I find that claimant's condition had materially worsened as of March 13, 1990, when claimant's complaints had considerably worsened and he was again required to seek treatment from Dr. Mack and Dr. Gill. I rely upon the opinions of Dr. Gill and Dr. Button in support of my conclusion that a pathological change accompanied claimant's sustained increase in symptoms. Kemper was on the risk as of March 13, 1990, therefore, Kemper became responsible for the condition beginning on that date. However, our analysis does not end there.

The medical evidence supports my further finding that continued work activities on and after April 11, 1990, when UEI came on the risk, materially worsened the underlying bilateral CTS condition. (Exs. 50, 55, 57, 58). In addition to Dr. Gill's opinion, Dr. Button, a hand surgeon, testified at deposition that claimant's condition had deteriorated and he had an increased level of symptoms and explained that, if claimant's wrists were "opened-up" in April 1990 and again in July 1990, there would probably have been pathological changes in the nervous system observable at the microscopic level in the progression of his condition. (Ex. 58). Accordingly, I conclude that Kemper has carried its burden of proving that claimant sustained a new occupational disease involving the same condition.

However, since Dr. Gill and Dr. Button appear to agree that the continuation of activities over time is required before a pathological worsening can result, UEI could not become responsible merely by virtue of having assumed coverage on April 11, 1990. A pathological worsening after April of 1990 and before July of 1990 is evident in this record. Therefore, I would conclude that responsibility for further compensable medical services and disability should be the responsibility of UEI beginning June 1, 1990, the first date of disability arising on the claim. ORS 656.308(1); Donald C. Moon, supra.

In FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984) clarified 73 Or App 223 (1985) the court recognized that it is always a defense to application of the last injurious exposure rule to prove that a prior employment exposure was the sole cause of claimant's disability, or that it was impossible for claimant's exposure with a particular employer to have caused disability. Given the court's analysis in Carey and Vaandering there is no rational reason to limit the impossibility defense to disability, just as there is no reason to limit application of the last injurious exposure rule itself to disability. Because both Kemper and UEI are perfectly correct to argue that the employment exposure while they were on the risk could not possibly have contributed to a need for treatment arising, and incurred, before that exposure began, each would be relieved of liability for those medical expenses which preceded its coverage.

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[3] Unlike proportioning of responsibility for the same benefits between successive employers/insurers, proportioning of the same benefit covering the same period of time between concurrent employers is allowed in Oregon. See e.g., SAIF v. Abbott, 103 Or App 49, 54 (1990). The appropriate portion to be paid by each insurer is established by the Director upon application of the parties. Loretta J. O'Rourke, 44 Van Natta 2264 (1992).

The distribution of responsibility above includes one additional merit that has not previously received special consideration from the courts. In SAIF v. Carey, supra, SAIF contended that use of the date of first medical treatment permitted the claimant to control which employer will become responsible for his condition by controlling the date on which he first sought treatment. While the court properly disregarded that argument, a similar consideration presents serious concerns. By delaying the filing of a claim, or by delaying the process of litigation to allow additional employers to contribute to claimant's disability, both the claimant and the employers or insurers could seek to target a specific party as the responsible party, and avoid liability despite actual contribution to the condition, even though the subsequent employment exposure was not long enough to have significantly contributed to causation or to have actually worsened the condition. This is possible, however, only where the the application of the last injurious exposure rule always depends on the date of disability, where disability subsequently develops. The tactical maneuvering that frequently occurs in responsibility litigation is attributable to just this motivation. By focusing on the first triggering event, regardless of whether that event results in disability, for the initial assignment of liability, this decision focuses on the relationship between the parties at the first instant in time when a claim could, or should, have been filed. That is the appropriate time for the determination of initial responsibility, regardless of whether the assignment is made on the basis of an artificial rule, or on the basis of actual contribution to causation.

This application of the last injurious exposure rule conforms not only to the rule itself, and its application in Oregon to date, but also to sound principles of common sense. The rule is an arbitrary method of assigning liability. Nevertheless, if the rule's arbitrariness is limited, the application of the rule is more likely to be perceived as fair. The resolution suggested above will produce the same result regardless of when the original claim is filed. Consequently, this application improves predictability, limits gamesmanship, and provides for the prompt and orderly provision of benefits required by ORS 656.012(2), while at the same time achieving the policy goals discussed in Mathis and Inkley as described above.

Finally, I note that while this claim was presented to the Referee, and to the Board on review, under the last injurious exposure rule, that rule is not necessarily the only, or even the most appropriate, method for resolution of this dispute. In Bracke v. Baza'r, supra, the Court considered whether an employer/insurer could use the last injurious exposure rule defensively where the claimant had proven actual causation. It stated that:

> "There is no reason to apply the rule with any greater arbitrariness than is required to achieve its purposes, but there is no basis in this case to recognize an exception or qualification of the rule. It is arguable that an employer has no interest in the unnecessary dominance of an artificial rule when a claimant foregoes the benefit of the rule and relies upon proof of actual causation. To allow that would be to allow an employer to inject the rule into a case to defeat the very interests of a claimant which the rule is intended to serve." 293 Or at 250 n 5.

In Boise Cascade Corp v. Starbuck, supra, the Court carried this consideration somewhat further and noted that the referee and the Board are free to decide a case based on causation actually proven, rather than by applying the last injurious exposure rule. The Court expressed no limitation based on which party sought to prove actual causation or which party sought to rely on the rule. It stated that:

> "If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker against the last employer whose employment may have caused the disability. On the other hand, if the trier of fact is convinced that the disability was caused by an earlier injury, or was not work related, such a finding may be made." 296 Or at 245.

In the present claim, the active litigation of the dispute has produced a well developed record which is sufficient to support the distribution of responsibility for benefits over time, including medical services, on the basis of actual causation. In this particular factual scenario, that distribution is identical to the distribution produced above with application of the last injurious exposure rule.

To the extent that the majority opinion establishes that UEI is responsible for claimant's claim after June 1, 1990, I agree with the allocation of responsibility. However, for each of the above stated reasons, I am unable to agree with the majority insofar as it assigns responsibility for the entire claim to UEI, and, therefore, respectfully dissent from that portion of the Order.

In the Matter of the Compensation of
DONAT E. FLORES, Claimant
WCB Case Nos. 91-18278 & 92-00641
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Lipton.

Claimant requests review of that portion of Referee Galton's order that affirmed the Director's order finding that claimant is not eligible for vocational services. On review, the issue is vocational assistance.

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

As a preliminary matter, claimant raises for the first time on review the issue of the insurer's alleged violation of the time limits provided in ORS 656.340(1)(b)(A) and (4). (See App. Br. at 44-46). Because this issue was not raised at hearing, we decline to address it on review. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991).

The Director found that claimant's attending physician had approved claimant's return to his previous employment and concluded, therefore, that claimant was ineligible for vocational assistance under OAR 436-120-040. Applying ORS 656.283(2), the Referee found that the Director did not abuse his discretion and did not enter the order upon unlawful procedure. See ORS 656.283(2). Accordingly, the Referee affirmed the Director's 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 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 finds the historical facts relevant to the dispute and, 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). An error of fact cannot serve as a basis in itself for reversing the Director's decision. Colclasure v. Wash. County School Dist No. 48-J, 117 Or App 128, 132 (1992).

Claimant contends that the Director's order is invalid under ORS 656.283(2)(d) because the Director abused his discretion. Claimant's argument is based on his disagreement with the Director's factual finding that claimant's attending physician released him to his job at injury. Claimant maintains that, although his attending physician released him to return to work, the job description provided to his attending physician did not adequately describe the actual duties claimant performed.

Even were we to agree with claimant's contention that the Director erred in finding that claimant had been released to his previous job at injury, the court in Colclasure has ruled that a fact-finding error is not a statutory basis for modifying the Director's order. Id.

Claimant further alleges that the Director abused his discretion because the procedure used to gather information was incomplete through: (1) failure to direct the insurer's vocational consultant, Mr. Davis, to investigate claimant's disagreement with the job description; (2) the Rehabilitation Review Section's (RRS) failure to meet with claimant; (3) RRS's failure to convene any meetings to resolve the dispute; (4) failure of RRS in acknowledging claimant's telephone response on December 3, 1991; and (5) denial of vocational services on the basis that claimant and his attorney failed to provide adequate information.

The majority of the court in Colclasure (at footnote 2) indicated that unlawful procedure or abuse of discretion could be found if: "the Director decided a claim by flipping a coin or that he had refused to give the parties an equal opportunity to present their positions." Colclasure v. Washington Co. School Dist. No. 48-J, supra. However, it does not appear that the Director's actions in this case were of the degree described by the Colclasure court. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated April 22, 1992 is affirmed.

In the Matter of the Compensation of
MAURICE A. FROST, Claimant
WCB Case No. 91-03000
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Lipton.

The insurer requests review of Referee Emerson's order that set aside its denial of claimant's claim for a left arm injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was injured as he was leaving the employer's premises at the end of his work shift. The injury resulted when claimant used his truck to push open a guard gate. When the gate rebounded, claimant attempted to prevent it from smashing his truck by holding out his arm. Thereafter, the gate struck claimant's arm, breaking it.

The sole issue before the Referee was whether claimant's injury arose out of and in the course of his employment. The Referee concluded that it did. The insurer argues that, because claimant's use of his truck to open the gate was a "personal comfort" activity that was not authorized by the employer, claimant's injury is not sufficiently work connected. We agree.

Generally, all injuries that arise out of and in the course of a worker's employment are compensable. See ORS 656.005(7)(a). Because the employer controls its premises, injuries that occur on the employer's premises typically arise out of and are in the course of a worker's employment, unless an exception applies. Cope v. West American Ins. Co., 309 Or 232, 238 (1990). One exception is the "personal comfort" doctrine. Under that doctrine, the work connection of an on premises injury is severed if the injury resulted from a personal comfort activity that was not expressly or impliedly allowed by the employer. Clark v. U.S. Plywood, 288 Or 255, 266 (1980).

In Boyd v. SAIF, 115 Or App 241 (1992), the court held that an injury that occurs on employer controlled premises while the employee is traveling to and from work is work connected. See William F. Gilmore, 45 Van Natta 410 (1993); Shirley D. Ward, 45 Van Natta 388 (1993). Nevertheless, the court recognized that the work connection of going and coming activities may be severed if the "claimant was engaged in activity of a personal nature," when the injury occurred. Boyd v. SAIF, supra, 115 Or App at 244; see Albee v. SAIF, 45 Or App 1027, 1030 (1980).

Although the Boyd decision abolished the "going and coming" exception, insofar as on premises injuries are concerned, it affirmed the continued applicability of the "personal comfort" doctrine. Consequently, while he was leaving the employer's premises, claimant was in the course of his employment. However, that work connection was severed if claimant also engaged in a "personal comfort" activity that was not expressly or impliedly acquiesced in by the employer. Agripac, Inc. v. Zimmerman, 97 Or App 512, 514 (1989).

At hearing, the parties agreed that claimant's use of his truck to open the gate was a personal comfort activity. Claimant's evidence showed that the gate could be opened either by pushing it open by hand or by pushing it open with a vehicle. Inasmuch as the record reflects that it was "understood" that the preferred method of opening the gate was to push it open by hand, we agree with the parties that claimant's act of pushing the gate open with his truck was a "personal comfort" activity. Thus, the only remaining issue is whether that activity was expressly or impliedly acquiesced in by the employer. The Referee concluded that the employer had impliedly permitted employees to use their vehicles to open the gate, because the evidence showed that employees had used their vehicles to open the gate in the past, and the employer did not expressly prohibit that conduct. We disagree.

Before an employer can acquiesce in or impliedly allow conduct, it must have actual or implied knowledge of that conduct. Knowledge can be implied if it is shown that the injurious activity was a "common practice or custom in the work place." See Clark v. U.S. Plywood, supra 288 Or at 267.

The record does not reflect that the employer, or any supervisor, actually knew that employees sometimes opened the gate with their cars. Nor is there evidence from which such knowledge can be inferred. Claimant proved that during the four to five years that the gate was in use, two people pushed the gate open with a car on five to 12 occasions. That frequency of occurrence is not sufficient for us to infer that the conduct was a "common practice or custom in the work place." 288 Or at 267. Moreover, there is no evidence that the employer or any supervisor was actually aware of those employees' sporadic activities.

Consequently, we conclude that the employer did not authorize or acquiesce in claimant's "personal comfort" activity.[1] Accordingly, claimant's injury did not arise out of nor occur in the course of his employment.

ORDER

The Referee's order dated November 3, 1992 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

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[1] By way of comparison, pushing that gate open by hand, which was understood to be the proper way to open the gate, was an activity that the employer expressly or impliedly acquiesced in. Consequently, if claimant had been injured while opening the gate in that manner, the work connection established by Boyd would likely not have been severed.

In the Matter of the Compensation of
SHANNON K. HARTSHORN, Claimant
WCB Case No. 92-01934
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Crumme's order that: (1) directed it to pay claimant temporary disability benefits for the period of February 9, 1991 through March 25, 1992; and (2) assessed a penalty for SAIF's allegedly unreasonable refusal to pay such compensation. In her brief, claimant argues that she is entitled to assessed attorney fees under ORS 656.382 and 656.386. SAIF has moved the Board to strike supplemental briefs submitted by claimant. On review, the issues are the motion to strike, temporary disability, and penalties and attorney fees. We deny the motion to strike and reverse.

FINDINGS OF FACT

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

Claimant originally sustained a back injury in April 1987. In February 1990 and March 1991, SAIF denied aggravation claims. Claimant requested a hearing from the denials. On January 8, 1992, the parties appeared before Referee Hazelett. At the beginning of the hearing, Referee Hazelett stated that the case was "settled on the record by the parties by SAIF Corporation agreeing to rescind its denial letter of February 22, 1990; March 8, 1991; and March 11, 1991. All issues related to those denials are hereby settled by this Order. The only remaining issue is the attorney fee to be assessed[.]" (Ex. 1A-2).

On February 5, 1992, claimant filed a request for hearing based on SAIF's failure to pay temporary disability. On February 28, 1992, Referee Hazelett issued an Opinion and Order stating that the "issues identified by pleadings in the record have been resolved by the parties." (Ex. 2-1). The order went on to address the remaining issue of an assessed attorney fee, awarding $5,230 as a reasonable fee. (Id).

On March 9, 1992, SAIF's attorney requested Referee Hazelett to amend his order to reflect that SAIF had rescinded its denials so that it could commence temporary disability payments to claimant. (Ex. 4). On March 27, 1992, Referee Hazelett issued an "Order of Abatement and Reconsideration" ordering that the denial letters had been set aside and remanding the claim to SAIF for acceptance and processing in accordance with the law. (Ex. 6-2).

On March 13, 1992, SAIF paid claimant temporary disability for the period from August 30, 1990 to February 8, 1991. (Ex. 7-2). On April 22, 1992, SAIF paid claimant temporary disability for the period from March 26, 1992 to April 16, 1992. (Id). SAIF has not paid temporary disability for the period of February 9, 1991 to March 25, 1992.

On April 3, 1992, SAIF requested Board review of Referee Hazelett's order. See WCB Case No. 90-04761. On April 28, 1992, two days before the scheduled hearing in the instant matter, SAIF notified the Board of its intent to withdraw its appeal in WCB Case No. 90-04761. On May 7, 1992, the Board issued an order dismissing SAIF's request for review in WCB Case No. 90-04761. On April 27, 1992, claimant filed an amended request for hearing, again based on SAIF's failure to pay temporary disability benefits for the disputed period.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

With its reply brief, SAIF included a copy of a June 18, 1992 Notice of Closure, which awards certain periods of temporary disability as well as unscheduled permanent disability. Citing Betty R. Young, 44 Van Natta 47 (1992), SAIF requested that the Board take "judicial notice" of this document. In response to SAIF's arguments in its reply brief based on the Notice of Closure, claimant submitted supplemental briefing. Several months later, claimant submitted an additional supplemental brief. SAIF has moved that the Board strike claimant's supplemental briefs.

We conclude that, under the circumstances present here, claimant's initial supplemental briefing is permissible. We note in this regard that the supplemental argument contained in claimant's supplemental brief is solely in response to the arguments presented in SAIF's reply brief relating to the Notice of Closure. Further, we note that the Notice of Closure was issued after the hearing was held here and the record was closed. Therefore, we conclude that extraordinary circumstances beyond claimant's control exist to permit her to respond to the new material raised in SAIF's reply brief. See OAR 438-11-020, 438--11-030.

With regard to claimant's later supplemental brief, we note that the argument therein does not respond to new material contained in SAIF's reply brief. Rather, claimant cites a recent Board decision involving the issue of penalties and attorney fees and presents argument based on that decision.

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 claimant's later supplemental material only to the extent it advises us of recent development in the law. See Debra A. West, 43 Van Natta 2299 (1991).

Official Notice

SAIF requests that we take official notice of a Notice of Closure that issued June 18, 1992 and awarded no temporary disability for the disputed period of February 9, 1991 through March 25, 1992. We may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2); Efrain C. Espinoza, 45 Van Natta 348, 349 (1993). Because the document in this case is an act of a state agency, we conclude that we may take official notice of the order's existence. Efrain C. Espinoza, supra. However, for the reasons that follow, we find that the Notice of Closure has little probative value to the issue in this case.

Temporary Disability

Reasoning that SAIF had accepted the claim at the January 8, 1992 hearing before Referee Hazelett, Referee Crumme concluded that SAIF was obligated to begin temporary disability payments within 14 days of January 8, 1992. Determining that claimant's disability began February 8, 1991 and finding no grounds to justify a termination of temporary disability under ORS 656.268(3) prior to March 26, 1992 (when SAIF began paying temporary disability), the Referee ordered SAIF to pay claimant such benefits for this period. The Referee also assessed a penalty of 25 percent, finding that SAIF's conduct was unreasonable. We disagree with the Referee's reasoning.

Payment of temporary disability benefits must begin within 14 days of the date of a final "litigation order" authorizing retroactive temporary disability. OAR 436-60-150(4)(f). However, filing of an appeal by the carrier stays payment of the compensation appealed, including retroactive temporary disability benefits. ORS 656.313(1)(a); Steven S. Ewen, 45 Van Natta 207, 209 (1993); Walden J. Beebe, 43 Van Natta 2430 (1991).

Here, at the January 8, 1992 hearing before Referee Hazelett, it was announced that SAIF's denials had been settled. Although the Referee announced this settlement as an "order" at that time, such an agreement does not constitute a "settlement stipulation" unless approved in writing by a Referee. OAR 438-09-001(3). Thus, Referee Hazelett's oral announcement did not trigger SAIF's responsibility to commence payment of temporary disability. Moreover, since Referee Hazelett's February 27, 1992 order neither approved the parties' agreement nor set aside denials, SAIF's obligation to begin temporary disability likewise did not begin at that time. Alternatively, even if the order triggered such an obligation, the order was abated and reconsidered within 30 days. Thus, because the February 27, 1992 order did not become final, SAIF was not required to pay TTD within 14 days of the date of the order.

Instead, SAIF's claim processing responsibility to provide TTD was not initiated until issuance of Referee Hazelett's March 27, 1992 reconsideration order. However, because SAIF timely requested Board review of this order, it was entitled to stay payment of the retroactive temporary disability awarded by Referee Hazelett's order. ORS 656.313(1). SAIF "withdrew" its appeal two days before claimant's April 30, 1992 hearing seeking the disrupted temporary disability. Nevertheless, SAIF's authority to stay payment of such retroactive benefits under ORS 656.313(1) remained in effect at the time of the hearing before Referee Crumme since the Board did not issue its order dismissing SAIF's request for hearing until May 7, 1992. See John G. Davison, 45 Van Natta 389 (1993).

Consequently, SAIF was under no legal obligation at the April 30, 1992 hearing to pay the "retroactive" temporary disability awarded by Referee Hazelett's order. ORS 656.313(1). Furthermore, SAIF's failure to pay the "retroactive" temporary disability was not unreasonable. Therefore, a penalty is not warranted. ORS 656.262(10).

ORDER

The Referee's order dated June 1, 1992, as reconsidered on July 20, 1992, is reversed.

In the Matter of the Compensation of
PATRICK J. IPOX, Claimant
WCB Case No. 92-05574
ORDER ON REVIEW
William Skalak, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Lipton and Hooton.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of his aggravation claim for a cervical condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant's compensable 1989 injury was the major contributing cause of his worsened cervical condition.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of claimant's aggravation claim, because she concluded that claimant failed to prove that his accepted 1989 nondisabling cervical injury was a material contributing cause of his worsened cervical condition. Claimant contends that he satisfied his burden of proof, because the reports of his treating physician are persuasive on that issue. We agree.

Claimant's 1989 compensable injury occurred in Oregon. Subsequently, he began working in Washington state. Claimant was working for his Washington employer when his cervical condition worsened.

An injured worker is entitled to additional compensation for worsened conditions resulting from the original injury provided that the original injury remains a material contributing cause of the worsened condition and the major contributing cause of the worsened condition is not an injury outside the course and scope of employment. ORS 656.273(1).

The existence of claimant's worsened condition is not disputed. Rather, the only issue is whether claimant's prior compensable injury is a material contributing cause of that condition and whether his noncompensable Washington work activities were the major contributing cause of that worsening. Because of the various possible causes of claimant's worsened cervical condition, specifically his 1989 injury and his subsequent out-of-state work activities, we conclude that the issue of medical causation is a complex one requiring expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Brett, claimant's treating neurologist, submitted several reports. In a November 11, 1991 chart note, Dr. Brett characterized claimant's 1989 compensable injury as a disc injury, and noted that claimant's subsequent worsening was "mainly precipitated by his further work activities" since that time. (Ex. 8). In a November 11, 1991 letter, Dr. Brett stated that he felt that claimant's worsened condition was "directly related to his work injury some three years ago with then pathologic worsening recently precipitated by further work activities and, to a lesser extent, activities of daily living." (Ex. 9).

After Dr. Brett surgically corrected claimant's cervical condition in November 1991, claimant was sent to two independent medical examinations (IME). Dr. Rosenbaum, M.D., conducted the first IME. In his report, he diagnosed claimant's 1989 injury as a cervical strain, and opined that that injury had no causal influence on claimant's subsequent cervical condition. (Ex. 17). Instead, he concluded that claimant's work activities on or about September 1991 were the cause of claimant's cervical condition. After reviewing Dr. Rosenbaum's report, Dr. Brett asserted that Dr. Rosenbaum's opinion that claimant's 1989 injury "was simply a strain is pure conjecture." (Ex. 19).

The second IME was conducted by the Medical Consultants Northwest. After examining claimant and reviewing his medical records, they concluded:

> "His problem is a ruptured cervical disc which occurred beginning with symptoms in July 1991. The disc was actually ruptured at the time that he developed arm symptoms, which may carry over into August 1991. There is no specific event and, indeed, many people develop cervical disc rupture during their sleep. The cause of cervical disc disease is unknown, and the cause of disc herniation is also unknown. While some people do develop it in the setting of a specific event, this is only the 'straw that broke the camel's back' and not the major cause of the disc herniation." (Ex. 20).

After reviewing the report from the second IME, Dr. Brett submitted another rebuttal, wherein he explained the etiology of claimant's cervical condition. He indicated that claimant had no neck problems prior to his 1989 injury, that after that injury claimant had intermittent pain over the next two years and that, with further "wear and tear" he developed a frank disc herniation. Based on that etiology, Dr. Brett opined:

> "that [claimant] sustained his annular injury at C5-6 with his original work injury in 1989. This then resulted in referred right scapular and shoulder pain intermittently with exacerbations of symptoms without precipitating event consistent with his disc pathology. This is clearly not a cervical strain, but is more consistent with a disc injury with referred pain which then deteriorated with frank disc herniation in 1991 requiring operative intervention." (Ex. 22).

The Referee discounted Dr. Brett's opinion, because she concluded that Dr. Brett changed his opinion. We disagree.

In a November 11, 1991 chart note, Dr. Brett indicated that claimant's cervical condition at that time represented a pathological worsening of his 1989 injury mainly precipitated by his further work activities. That chart note suggests that, at that time, Dr. Brett considered claimant's work activities in Washington to be the major contributing cause of his worsened condition. However, in a November 11, 1991 letter explaining that chart note, Dr. Brett asserted only that claimant's work activities in Washington could have caused claimant's condition. (Ex. 9). That statement suggests that, as of November 11, 1991, Dr. Brett had yet to determine the major contributing cause of claimant's condition. Consequently, we do not view the November 11, 1989 chart note as asserting an opinion that is inconsistent with Dr. Brett's subsequent opinion that claimant's 1989 injury was the major contributing cause of his worsened condition.

In evaluating the persuasiveness of medical evidence, we normally give more weight to the treating physician's opinion, absent some reason not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Moreover, when the experts disagree, we give more weight to the opinion that is based on the most complete information and is the better reasoned. Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Brett is claimant's treating physician. In addition, his reports are better reasoned and based on the most complete information. His reports explain how claimant's recurring neck pain subsequent to his 1989 injury is indicative of an annular injury at C5-6, rather than a cervical strain that, as the IME's indicate, would have resolved and not have caused recurring symptoms. Consequently, we give more weight to Dr. Brett's opinion. Dr. Brett concluded that claimant's 1989 compensable injury was the major contributing factor to claimant's worsened condition. (Ex 21A).

In fact, the insurer accepts the Referee's Findings of Fact including, inter alia, the factual basis for Dr. Brett's opinion which led him to opine that claimant's 1989 injury with an Oregon employer was the major contributing cause of the worsening of claimant's condition.

Claimant having established that his 1989 Oregon injury is the major contributing cause of his worsened condition, we need not decide whether the analysis in Miville v. SAIF, 76 Or App 605 (1985), was overturned by the 1990 amendments to ORS 656.273(1). Even were we to decide that the Miville analysis was overturned by ORS 656.273(1), we would conclude that the insurer has failed to prove that claimant's Washington work activities were the major contributing cause of claimant's worsened condition. In either event, the insurer's denial is set aside.

Claimant is entitled to an assessed attorney fee for prevailing against the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case,

we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,850, 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 claimant's counsel's statements of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 10, 1992 is reversed. The insurer's denial is set aside. The claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $3,850 for services at hearing and on Board review, to be paid by the insurer.

Board Member Hooton specially concurring.

I agree with the Order on Review, that claimant's aggravation claim is compensable. However, I write separately because I disagree with its conclusion that we need not reach the analysis in Miville v. SAIF, 76 Or App 603 (1985).

In 1990, the legislature amended ORS 656.273(1) to provide that an aggravation claim is not compensable if the major contributing cause of the claimant's worsened condition is an injury "not occurring within the course and scope of employment." In Lucky L. Gay, 44 Van Natta 2172 (1992), the Board concluded that, under that amendment, an aggravation claim is not compensable if the major contributing cause of the claimant's worsened condition is an injury resulting from "noncovered" employment. The logical extension of that case is the conclusion that Miville has been overruled. I dissented in that case, partly because the legislature did not intend for the 1990 amendments to ORS 656.273(1) to preclude aggravation claims when activities at noncovered employment are the major contributing cause of a worsened condition. For the reasons stated in my dissent in Lucky L. Gay, I adhere to that conclusion. Moreover, I also note that the majority's opinion in that case conflicts with a basic rule of statutory construction.

We must construe a statute in a manner that effectuates the intent of the legislature. England v. Thunderbird, 315 Or 633, 638 (1993). To ascertain that intent, we first look to the text and context of the statute. Boone v. Wright, 314 Or 135, 138 (1992). Other provisions of the statutory scheme are an important part of that context because, when the legislature uses the same term in more than one part of a statutory scheme, we must presume they intended those terms to have the same meaning, unless it manifests its intent to the contrary. Knapp v. City of North Bend, 304 Or 34, 41 (1987).

It is indisputable that, when it amended ORS 656.273(1), the legislature intended to preclude aggravation claims for worsened conditions resulting from activities "not occurring within the course and scope of employment." What is less clear, at least from the perspective of the majority in Lucky L. Gay, is what the legislature intended the words "course and scope of employment" to mean. We need not venture far to answer that question.

ORS 656.005(7)(a) defines a "compensable injury" as an accidental injury arising out of and "in the course and scope of employment." That statute does not limit the definition of a compensable injury to one that occurs in "covered" employment. Instead, it defines "compensable injury" broadly to include any injury in any employment. To the extent that the legislature did not intend an injury obtained in a specific employment to be compensable, it enacted exemptions for those employments. See, e.g., ORS 656.037; ORS 656.075. Consequently, we must conclude that the legislature intended the term "course and scope of employment," as used in ORS 656.005(7)(a), to include any employment, not just "covered" employment. Because the legislature did not manifest any intent for the term "course and scope of employment," to have a different meaning in ORS 656.273(1), we erroneously construed that term to refer only to covered employment in Lucky L. Gay.

In my view, the rule of Miville v. SAIF, supra, still applies without modification by the 1990 amendments to ORS 656.273(1). Under Miville, claimant can prevail on his aggravation claim if he proves that his 1989 compensable injury was a material contributing cause of his worsened condition and that he sought, but failed to obtain, benefits for that condition in Washington. That is true, even if his activities at his Washington employment were the major contributing cause of his worsened condition. He proved those things. Consequently, I concur in the result.

In the Matter of the Compensation of
MARGARET R. JONES, Claimant
WCB Case No. 92-07702
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Neidig and Lipton.

Claimant requests review of that portion of Referee Livesley's order which found that claimant's "cumulative trauma disorder" of the right upper extremity was the same condition denied by the SAIF Corporation's untimely appealed denial of claimant's right wrist and hand injury (neuroma) claim. Claimant also requests that this matter be remanded to the Referee for further evidence taking. On review, the issues are remand and compensability.

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

In August 1990 claimant sought treatment for pain in the right wrist and hand radiating up the forearm. Dr. Catlin, osteopath, noted a palpable mass on the wrist and speculated that it might be a neuroma. On September 11, 1990, SAIF issued the following denial:

> "You filed a claim for an alleged injury to your right wrist and hand, which occurred on or about July 27, 1990, while employed [with the employer].
>
> "We have reviewed the information in your file and find that there is insufficient evidence that your neuroma is the result of either a work-related injury or disease. Therefore, we must deny your claim." (Ex. 3). (Emphasis added).

Claimant did not timely request a hearing on this denial.

In November 1990 Dr. Jewell, hand surgeon, diagnosed claimant's pain condition as cumulative trauma disorder. Dr. Jewell did not find a neuroma, but he did note a ganglion cyst which he concluded did not contribute to claimant's condition. On June 4, 1992, claimant filed a request for hearing on, among other issues, a "de facto" denial.

The Referee concluded that SAIF's September 11, 1990 denial letter effectively denied claimant's cumulative trauma disorder, even though the disorder was not diagnosed until after the denial letter issued. Since claimant had failed to timely request a hearing on the September 1990 denial, the Referee dismissed claimant's hearing request concerning the compensability of his right hand/wrist condition.

Claimant does not contest the fact that the untimely appealed September 1990 denial is final by operation of law. See ORS 656.319(1)(b). Considering the finality of the denial, claimant may not litigate the same claim or claims which arise from the same transaction or series of transactions. See Carol D. Goss, 43 Van Natta 821 (1991), aff'd mem 110 Or App 151 (1991). Likewise, she is barred from claiming compensation for the same condition which was denied. See Popoff v. J.J. Newberrys, 117 Or App 242 (1992).

After reviewing the medical reports surrounding the issuance of SAIF's September 1990 denial, we conclude that the effect of the denial was to finally determine that claimant's July 27, 1990 injury / occupational disease claim for right wrist / hand condition (diagnosed as neuroma) was not compensable. In light of such circumstances, claimant must establish that her current right upper extremity condition must be different, or changed, from the condition which SAIF denied in September 1990. See Proctor v. SAIF, 68 Or App 333 (1984); Arthur D. Esgate, 44 Van Natta 875, 876 (1992); Irene Jensen, 42 Van Natta 2838 (1990).

Our review of the medical evidence establishes that, before and after the September 1990 denial, claimant has been seeking treatment for the same problem; i.e., right wrist and forearm pain. Prior to the denial, Dr. Catlin, claimant's family physician, suspected a neuroma. Subsequent to the denial, Dr. Jewell dispelled that suspicion and diagnosed "cumulative trauma disorder." Although the physicians have used different terminology in describing claimant's condition, they are addressing the same complaints.

In light of such circumstances, we conclude that claimant's current right hand / wrist condition, despite the new "post-denial" diagnosis, is the same condition that SAIF denied. Dr. Jewell has opined that the major contributing cause of claimant's "pain disorder" were her work activities. Nevertheless, since claimant failed to timely appeal SAIF's denial of her claim for the same condition and Dr. Jewell's opinion fails to specify that claimant's "post-denial" work activities changed her condition, we are unable to conclude that her current condition is compensable.

Given our conclusion above, we need not address claimant's motion for remand.

ORDER

The Referee's order dated September 15, 1992 is affirmed.

Board Member Lipton dissenting.

Today the majority decides that a denial of a wrist neuroma, allegedly arising from a wrist and hand injury, encompasses an upper extremity muskuloskeletal pain disorder diagnosed post-denial. Because claimant did not appeal the denial of a condition which she learned within sixty (60) days of the denial she did not have, the majority holds that claimant is precluded from pursuing a claim for the subsequently diagnosed condition. I disagree and dissent.

I accept the facts identified by the majority except to add that Dr. Jewell identified shoulder, upper back and chest pain which he identified as an upper extremity muskuloskeletal pain disorder for which claimant's work activities were the major contributing cause.

Dr. Jewell's diagnosis is far different from the neuroma SAIF denied as allegedly resulting from a wrist and hand injury. For that reason, the majority's reliance on Jane Mathey, 44 Van Natta 1646 (1992) is misplaced. In Mathey, supra, the two diagnoses ("carpal tunnel syndrome" and "cumulative trauma disorder") were actually interchangeable terms used to identify the same condition. Here, a neuroma and an upper extremity muskuloskeletal pain disorder, not only cannot be confused as the same condition, but the symptoms attributable to each are completely different. Therefore I do not see how a denial of the former condition can be held to encompass the subsequently diagnosed latter condition. Had the insurer accepted the neuroma, there is no precedent to support a finding that that acceptance included the subsequently diagnosed condition affecting a different area of the body. I submit that the reverse should also hold true.

I would hold that claimant is not precluded from pursuing her claim for upper extremity muskuloskeletal pain. I respectfully dissent from the majority's holding to the contrary.

In the Matter of the Compensation of
ROBERT D. KING, Claimant
WCB Case No. 91-06165
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Lipton and Brazeau.

Claimant requests review of that portion of Referee Mongrain's order that awarded 13 percent (41.60 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had awarded 17 percent (54.40 degrees) unscheduled permanent disability for the injury. In its respondent's brief, the self-insured employer contends that the Referee erred in declining to reduce claimant's award insofar as his current loss of earning capacity was compensated by his prior unscheduled permanent disability award for a 1985 compensable injury. On review, the issue is extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his finding concerning claimant's job-at-injury.

Because of the employer's concession, we find that claimant's job-at-injury was that of a "Logging-Tractor Operator," DOT 929.663-010, which has a medium strength rating.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disability adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of issuance of the Determination Order apply. Former OAR 436-35-003(2); OAR 438-10-010. Claimant's condition became medically stationary on September 26, 1990, and his claim was closed by Determination Order on November 6, 1990. Therefore, the standards that became effective October 1, 1990 apply. See WCD Admin. Order 15-1990.

We adopt the values and reasoning related to those values assigned by the Referee to impairment (11 percent) and age (1), and discuss only education and adaptability.

Education

The record contains a vocational report that lists claimant's jobs for the 10 years preceding the time of determination. Based on that report, the Referee found that claimant's highest SVP level for that period is a 7, as a sawyer. Former OAR 436-35-300(4). Claimant argues that the correct SVP level is 4, because his testimony at hearing proves that he did not work as a sawyer. We disagree.

At hearing, claimant described some of the jobs that he performed during the interval between his 1985 injury and his 1990 injury. (Tr. 18-21). That interval does not cover the full 10 years preceding the determination order. Conversely, the vocational report does cover the full 10 years, and purports to list all of claimant's jobs during that time. (Ex 51). We do not find a sufficient basis in the record to refute the report's validity. Consequently, we conclude that the Referee properly relied on the vocational report, and that claimant's highest SVP for the 10 years prior to determination is 7, for a value of 1.

Adaptability

Adaptability is based on a comparison of the strength required for the claimant's job-at-injury, as described by the Dictionary of Occupational Titles, and the strength requirement of the modified work that he returned to. Former OAR 436-35-310(3)(c). Claimant contends that his adaptability factor should be 2, instead of 1, as calculated by the Referee. The self-insured employer concedes that point, and we accept its concession. The adaptability factor is 2.

Computation of Unscheduled Disability

When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 2, the product is 4. When that value is added to claimant's impairment value, 11 percent, the result is 15 percent unscheduled permanent disability. Former OAR 436-35-289(7).

Application of ORS 656.214(5)

The Referee concluded that claimant's current unscheduled permanent disability award should not be reduced, to any extent, by his 1987 award for a 1985 compensable injury. We disagree.

ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. The worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, 42 Van Natta 2846, 2850 (1990). This principle applies equally whether a series of accidents involves injury to the same or different unscheduled parts of the body. Id. The methodology is as follows.

We first rate all permanent disability (considering only permanent impairment due to claimant's low back) under the standards. Here, we have found a total of 15 percent unscheduled permanent disability for the low back condition. We then determine whether, and to what extent, that disability figure includes unscheduled permanent disability (loss of earning capacity) present before the latest injury. Only that portion of lost earning capacity which was not present prior to the current injury shall be awarded. Every Mendenhall, 45 Van Natta 567, 570 (1993). This is not a mathematically precise process. Instead, we consider to what extent a prior loss of earning capacity resulted from the same permanent limitations and vocational factors as are relied upon in our subsequent evaluation of permanent disability. We will reduce the award by the amount that represents the previously compensated loss of earning capacity. Id.

The 1987 unscheduled permanent disability award was based on a finding that claimant was precluded from stooping and prolonged heavy lifting and bending. (Ex 38). That award also considered that claimant has only a high school education and that his past work experience involved mostly heavy work. Id. Claimant is now restricted to light work. The medical evidence indicates that his range of motion limitations and lifting restrictions are due, in large part, to the 1990 injury. Taking those factors into account, we conclude that 10 percent of the current award represents permanent disability which was not present prior to the 1990 back injury. Therefore, claimant is entitled to an award of 10 percent unscheduled permanent disability as "due to" the 1990 back injury.

ORDER

The Referee's order dated August 20, 1992 is affirmed in part and modified in part. In lieu of the Referee's awards and Order on Reconsideration, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for the low back. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH W. McDONALD, Claimant
WCB Case No. 91-07926
ORDER ON RECONSIDERATION
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of those portions of our April 22, 1993 Order on Review which: (1) found claimant was entitled to temporary disability benefits on the psychological component of his claim; (2) assessed a 25 percent penalty for the insurer's failure to comply with Referee Crumme's order; and (3) awarded claimant an assessed attorney fee of $1,000.

Specifically, the insurer contends that no qualified attending physician authorized temporary disability benefits for the psychological component of the claim. The insurer also contends that claimant's entitlement to temporary disability benefits after May 21, 1991, if any, was resolved by a Disputed Claim Settlement approved on December 8, 1992. In addition, the insurer requests authorization to offset allegedly overpaid temporary disability benefits on the back injury component of the claim, paid pursuant to a Stipulation and Order approved June 26, 1992. Finally, the insurer submits several documents not previously in the record and requests that we take administrative notice of these documents in our reconsideration.

On May 20, 1993, we withdrew our April 22, 1993 order for reconsideration. We have received claimant's response to the insurer's Motion for Reconsideration, as well as the insurer's reply to claimant's response. Accordingly, we proceed with our reconsideration.

Motion to Strike

After the completion of the supplemental briefing schedule concerning the insurer's Motion for Reconsideration, claimant submitted an additional brief, denominated an "Answer to Reply Regarding Motion for Reconsideration," on June 17, 1993. The insurer moves to strike claimant's submittal.

It is permissible for any party to provide supplemental authorities to assist the Board in its review. However, we do not consider any supplemental submission to the extent it contains additional argument. See Betty L. Juneau, 38 Van Natta 553, 556 (1986).

Claimant's June 17, 1993 submittal contains additional argument in response to the insurer's reply brief regarding its Motion for Reconsideration. In our May 20, 1993 Order of Abatement, we authorized claimant to submit a response to the insurer's Motion for Reconsideration, and claimant did so. We will not consider the further argument claimant submitted on June 17, 1993. Betty L. Juneau, supra. Accordingly, the insurer's Motion to Strike claimant's June 17, 1993 submittal is approved.

Administrative Notice of New Evidence

With its Motion for Reconsideration the insurer submitted documents not previously in the record. Specifically, the insurer submitted a Stipulation and Order, approved by Referee Schultz on June 26, 1992, and a Disputed Claim Settlement, approved by Referee Mills on December 8, 1992. (Motion for Reconsideration, App. B, C). The insurer requests that we take administrative notice of these documents and consider them in our reconsideration.

The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). We have previously taken administrative notice of approved stipulations on a claim. See Rita M. Duncan, 42 Van Natta 1854 (1990). We consider the approved Disputed Claim Settlement to be essentially the same as an approved stipulation for purposes of administrative notice, since both are orders approved by a referee. Accordingly, we grant the insurer's request to take administrative notice of the June 26, 1992 Stipulation and Order and the December 8, 1992 Disputed Claim Settlement.

The parties submitted other documents, including the Department's Bulletin No. 215, the insurer's July 10, 1990 letter to claimant sent pursuant to that Bulletin, and claimant's attorney's May 4, 1993 letter to the insurer's attorney. Because of our disposition of the insurer's Motion for Reconsideration, these documents are unnecessary and will not be considered.

Temporary Disability

On reconsideration, the insurer contends that the December 8, 1992 Disputed Claim Settlement (hereafter "DCS") resolves the question of claimant's entitlement to temporary disability benefits after May 21, 1991. (See Appendix C of Insurer's Motion for Reconsideration). We agree.

Because of the procedural complexity of this case, we first briefly review the relevant procedural history.

In March 1990, claimant made a claim for a psychological condition, allegedly related to his compensable back injury. The insurer denied the claim on July 17, 1990, and claimant requested a hearing.

Referee Crumme' issued an order, as reconsidered on May 21, 1991, which found, inter alia, that claimant's psychological condition was compensable and directed the insurer to process the claim in accordance with law. The insurer requested review of portions of Referee Crumme's order, including that portion which found the psychological claim compensable.

In June 1991, while Board review of Referee Crumme's order was pending, claimant requested a hearing seeking enforcement of Referee Crumme's order. In the September 1991 hearing before Referee Galton, claimant sought temporary disability benefits due to his psychological condition from the date of Referee Crumme's order, May 21, 1991, forward. Referee Galton's order issued, as reconsidered, on January 15, 1992, ordering the payment of temporary disability benefits from March 1988 until closure.

The insurer requested review of Referee Galton's order, which is the subject of the present case. Our Order on Review issued on April 22, 1993. Regarding the temporary disability issue, our order directed the insurer to process the psychological claim to closure and to pay the temporary disability due under the psychological claim, as ordered in Referee Crumme's May 21, 1991 order, less any amounts already paid for the same period on the back claim. Order on Review at 5-6. The insurer moved for reconsideration of this portion of our order.

Meanwhile, on May 28, 1992, we issued our (reconsidered) Order on Review of Referee Crumme's order, affirming the Referee's determination that claimant's psychological condition is compensable. Kenneth W. McDonald, 44 Van Natta 692, on recon 44 Van Natta 1052 (1992). The insurer appealed our order to the Court of Appeals, which dismissed the insurer's appeal on October 21, 1992.

While review of Referee Galton's order was pending before us, the parties entered into a DCS, approved December 8, 1992, which concerned the parties' dispute regarding compensability of a proposed back surgery and entitlement to temporary disability benefits under the Crumme' order. The insurer contends that the DCS resolved the dispute concerning claimant's entitlement to temporary disability benefits after May 21, 1991, the date of Referee Crumme's order. Claimant does not dispute this contention. After our review of the DCS, we agree with the insurer that it resolved claimant's entitlement to temporary disability benefits after May 21, 1991.

The parties' contentions are set forth at page 6 of the DCS. Claimant contended, in relevant part, that "the orders issued by Referee Douglas Crumme require payment of temporary disability compensation from the date of those orders, through the present date" and continuing until termination is authorized under ORS 656.268. The insurer contended, in relevant part, that "no temporary disability compensation is due pursuant to the orders issued by Referee Douglas Crumme for any period of time subsequent to the date of Referee Crumme's orders." (DCS at 6).

The DCS further represents that the parties agreed to enter into the settlement "in lieu of any and all compensation which could be claimed by claimant with respect to issues involving temporary disability compensation" and that "all litigation involving these issues is fully and finally settled." (DCS at 8).

Finally, claimant stipulated:

> "[A]ll disagreements, all litigation, all Requests for Hearing and all other past and present disagreements, litigation and Requests for Hearing which have arisen or presently arise out of the competing contentions of claimant and insurer as set forth above shall be resolved by this Disputed Claim Settlement including, but not limited to, allegations by insurer to recover overpayments and allegations by claimant to the entitlement to penalties, attorney fees, temporary disability compensation and permanent disability compensation up through the date of the referee's signature hereon and that all pending claims made or unmade and all pending decisions made or unmade regarding such issues are resolved hereby." (DCS at 9) (Emphasis added).

Since our Order on Review of Referee Galton's order addressed the issue of claimant's entitlement to temporary disability compensation under Referee Crumme's May 21, 1991 order, and since at the time the DCS was approved on December 8, 1992, our decision was "pending" and "unmade," we find that the DCS applies to the present case and resolves the issue of claimant's entitlement to temporary disability compensation after May 21, 1991.

The parties assume that our order also has the effect of deciding claimant's entitlement to temporary disability benefits due on the psychological claim for the period prior to Referee Crumme's order. Claimant contends that since we directed the insurer to pay temporary disability benefits on the psychological claim, as ordered by Referee Crumme', he became entitled to temporary disability benefits for the period before the Crumme' order once that order became final. We disagree with claimant's contention regarding the effect of our order.

Our review is limited to Referee Galton's order. In the Galton hearing, claimant sought enforcement of the Crumme' order, claiming temporary disability compensation from May 21, 1991 forward. (Tr. 1-2). At the time of the Galton hearing in September 1991, the insurer's appeal of the Crumme' order was pending. Pursuant to ORS 656.313, the payment of compensation due under the Crumme' order was stayed, except temporary disability benefits that accrue from the date of the order appealed from. ORS 656.313(1)(a)(A). Therefore, the only issue ripe for adjudication in the Galton hearing was claimant's entitlement to temporary disability benefits after May 21, 1991, the date of the Crumme' order. See Gilbert T. Hale, 44 Van Natta 729, 730 (1992). Similarly, the only temporary disability issue before us on review is claimant's entitlement to benefits after May 21, 1991.

Accordingly, our order did not and could not decide claimant's entitlement to temporary disability benefits due on the psychological claim prior to the Crumme' order.

Following our reconsideration of the temporary disability portion of our order, and in light of the December 8, 1992 Disputed Claim Settlement, we find it unnecessary to modify that portion of our order which pertains to the payment of temporary disability compensation under Referee Crumme's May 21, 1991 order. However, we wish to clarify the effect of our order in light of the December 8, 1992 DCS.

Our original order had the effect of ordering payment of temporary disability benefits from May 21, 1991 forward. Under the terms of the DCS, claimant had already settled out his entitlement to temporary disability benefits for the period May 21, 1991 to December 8, 1992, the date of the DCS. (See DCS at 9). Therefore, the temporary disability issue for the period May 21, 1991 to December 8, 1992 has been resolved, and our order has no effect with respect to that period. See Inez M. Horsey, 45 Van Natta 441 (1993).

Nevertheless, our order directs the insurer to pay temporary disability benefits that are due under the Crumme' order. When the Crumme' order became final, claimant's entitlement to benefits for his psychological condition for any period before the Crumme' order became ripe for adjudication. See Gilbert T. Hale, supra. However, that issue was not decided by our April 22, 1993 order and must be adjudicated separately. Similarly, claimant may be entitled to benefits for his psychological condition after December 8, 1992, the date of the DCS. That issue also is not before us on review and must be adjudicated separately.

Attending Physician

Since our order decided only claimant's entitlement to temporary disability benefits after May 21, 1991, which issue was resolved by the DCS, and since the issue of claimant's entitlement to benefits either before May 21, 1991, or after December 8, 1992 is not ripe for our review in this case, we find that the attending physician issue is moot at this time. Accordingly, we withdraw that portion of our order which addressed whether temporary disability benefits after May 21, 1991 were authorized by a qualified "attending physician."

Because the issue is moot, we need not consider the documents submitted by the parties on reconsideration regarding the "attending physician" issue.

Penalties

Our order directed the insurer to pay the penalty ordered by Referee Crumme', which was based on the compensation due under his order. In addition, we assessed another penalty for the insurer's separate act of misconduct in failing to comply with the Crumme' order ("Board penalty"). Order on Review at 6. We assessed the penalty on the temporary disability benefits ordered by Referee Crumme'. Since we cannot assess a second penalty on the same amount of compensation, our order had the effect of assessing a penalty only on the temporary disability benefits due after May 21, 1991. See Mollie E. Barrow, 43 Van Natta 617, 618 (1991).

The insurer contends on reconsideration that, according to the terms of the DCS, claimant is not entitled to a penalty. After our review of the DCS, particularly the portions quoted previously, we agree with the insurer. Furthermore, since the DCS resolved the issue of claimant's entitlement to temporary disability benefits after May 21, 1991, there is no longer any compensation due on which to base a penalty. Accordingly, we withdraw that portion of our order which assessed a penalty for the insurer's unreasonable failure to comply with Referee Crumme's order.

Attorney Fees

In our April 22, 1993 Order on Review, we awarded claimant a $1,000 assessed attorney fee for his counsel's services on review, pursuant to ORS 656.382(2). The insurer contends on reconsideration that claimant is not entitled to attorney fees, pursuant to the DCS. (See DCS at 9).

Because of our disposition of the issue of claimant's entitlement to temporary disability benefits after May 21, 1993, claimant's compensation has been reduced on reconsideration. Therefore, claimant is not entitled to an assessed attorney fee pursuant to ORS 656.382(2) for his attorney's services on review. Accordingly, we withdraw that portion of our order which awarded claimant an assessed attorney fee of $1,000.

Request for Offset Authorization

In its Motion for Reconsideration, the insurer seeks authorization of an offset to recover alleged overpayments made pursuant to the parties' June 26, 1992 Stipulation and Order. See Appendix B of Insurer's Motion for Reconsideration.

The insurer did not raise the offset issue at hearing before Referee Galton. We recognize that the issue could not have been raised at that time. Nevertheless, our review is confined to the issues presented at hearing. Accordingly, inasmuch as the insurer did not seek an offset at hearing, we decline to address the issue on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

CONCLUSION

Pursuant to our reconsideration, we withdraw the following portions of our April 22, 1993 order: (1) all discussion pertaining to the "attending physician" dispute; (2) the second penalty assessed against the temporary disability compensation ordered by Referee Crumme', which was for the insurer's unreasonable failure to comply with Referee Crumme's order; and (3) an assessed attorney fee in the amount of $1,000 for claimant's attorney's services on review.

We clarify that portion of our order which directs the insurer to pay temporary disability compensation due under the May 21, 1991 order of Referee Crumme', as follows. No temporary disability compensation is due for the period May 21, 1991 to December 8, 1992, pursuant to the December 8, 1992 Disputed Claim Settlement. Our order does not decide whether temporary disability compensation is due for any period before May 21, 1991 or after December 8, 1992.

We decline to consider the insurer's request for offset authorization for temporary disability payments made pursuant to the June 26, 1992 Stipulation and Order.

Accordingly, on reconsideration, as modified herein, we adhere to and republish our April 22, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA E. McGRATH, Claimant
WCB Case No. 92-09572
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of that portion of Referee Thye's order that awarded claimant an assessed attorney fee for allegedly prevailing over its aggravation denial. On review, the issue is attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

At the commencement of the hearing, the parties stipulated that claimant had not made a claim for aggravation, and that SAIF would void its aggravation denial. The sole issues considered at hearing were an assessed fee pursuant to ORS 656.382 for SAIF's allegedly unreasonable denial, and an assessed fee pursuant to ORS 656.386 for allegedly prevailing on a denied claim. The Referee found that SAIF's denial was not unreasonable; claimant does not appeal that decision.

In addition, notwithstanding his acknowledgment that voiding the denial might not result in the payment of any compensation to claimant, the Referee awarded claimant's counsel an assessed fee for obtaining SAIF's agreement to declare its denial void. On review, SAIF argues that claimant's attorney obtained no compensation or benefit for claimant and, therefore, is not entitled to a carrier-paid attorney fee. We agree.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.386(1) provides, in pertinent part:

> "[i]n such rejected cases where the claimant prevails finally in a hearing before the referee . . . the referee . . . shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." (emphasis supplied)

Such a fee is to be paid by the insurer or the self-insured employer.

The statute makes it clear that to be entitled to an assessed attorney fee, claimant must "prevail" on a claim, that is, "obtain" compensation. Here, claimant stipulated at hearing that she had made no claim for compensation. Moreover, when SAIF voided its denial, it did not grant claimant any benefits. Under these circumstances, we find that claimant did not prevail on her aggravation claim. See Candy M. Kayler, 44 Van Natta 2424 (1992) (where claimant's aggravation claim rendered moot by operation of law, claimant did not "prevail" on her aggravation claim). Compare Safeway Stores, Inc. v. Hayes, 119 Or App 319 (April 21, 1993) (where the parties entered into a stipulation, after the hearing was held but before the referee issued a decision, whereby the carrier accepted the claim, claimant "prevailed").

The legislature has not authorized the Board to award attorney fees to a claimant's attorney in such a case. Accordingly, we reverse the Referee's award of an assessed attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated December 23, 1992 is affirmed in part and reversed in part. That portion of the order that assessed an attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
DENNIS D. MYERS, Claimant
WCB Case Nos. 91-15526 & 91-08569
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau, Neidig and Hooton.

Claimant requests review of that portion of Referee Herman's order that found that the self-insured employer had not accepted claimant's preexisting spondylolysis condition. CNA Insurance Companies cross-requests review of those portions of the Referee's order that: (1) set aside its partial denial of claimant's L5-S1 condition; and (2) upheld the employer's partial denial of claimant's claim for the same condition. On review, the issues are scope of acceptance, compensability and responsibility.

The Board affirms and adopts the order of the Referee.

Claimant is entitled to an attorney fee for services on review for prevailing against CNA's cross-request for review on the issues of compensability and responsibility. After considering the factors set forth in OAR 438-15-010(4), we find that $800 is a reasonable assessed fee for claimant's counsel's efforts on review, to be paid by CNA. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by that portion of claimant's cross-respondent's brief), the complexity of the issues presented and the value of the interest involved.

ORDER

The Referee's order dated June 23, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $800, to be paid by CNA Insurance Companies.

Board Member Hooton concurring and dissenting.

I agree with the majority on the issues of compensability and responsibility for claimant's L5-S1 condition. I disagree, however, with the majority resolution of the question whether the self-insured employer had accepted claimant's spondylosis condition when it accepted the claimant's "original injury" in 1982. From that portion of the Referee's order, as adopted by the majority, I respectfully dissent.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In Electric Mutual Liability Ins. Co. v. Automax, 113 Or App 531 (1992), the court remanded to the Board for a finding regarding whether a worker's accepted shoulder and arm strain was a symptom of, or caused, his bilateral carpal tunnel condition. On remand, we found that there was no evidence that the claimant's accepted strain was a symptom of, or was caused by his bilateral carpal tunnel condition. The record only indicated that carpal tunnel symptoms had existed for a year prior to the time the strain was accepted. Thus, we concluded that the insurer had not accepted the bilateral condition when it accepted the claimant's strain. Robert J. Hughes, 44 Van Natta 2106 (1992).

In the present case, claimant was treated by the employer's physician, Dr. Martin, in June 1982 for a gradual onset of "back ache in the low back area." Dr. Martin found no specific incident of injury, but he noted claimant's pre-employment physical had indicated a spondylolysis condition. The employer subsequently filled out an 801 form which described claimant's condition as a gradual onset, with a diagnosis of "strain." That diagnosis did not reflect the claim made by claimant, or the condition identified by the treating physician. The 801 form did not accept claimant's condition.

In July 1982, Dr. Martin reported that claimant's physician, Dr. Buchanan, had diagnosed spondylolisthesis at L-5, S-1, and L-5 spondylolysis. Dr. Martin noted that Dr. Buchanan felt that claimant's problem was congenital and could cause back problems. Accordingly, Dr. Martin suggested physical conditioning and restrictions as he felt that claimant's back problem had "become symptomatic."

On July 1, 1982, a memo to the employer's file was prepared which attached claimant's preemployment physical. The memo provided that claimant's present condition was thought to be related to his congenital condition. The memo further provided that claimant's claim should be looked into before it was accepted. Consequently, by that time, the employer had all of the information necessary to evaluate the role of the preexisting condition on the then current claim, along with a specific instruction that it was the employer's belief that the preexisting condition was responsible for causation.

In August 1982, claimant was treated by Dr. Erkkila, M.D., who diagnosed spondylolysis and spondylolisthesis. He reported that claimant had exceeded his fatigue limit when he was transferred to the mag deck at work. On August 25, 1982, Dr. Erkkila treated claimant for low back discomfort in association with his degenerative condition.

On a December 14, 1982 Form 1502, the employer accepted claimant's "disabling" "original injury." The Form 1502 did not reference a strain, but provided only: "Previously deferred disabling now accepted." (Ex. 19).

Under the circumstances, I find this case distinguishable from Hughes, supra, in which there was no evidence that claimant's strain was a symptom of, or caused by the bilateral carpal tunnel condition. Here, the medical reports of Dr. Martin and the other physicians who treated claimant prior to acceptance, establish that claimant's symptoms were caused by the spondylolysis/ spondylolisthesis condition, and provides no support for the conclusion that a claim was ever made for a "strain".

Finally, although the employer argues that a low back strain was the accepted claim, the strain described on the Form 801 was not accepted at the time the form was submitted. Additionally, the Form 1502 which eventually accepted claimant's claim issued after the employer had obtained reports regarding claimant's condition, yet provided only that claimant's "original injury" was accepted. I, therefore, conclude that the employer accepted claimant's spondylolysis/spondylolisthesis condition. Accordingly, I would reverse the Referee on the scope of acceptance issue, and set aside the employer's partial denial.

June 30, 1993 Cite as 45 Van Natta 1259 (1993)

In the Matter of the Compensation of
BRIAN RILEY, Claimant
WCB Case No. 92-10688
ORDER ON REVIEW
Gloria Schmidt, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The insurer requests review of that portion of Referee Livesley's order that set aside its denial of claimant's claim for a left ankle 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 Referee's finding that, based on inconsistencies in her testimony, Rhonda Dietrick is not a credible witness. Based on the substance of her testimony, Rhonda Dietrick is a credible witness.

We do not adopt the Referee's finding that Exhibit 8, the employer's first aid log, contains duplicate and inconsistent entries. Exhibit 8 accurately reflects claimant's visits to the employer's first aid station on July 27 and 28, 1992.

On July 28, 1992, claimant reported a left ankle injury to the employer, but reported to the employer that he did not know how that injury occurred.

In the 48-hour period prior to reporting his left ankle injury, claimant reported a right foot injury and a head injury to the employer, and fully explained how those two injuries occurred. The employer's first aid log accurately reflects those reports.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant proved that he sustained a compensable injury involving his left ankle. We disagree.

Claimant contends that his left ankle injury resulted from a discrete injurious event. It is, therefore, claimant's burden to prove that his work was a material contributing cause of his need for treatment. Jon A. Rogers, 44 Van Natta 2313, 2315 (1992); Mark N. Wiedle, 43 Van Natta 855, 856 (1991).

The medical evidence establishes that claimant injured his left ankle on July 28, 1992. A medical report on that date notes that claimant's ankle was swollen and tender, and diagnosed an ankle sprain. (Ex. 1). Consequently, the only issue is whether that injury occurred within the course and scope of claimant's employment.

The parties do not dispute that claimant reported a left ankle injury to his employer before he left work on July 28, 1992. (Ex. 8). Moreover, the record reflects that, immediately after claimant left

work, he went to a private medical facility where that injury was diagnosed as a left ankle sprain. (Ex. 1). Although it is possible that claimant injured his left ankle after he left work, claimant's mother testified that when she picked claimant up from work, he was limping and his ankle appeared swollen. (Tr. 40-41).

Considering the close temporal relationship between her observations and claimant's departure from work, we agree with the Referee that claimant's injury occurred on the employer's premises. However, not every injury that occurs on an employer's premises is within the course and scope of the worker's employment. See e.g., Clark v. U.S. Plywood, 288 Or 255 (1980). Consequently, claimant must prove not only where his injury occurred, but also how it occurred. We conclude that claimant failed to meet that burden.

When examined by his private physician, claimant reported that he injured his ankle when he jumped out of the way of a truck and slipped on a beet. (Ex. 1). At hearing, he testified that that was the mechanism of injury that he reported to the employer on July 28, 1992. (Tr. 20). However, no corroborating evidence was presented that verified claimant's testimony. To the contrary, Rhonda Dietrick, the nurse who first examined claimant's ankle at the employer's facility, testified that claimant stated that he did not know how the injury occurred. (Tr. 66). Her chart notes of the examination confirm that report. (Ex. 2A). Ellen Kelley, the employer's safety coordinator, also testified that, on July 28, 1992, claimant reported to her that he did not know how he hurt his ankle. (Tr. 95).

The Referee rejected Dietrick's testimony, because her version of the relevant events conflicted with claimant's, was inconsistent and was based on unreliable records. He rejected Kelley's testimony because she could not recall precise details concerning the sequence of events.

We are as capable as the Referee at assessing credibility when the determination is based on the substance of the evidence. Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984); Angelo L. Radich, 45 Van Natta 45, 46 (1993). We find, based on the substance of their testimony, that witnesses Dietrick and Kelley are credible. Any discrepancies or inconsistencies in the factual details of their stories were minor. Further, presenting a contrary version of events is not, by itself, a sufficient reason to discredit a witness.

We further find that the employer's first aid log accurately reports the information contained therein. Contrary to the Referee's conclusion, we find nothing that suggests that the record was "doctored," or that it indicates inconsistent reports. Dietrick's testimony based on that report was, therefore, also reliable.

The first aid log reflects that on prior visits to the employer's first aid station, claimant was able to recall and relate the mechanism of each of his injuries. When asked how he injured his head on July 27, 1992, the log reflects that claimant reported that he hit a bar. (Ex. 8). When asked how he had injured his right foot on July 27, 1992, the log reflects that claimant reported that a beet fell on it. (Ex. 8). Nevertheless, when asked how he injured his left ankle on July 28, 1992, the record reflects that claimant reported that he was unsure.

Considering the severe nature of the event claimant now contends resulted in his left ankle injury, when compared to the relatively minor events that resulted in his prior injuries, we find it inconsistent that claimant would have neglected to mention the former event, had it happened, when he first reported his injury to the employer. Consequently, we conclude that, based on inconsistencies in the record, claimant's description of the mechanism of his injury is not credible. Inasmuch as claimant has failed to offer any credible evidence as to how his left ankle injury occurred, we conclude that he failed to prove that he was injured within the course and scope of his employment.

ORDER

The Referee's order dated November 27, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the insurer's denial of claimant's claim for a left ankle condition is reversed. The insurer's denial is reinstated and upheld. The Referee's award of a $2,800 assessed attorney fee is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOEL O. SANDOVAL, Claimant
WCB Case No. 91-16912
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Lipton and Brazeau.

The insurer requests review of that portion of Referee Quillinan's order which found that claimant's low back injury claim was prematurely closed. Claimant cross-requests review, contesting the Referee's offset authorization. On review, the issues are premature closure and offset. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's conclusion with regard to this issue.

Offset

The Referee authorized the insurer to offset $4,761.33 in allegedly over paid temporary disability benefits which were found not owing pursuant to Orders on Review dated March 26, 1992, March 31, 1992 and September 28, 1992. (Exs. 23A, 25, 25A). Claimant contends that the Referee's authorization is premature and should be addressed when the claim is properly closed.

ORS 656.268(13) authorizes adjustments in compensation due to overpayment only at the time of closure by Determination Order or Notice of Closure. However, we have previously held that we may approve an offset against future compensation under circumstances not involving a Determination Order or Notice of Closure. Steven F. Sutphin, 44 Van Natta 2126 (1992); Steve E. Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 517 (1993). However, 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).

Sutphin and Maywood, supra, however, do not involve premature claim closure and, thus, are distinguishable from the instant case. In Sutphin, the claim was closed by a Determination Order which did not authorize an offset. The insurer informed the claimant that he had been overpaid temporary total disability benefits, and that it would deduct the amount from his award of permanent disability. At hearing, the insurer's offset request was granted, although the insurer was also assessed a penalty for failing to notify the claimant of the offset. We reasoned that the Board's authority to authorize recovery of overpayments was not confined to the Notice of Closure process of ORS 656.268(13) and that, if a request is properly made at hearing, offset may be authorized.

In Maywood, the insurer erroneously made duplicate payments of permanent disability benefits. The referee allowed the offset even though it occurred as the result of a stipulation rather than a Determination Order. Because the overpayment was a matter concerning a claim, we concluded that we had authority to consider the request for offset of the overpayment.

Here, as a result of the Referee's premature closure finding and our adoption of that finding, the claim remains open. Thus, additional temporary disability benefits will likely be paid prior to the closure of the claim. Moreover, the insurer has not contested claimant's contention that the offset request should be deferred. Under such circumstances, we consider it appropriate to defer a determination concerning the insurer's offset request until claim closure. ORS 656.268(13). Inasmuch as we decline to address the insurer's request at this time, we vacate the Referee's offset authorization.

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 $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 October 2, 1992 is affirmed in part and vacated in part. That portion which authorized an offset of overpaid temporary disability benefits against any future permanent disability award is vacated. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $800, payable by the insurer.

In the Matter of the Compensation of
KATHY A. SCHALK, Claimant
WCB Case No. 91-18475
ORDER ON REVIEW (REMANDING)
Doblie & Associates, Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Quillinan's order that dismissed her request for hearing for unjustified delay. In its respondent's brief, the SAIF Corporation has offered evidence not previously admitted into the record. We treat the submission as a motion for remand. On review, the issues are remand and whether the Referee should have dismissed claimant's hearing request. We remand.

FINDINGS OF FACT

Claimant filed a hearing request on December 30, 1991. A hearing was originally scheduled for March 24, 1992. On that date, the hearing was postponed because of claimant's inability to appear. The matter was then reset for hearing for August 3, 1992. It was again postponed at the request of claimant's counsel, due to a conflict with another proceeding.

In March 1992, the SAIF Corporation served Dammasch State Hospital (Dammasch) with a subpoena duces tecum requesting claimant's hospital file. On March 26, 1992, Dammasch returned SAIF's subpoena, relating that it could not release information regarding claimant without her authorization.

On August 6, 1992, SAIF filed a motion for discovery, stating that it had asked claimant to sign a release authorization on April 14, 20, June 9 and August 6, 1992. On August 8, 1992, claimant signed the pertinent release. On August 20, 1992, Dammasch reported that it had no record of claimant's hospitalization in that facility.

On August 26, 1992, SAIF moved to dismiss claimant's hearing request, alleging that the first postponement of claimant's hearing was based on her alleged misrepresentation that she could not attend because of her in-patient hospitalization at Dammasch. SAIF, therefore, asserted that claimant had unjustifiably delayed her hearing, justifying the dismissal of her request for hearing.

On September 2, 1992, claimant responded to SAIF's motion to dismiss, asserting that SAIF's motion was based on pure allegation, rather than evidence. Claimant then requested an opportunity to respond to SAIF's allegations.

On September 17, 1992, the Referee dismissed claimant's hearing request, stating that:

". . . "The August 20, 1992 report from Dammasch raises the distinct possibility that claimant was not a patient at Dammasch Hospital on the date originally set for hearing in March 1992 . . . If claimant was not a patient, then the request for postponement was either a fraud or misrepresentation, and the postponement should not have been granted.

"Thereafter, claimant's refusal to sign a release for records constituted further delay in the proceedings. Claimant delayed five months before signing a release, presumably because she did not wish the earlier misrepresentation to be discovered."

Concluding that there had been an unjustified delay of well over 60 days, the Referee dismissed claimant's hearing request.

On September 22, 1992, claimant requested reconsideration of the Referee's September 17, 1992 order and again requested an evidentiary hearing. On September 29, 1992, the Referee issued an Order on Reconsideration. The Referee's order provided that the basis for the dismissal was:

". . . not based upon claimant's or employer's alleged misrepresentation concerning hospitalization. While this is a disputed matter of fact, it is not relevant to this decision . . . Claimant refused, for over 60 days to provide a medical release which would have allowed for a prompt resolution of this matter and allowed the case to go forward . . . Claimant has offered no justification or explanation for this delay."

CONCLUSIONS OF LAW AND OPINION

A hearing request may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days. OAR 438-06-071(1). Reasoning that claimant had offered no justification or explanation for her refusal to provide a medical release for more than 60 days, the Referee concluded that claimant's conduct constituted an unjustified delay of the hearing. Consequently, the Referee dismissed the hearing request.

Since the hearing was initially scheduled for March 24, 1992 and was subsequently rescheduled for August 3, 1992, the hearing was delayed for more than 60 days. Nevertheless, the pivotal question for resolution is whether that delay was "unjustified." See OAR 438-06-071(1). The Referee determined that claimant's refusal to provide a medical release for over 60 days while her hearing request was pending satisfied this requirement. Claimant challenges that determination, asserting that she was reluctant to sign a release to an institution to which she had not been a patient. In reply, SAIF argues that such an assertion does not justify claimant's failure to sign such a release for more than 60 days.

Both parties have presented strenuous and plausible arguments regarding whether the hearing delay was "unjustified." However, the record as presently developed is insufficient for us to resolve those arguments. Consequently, we consider it appropriate to remand this matter to the Referee. See ORS 656.295(5).

Accordingly, the Referee's order dated September 17, 1992, as reconsidered on September 29, 1992, is vacated. This matter is remanded to Referee Quillinan for further proceedings consistent with this order; i.e., take evidence, make findings and render conclusions concerning whether claimant unjustifiably delayed the convening of her hearing. See OAR 438-06-071(1). These proceedings shall be conducted in any manner that the Referee determines will achieve substantial justice. If the Referee finds that the delay was justified, the case will proceed to a hearing on the merits at a time determined by the Referee. If the Referee finds that the delay was unjustified, the Referee shall issue another order dismissing claimant's hearing request.

With regard to SAIF's submission of additional evidence on review, we need not address the issue because of our decision to remand this matter to the Referee.

ORDER

The Referee's order dated September 17, 1992, reconsidered on September 29, 1992, is vacated. This matter is remanded to Referee Quillinan for further proceedings consistent with this order.

In the Matter of the Compensation of
BRYAN S. STANHOPE, Claimant
WCB Case No. 92-05908
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Lipton.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's current condition as not related to a compensable 1986 low back injury. On review, the issue is compensability.

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

Exhibits 1 through 30, 10B, and 26A were admitted into evidence.

At hearing, claimant argued that the employer's December 1991 Own Motion referral to the Board constituted "acceptance" of claimant's current condition pursuant to ORS 656.262. Therefore, he contended, the employer's April 1992 denial constituted a "back-up" denial under section (6) of that statute, requiring the employer to prove by clear and convincing evidence that the 1986 injury is not a material contributing cause of claimant's current disability and need for surgery. Ruling from the bench, the Referee held that an Own Motion recommendation form is not "a proper mode of accepting a claim." We agree that the employer did not accept claimant's current condition.

Whether an acceptance occurs is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449 (1992). On this record, we conclude that the employer's submission of an Own Motion referral form to the Board did not constitute an "acceptance."

A carrier must process any claim for additional compensation for a worsened condition filed after the expiration of a claimant's aggravation rights as a request for Own Motion relief. OAR 438-12-020. In doing so, the carrier is required to notify claimant and the Board in writing whether it recommends that the claim be "reopened" or "denied." OAR 438-12-025(2); 438-12-030. Here, the employer checked boxes on the form which indicated that claimant's condition required surgery or hospitalization, and that the surgery or hospitalization was reasonable and necessary for the compensable injury. However, the employer qualified its response to the latter inquiry by noting that as of the date of form completion, it had not yet received a copy of the surgical report. Moreover, the employer specifically recommended that claimant's claim be denied. Under these circumstances, we find that the employer's referral to the Board to exercise Own Motion jurisdiction does not conform to the provisions of ORS 656.262(6). Further, we decline to characterize the employer's submission of the required form as claim acceptance. See SAIF v. Tull, supra.

Accordingly, it remains claimant's burden to prove that the 1986 compensable back injury is causally related to his disability and need for surgery in 1991. For the reasons expressed by the Referee, claimant has not established either a material or major relationship between the compensable injury and either his L4-5 herniated disc or L5-S1 spinal stenosis.

ORDER

The Referee's order dated September 10, 1992 is affirmed.

In the Matter of the Compensation of
CHARLES C. TAYLOR, Claimant
WCB Case No. 90-15177
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Donald Dickerson, Attorney
D. Kevin Carlson, Department of Justice

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's denial of claimant's claim for injuries sustained in a motor vehicle accident. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

Claimant was hired by the Millers to haul a load of hay on a one-time basis. Claimant expected to work 12 hours at the rate of eight dollars an hour.

CONCLUSIONS OF LAW AND OPINION

The Referee was not persuaded that the Millers were subject employers. In reaching that conclusion, the Referee found that Fred Jack and claimant were not credible witnesses. The Referee based his findings on the substantive record, not on demeanor. Under such circumstances, we are equally competent to evaluate the substance of Jack and claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 288, 285 (1987).

After conducting our review, we do not find claimant's or Jack's version of the events on and about March 16 and 17, 1990 to be less reliable or credible than the Millers. We acknowledge that some of the witnesses' testimony is in conflict. However, in making our final determination, we do not rely on the testimonial evidence that is in dispute.

The Referee found that the Millers were not "subject employers" pursuant to ORS 656.005(13) at the time of the injury. We agree that the employers were not "subject employers" but we offer the following analysis.

ORS 656.027 provides that all workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"(3)(a) A worker whose employment is casual and either;

"(A) The employment is not in the course of the trade, business or profession of the employer; or

"(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

"(b) For the purposes of this subsection, 'casual' refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

Here, claimant was hired by the Millers to haul a load of hay, on a one-time basis. Claimant expected to work 12 hours at the rate of eight dollars an hour. Therefore, we find that claimant's employment was casual. See Ray McDonald, 42 Van Natta 2753 (1990).

We must also address whether claimant's employment was in the course of the trade, business or profession of a nonsubject employer. Here, claimant's employment, hauling hay, was in the course of Miller's business. Further, as all other persons working at the Millers were employees of a leasing

company, claimant has not shown that the Millers had other employees working for them. The employer, therefore, has not been shown to have been a subject employer within the meaning of ORS 656.023(3)(a)(B)(b). Because claimant's employment was casual and the employment was in the course and trade of a nonsubject employer, claimant is not a subject worker for purposes of the workers' compensation act. ORS 656.027(3)(a)(B)(b).

ORDER

The Referee's order dated October 22, 1992 is affirmed.

June 30, 1993 Cite as 45 Van Natta 1266 (1993)

In the Matter of the Compensation of
WILLIAM R. TOMPSETT, Claimant
WCB Case No. 92-08026
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Livesley's order which set aside its denial of claimant's occupational disease claim for binaural hearing loss. On review, Liberty contends that it is not responsible for the claim. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact which were based on the parties' stipulated facts.

CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim against SAIF's insured on December 18, 1991. SAIF issued a denial on March 2, 1992. Claimant did not request a hearing concerning that denial.

Claimant then filed a claim against Liberty's insured which Liberty denied on June 10, 1992. Claimant requested a hearing concerning that denial. In the denial letter, Liberty stated that claimant's work at SAIF's insured was potentially responsible for claimant's condition.

ORS 656.308(1), the responsibility statute implemented by the legislature in 1990, applies to occupational disease claims as well as injury claims. Liberty Northwest Insurance Corporation v. Senters, 119 Or App 314 (1993); Donald C. Moon, 43 Van Natta 2595, 2596 n. 1 (1991). The statute, however, addresses only shifting of responsibility, not its initial assignment. Fred A. Nutter, 44 Van Natta 854 (1992). Consequently, because there is no accepted claim in this case, we do not apply ORS 656.308. Instead, we apply the last injurious exposure rule.

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

The Supreme Court, in Runft v. SAIF, 303 Or 493 (1987), held that a carrier cannot use the last injurious exposure rule defensively to avoid responsibility where the claimant has not filed a claim against the later employer, and that employer has not otherwise been made a party in the proceeding. Runft v. SAIF, supra, 303 Or at 495.

Here, claimant had filed a claim for binaural hearing loss against SAIF. Nevertheless, claimant did not seek a hearing regarding SAIF's denial of his claim. Under these circumstances, we conclude that Liberty should not be barred from using the last injurious exposure rule defensively. See Connie A. Martin, 42 Van Natta 495 (1990) (insurer not precluded from using rule defensively where the claimant withdraws hearing request challenging denial of other potentially responsible carrier). Further, notwithstanding the fact that we conclude that Liberty may use the last injurious exposure rule as a defense, we also conclude that claimant has established compensability against Liberty by proving actual causation of his hearing loss by its insured. Runft v. SAIF, supra, 303 Or at 501; see Boise Cascade Corp. v. Starbuck, 296 Or 238, 243-45 (1984).

Claimant did not lose time from work. Thus, the "date of disability" is the time claimant first sought medical treatment for hearing loss, and responsibility is assigned to the carrier on the risk at that time. Claimant had an audiogram performed on June 11, 1991 by Springfield Hearing Center. At that time, he had stopped working for Liberty's insured and had not yet started working for SAIF's insured. The Hearing Center referred claimant to Dr. Conway, otolaringologist, who saw claimant on June 26, 1991 and verified hearing loss.

Liberty argues that the date of the audiogram was not the date that claimant first sought medical treatment because the person who performed the audiogram does not qualify as a doctor or physician. See ORS 656.005(12). Rather, Liberty argues that claimant first sought medical treatment on June 26, 1991 when he saw Dr. Conway. Claimant was working for SAIF's insured at that time.

Claimant, citing Robert A. Lusk, 42 Van Natta 1584 (1990), argues that the "onset of disability" is when permanent disability manifests itself. In the present case, that date would be the date of the June 11, 1991 audiogram, and would first fix responsibility with Liberty's insured. We have recently concluded that because the Court of Appeals reversed Lusk, our holding in that case is of no precedential value. See Billy D. Davidson, 45 Van Natta 825 (1993). In any event, we need not resolve this "onset" question because, even if the date of disability is the date claimant first sought treatment from a medical doctor, Liberty is still responsible for the claim.

An audiogram was administered before claimant started working for SAIF's insured. On referral from the hearing center, claimant was examined by Dr. Conway, otolaringologist, on June 26, 1991, after beginning work for SAIF's insured. In his report, Dr. Conway made no reference to any work exposure from that employer that could have contributed to claimant's hearing loss. Rather, Dr. Conway reviewed the audiometric findings from the hearing center that found claimant suffered high frequency sensorineural hearing loss before beginning work for SAIF's insured. (Ex. 2). He agreed that claimant needed hearing assistance. Id.

Claimant attended an independent medical examination on May 12, 1992. Referring to noisy employment with Liberty's insured for the last five years, the audiologist did not attribute any employment contribution to SAIF's insured. In light of such circumstances, we conclude that employment at Liberty's insured was the sole cause of claimant's binaural hearing loss. Consequently, Liberty is responsible for the hearing loss claim.

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 attorney's services 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 claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 6, 1992 is affirmed. For services on review, claimant's attorney is awarded $750, to be paid by Liberty Northwest.

In the Matter of the Compensation of
KRISTINE M. TRUMP, Claimant
WCB Case No. 91-12088
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of those portions of Referee Nichols' order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 28 percent (89.6 degrees), as awarded by Determination Order/Order on Reconsideration, to 44 percent (140.8 degrees); and (2) declined to increase claimant's award of scheduled permanent disability beyond the 5 percent (9.6 degrees) awarded by the Order on Reconsideration for loss of use or function of the left arm. The insurer cross-requests review of that portion of the Referee's order that increased claimant's award of unscheduled permanent disability. On review, the issues are extent of unscheduled and scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

In February 1991, claimant was examined by Drs. Gritzka, Snodgrass and Bellville of Western Medical Consultants. They reported that claimant was medically stationary and evaluated her permanent impairment. Dr. Stephens, claimant's attending physician, concurred with the Consultants' report. Based on Dr. Stephens' concurrence, claimant's claim was closed by Determination Order on April 3, 1991, with awards for 28 percent unscheduled permanent disability and 5 percent scheduled permanent disability for loss of use or function of the left arm.

Thereafter, claimant's counsel referred claimant to Dr. Slack for an evaluation and disability rating. Dr. Slack examined claimant on August 2, 1991 and issued a report concerning the extent of claimant's permanent disability. Dr. Stephens concurred with Dr. Slack's report.

On August 28, 1991, an Order on Reconsideration issued which affirmed the Determination Order in its entirety. The order explained that the Director was required by a circuit court judge's injunction to issue a reconsideration order "regardless of whether the reconsideration process has been completed." The Order on Reconsideration did not consider Dr. Slack's report or Dr. Stephens' concurrence.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee admitted Dr. Slack's August 2, 1991 report (Ex. 26) with which Dr. Stephens had concurred. However, the Referee did not consider the report in rating the extent of claimant's permanent disability because it was based on a post-closure examination. Claimant contends that the Referee erred in not considering Exhibit 26. We agree with the Referee that Exhibit 26 should not be considered, but offer the following reasoning.

In 1990, the legislature amended ORS 656.268 to establish a mandatory reconsideration process that must be completed prior to requesting a hearing on extent of permanent disability. ORS 656.268(4)(e); 656.268(5); 656.268(6)(b); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991). To implement the reconsideration process, the legislature also amended several other statutes governing when the extent of permanent disability is to be evaluated and what type of evidence may be used to establish extent of permanent disability. In addition, the Director has promulgated several administrative rules concerning the reconsideration process. In order to fully address the evidentiary question presented in this case, we find it necessary to review the relevant statutory changes.

Under the current statutory scheme, the extent of a worker's permanent disability is evaluated by referees and the Board as of the time of the Reconsideration Order. ORS 656.283(7); 656.295(5). Thus, we have held that, with the exception of a medical arbiter's report under ORS 656.268(6)(a)[as amended in 1991], any medical evidence generated after the date of the Order on Reconsideration

cannot be used to evaluate the extent of permanent disability. See Nancy A. Worth, 44 Van Natta 2345 (1992); Teresa L. Erp, 44 Van Natta 1728 (1992); Tor J. East, 44 Van Natta 1654 (1992).

In addition to specifying when a worker's permanent disability is to be rated by referees and the Board, the legislature also placed new restrictions on whom may evaluate a worker's permanent disability. ORS 656.245(3)(b)(B) states: "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." We have interpreted ORS 656.245(3)(b)(B) to mean that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure can make findings concerning the worker's impairment. Dennis E. Connor, 43 Van Natta 2799 (1991). We have further held that impairment findings from a physician, other than the attending physician at the time of claim closure, may be used only if those findings are ratified by the attending physician. Alex J. Como, 44 Van Natta 221 (1992). See also OAR 436-10-080(5).[1]

The question before the Board in the present case turns on the meaning and appropriate application of ORS 656.268(5), which provides:

> "Within 10 working days after the department receives the medical and vocational reports relating to an accepted disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary the department may require additional medical or other information with respect to the claim, and may postpone the determination or reconsideration for not more than 60 additional days. If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration. 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." (Emphasis added.)

In Mark A. Pendell, 45 Van Natta 1040 (1993), we discussed the meaning and appropriate application of ORS 656.268(5) which expressly requires the Appellate Unit to consider reports submitted by the claimant or insurer which correct erroneous information and 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). The legislative history concerning the reconsideration process in general, and ORS 656.268(5) in particular, reveals a legislative purpose to reduce litigation by providing an administrative process prior to hearing that corrects mistakes made by insurers or the Workers' Compensation Division in their initial rating of extent of permanent impairment. Mark A. Pendell, supra. We stated in Pendell:

> "In our view, ORS 656.268(5) is not primarily a limitation on the authority of the Appellate Unit to consider relevant and material evidence from the attending physician. Rather, we believe that to advance its purpose, it is properly to be construed as a grant of authority, indeed a direction, to receive evidence submitted from the attending physician establishing the full extent of the worker's impairment at claim closure."

In Pendell, the Determination Order was based on a chart note by the claimant's attending physician, which was very limited and did not address all inquiries relevant to the determination of his permanent impairment. The claimant requested reconsideration of the Determination Order and, with

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[1] OAR 436-10-080(5), promulgated by the Director, provides:

> "If the attending physician refers the worker to a consulting physician for all or any part of a closing examination, the attending physician must review the report and concur in writing, or write a report describing any findings with which the attending physician disagrees. If the attending physician feels that the consulting physician's report adequately describes all of the findings of impairment, the attending physician may by written concurrence submit the report in lieu of the attending physician's own closing examination report."

his request, submitted a supplemental report from his attending physician which was generated after the Determination Order, but based on an examination prior to claim closure. In contrast to the chart note, the supplemental report contained complete findings regarding the claimant's permanent impairment which took into account the standards for evaluating the extent of permanent impairment. We concluded that the supplemental report could be considered pursuant to ORS 656.268(5). Id.

The medical report at issue in the present case (Ex. 26), like the supplemental report in Pendell, was generated after claim closure and submitted by claimant at the reconsideration proceeding. The similarity stops there, however. We do not find, as we did in Pendell, that the post-closure report was submitted to correct any deficiencies in the attending physician's closing reports. The closing reports by attending physician, Dr. Stephens, are letters concurring with the impairment findings of Drs. Gritzka, Snodgrass and Bellville in their independent medical examination (IME). (See Exs. 19-23). In so concurring, Dr. Stephens lauded the IME report for its thoroughness and fairness, noting the apparent discrepancies between claimant's objective physical findings on examination and the physical abilities she demonstrated in the physical capacities evaluation. (Ex. 23).

Based on our review of the IME report, we agree with Dr. Stephens' assessment. The IME report reflects a thorough, well-reasoned effort to evaluate claimant's permanent impairment under the applicable standards for evaluating the extent of permanent disability. Because we find that the IME report was a complete evaluation of claimant's permanent impairment, and the attending physician concurred with that report, we are not persuaded that the attending physician's closing reports were deficient prior to claim closure. Therefore, we conclude that Exhibit 26 does not qualify as either a corrective report or "medical evidence that should have been but was not submitted" by the attending physician. For these reasons, we do not consider Exhibit 26 in rating the extent of claimant's permanent disability.

Extent of Unscheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the extent of claimant's unscheduled permanent disability with the following supplementation.

The insurer contends that the Referee erred in considering claimant's bilateral shoulder impairment on the basis that is not part of its accepted claim. Although we agree that the insurer did not initially accept claimant's bilateral shoulder condition, Dr. Slack's unrebutted report, with which Dr. Stephens concurred, states that the compensable injury is the major contributing cause of her bilateral shoulder impairment. (Ex. 26-2). While we do not consider Dr. Slack's report for purposes of rating the extent of claimant's permanent disability, it is competent evidence concerning the causal relationship between claimant's compensable injury and her bilateral shoulder condition. Accordingly, we find that the Referee properly considered claimant's bilateral shoulder condition in evaluating the extent of claimant's unscheduled permanent disability.

Extent of Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the extent of claimant's scheduled permanent disability.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the reduction of claimant's unscheduled permanent disability award is $1,000, to be paid by the insurer. See Kordon v. Mercer Industries, 94 Or App 582 (1989). 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 20, 1991, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
ALBERT VELA, Claimant
WCB Case No. 92-08269
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Lipton and Gunn.

The insurer requests review of that portion of Referee Crumme's order that set aside its denial of claimant's cervical and lumbosacral strain injuries, as well as current disability and need for treatment relating to the lumbosacral strain. The insurer also has requested that we review a medical record not available at hearing. We treat this request as a motion to remand. On review, the issue is compensability.

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

The Referee found that, "on balance", claimant was a credible witness. The insurer challenges this conclusion, asserting that claimant's testimony that he was injured at work was impeached to such a degree that the Referee should have found that he was not credible.

In support of its argument, the insurer first notes that claimant initially reported an injury date of May 15, 1992, a day that he did not work, and then later reported to physicians and testified at hearing that he was injured on May 22, 1992. We agree that claimant provided inconsistent dates of injury. When claimant initially sought treatment on May 28, 1992, he stated that he was injured approximately two weeks prior to the examination. (Ex. 4). Claimant also cited May 15 on the 801 form. Furthermore, Dr. Braddock, claimant's treating physician, reported that claimant was "quite specific" regarding the accident and that he had stated that he was injured on May 15 between 9 and 10:00 in the morning. (Ex. 13-1).

The claim was denied on June 11, 1992. The denial put in issue the discrepancy in the dates that had been profferred as claimant's injury date. Thereafter, beginning on June 24, 1992, medical reports cited May 22, 1992 as the date of injury. (Exs. 14, 16). Claimant also told Dr. Miller, who evaluated claimant's neck discomfort, that he was injured on May 22, 1992. (Ex. 18-1).

Claimant attempted to explain the discrepancy in dates by testifying that he had told a nurse during the May 28 examination that he had been injured "two Fridays" prior to that date, not realizing that the next day was Friday and thereby getting his "Fridays mixed up." (Tr. 23). Claimant further testified that, based on his confusion, a nurse chose May 15 as the accident date. (Id). We do not find this explanation persuasive; the evidence shows that claimant reported to the physician that he had been injured two weeks from May 28 and, therefore, indicated a period well before May 22. However, claimant had no reason to be concerned about his precision until he received the denial which called into question his reporting of his injury date.

The insurer also argues that no one who testified at hearing witnessed claimant's accident. We agree with the Referee, however, that none of the coworkers who testified were necessarily in a position to witness an accident. Danny Sikes, who worked with claimant every day except during the busy season, stated that he was "not sure" whether he worked with claimant on May 22, 1992. (Tr. 89). Mr. Sikes also emphasized that he "wasn't there" and "didn't see it happen." (Id. at 83).

The insurer further asserts that claimant "concocted the workers' compensation scheme so that he could be off work and get paid." In support of this assertion, the insurer contends that claimant was not motivated to work. Although there was evidence that claimant used his vacation time shortly after acquiring it and that he requested an additional leave of absence, the medical evidence establishes that claimant was physically injured. There is no persuasive evidence that claimant was malingering or that his symptoms were manufactured. Furthermore, the accident occurred following claimant's voluntary early return from a leave of absence.

The record does support the insurer's contention, however, that claimant did not report a work-related injury until May 29, 1992. Claimant's testimony that he told "someone" about his injury on May 22, 1992 is not persuasive. Furthermore, when claimant reported an injury to David Warren, he stated that he was not sure how he was injured but assumed it was work-related. (Tr. 40).

Although not statutorily required, we generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Although the question is close, we do so in this case as well. Claimant provided an inconsistent date of injury and failed to report a specific incident of injury to his employer. These facts weigh against finding claimant credible. However, claimant consistently reported the details of his injury to his medical providers. Furthermore, his injury was consistent with the purported mechanism of the injury. Furthermore, we conclude that there is insufficient evidence to dispute claimant's contention that he sustained an injury at work. Therefore, we conclude that claimant was credible.

After submitting its brief on review, the insurer submitted a medical report of an examination conducted after hearing stating that, according to claimant, his symptoms "did not come on so much as a result of one specific injury as multiple events precipitated his symptoms." The insurer requests that we consider this report on review.

We have no authority to consider any evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, inconsistently 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).

Although here the report concerns claimant's disability and was based on a post-hearing examination and therefore was not available at hearing, we find that it is cumulative evidence concerning claimant's credibility. As detailed above, there is substantial evidence regarding claimant's credibility. Under such circumstances, we consider the present record to be sufficiently developed and that the post-hearing medical report is not reasonably likely to affect the outcome of the case. Therefore, we deny the motion.

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

ORDER

The Referee's order dated October 19, 1992 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
GRACE L. WALKER, Claimant
WCB Case No. 92-03586
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Tenenbaum's order that: (1) set aside its denial of claimant's right finger injury claim; and (2) assessed a penalty for an alleged discovery violation. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant had worked for the employer for approximately three weeks at the time of injury. For approximately three or four days prior to the incident, claimant had worked operating a bandsaw to cut shoe sole wedges. She received brief on-the-job training by an experienced co-worker in the operation of the machine. The bandsaw is equipped with safety devices which (if operated properly) would avoid contact between a worker's fingers and the saw.

Claimant worked Monday through Friday from 7:00 a.m. to 3:30 p.m. On Wednesday, January 29, 1992, at approximately 9:30 a.m., claimant sustained a near amputation of her right long finger at the DIP joint while operating the bandsaw.

Shortly after the incident, claimant tested positive for methamphetamines, cocaine, codeine, morphine, and marijuana.

The insurer denied the claim on the ground that the major contributing cause of the injury was claimant's unlawful consumption of controlled substances, under ORS 656.005(7)(b)(C).

Dr. Jacobsen testified that claimant's urine test showed extremely high doses of cocaine and methamphetamines, which indicated regular chronic use. (Tr. 130-131, 143). Although directly equating impairment with urine drug quantitative levels could not be done, a correlation between the dosage, the toxic effects, and the impairment from the toxicity could be made. (Tr. 137, 138, 148). The toxic effects include, among other things: attention deficit, poor judgment, sleep deprivation, and impairment of motor skills. (Tr. 134, 147). Based on those factors, Dr. Jacobsen concluded that claimant was impaired at the time of the accident. (Tr. 143, 151).

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the denial, reasoning that the employer had failed to prove, by clear and convincing evidence, that the major contributing cause of the injury was claimant's unlawful consumption of the controlled substances. We disagree.

Prior to 1990, a worker's consumption of alcohol or of a controlled substance, in and of itself, did not preclude compensability where the claimant otherwise established that the injury arose out of and in the course of employment. See Simons v. SWF Plywood, 26 Or App 137 (1976). In 1990, when the legislature amended ORS 656.005, it expressed an intent to limit compensability in such cases. The legislature amended ORS 656.005(7) to add subsection (b)(C), which provides that the following type of injury is not a "compensable injury":

> "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."

The Referee found, and the parties do not dispute, that the employer neither permitted, encouraged nor had actual knowledge of claimant's consumption of the controlled substances. The dispute involves the parties' burdens of proof and whether claimant's consumption of controlled substances was unlawful.

ORS 656.005(7)(b)(C) does not expressly place the burden of proof on the employer. Because the language is unclear, we look to legislative history as an aid in determining legislative intent. See State v. Leathers, 271 Or 236 (1975). During the 1990 House Floor proceedings, Representative Mannix explained ORS 656.005(7)(b)(C) as follows:

> ""[W]here the major contributing cause of the injury incident is the worker's consumption of illegal drugs or alcohol, unless the employer permitted, encouraged, or had actual knowledge of the consumption, the employer still must come forward and prove that this all occurred, by clear and convincing evidence. So, what we're saying is alleging consumption or use is not enough. The employer is going to have to come forward and prove, by clear and convincing evidence, that this situation occurred. Usually the burden of proof in a claim is on the worker. Here, the burden of proof will be on the employer by clear and convincing evidence. So, this is a narrow exception to the compensability standards." Tape Recording, House Special Session, Floor Debate, May 7, 1990, Tape 2, Side A at 163-173.

In light of such comments, we agree with the Referee's analysis that claimant must first establish a prima facie case of compensability, i.e., that the injury arose out of and in the course of employment and that the on-the-job injury was a material contributing cause of the disability or need for treatment. Further, Mannix's explanation makes clear that to defeat a finding of compensability, the employer carries the burden of proving, by clear and convincing evidence, that claimant's consumption of controlled substances was the major contributing cause of the injury. See also Roger D. Hart, 44 Van Natta 2189 (1992) (under amended ORS 656.273(1), if the claimant proved that the compensable injury was a material contributing cause of the worsened condition, the employer had the burden of proving that an off-the-job injury was the major contributing cause of the worsened condition in order to defeat the aggravation claim.)[1] To be "clear and convincing," evidence must be free from confusion, fully intelligible, and distinct. To be both clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

We adopt the Referee's findings and conclusion that claimant established that the injury occurred in the course and scope of employment and was a material contributing cause of her disability and need for treatment. The next inquiry is whether the insurer proved by clear and convincing evidence that claimant's unlawful consumption of controlled substances was the major contributing cause of the injury.

Claimant contends that the insurer failed to prove, as highly probable, that claimant's consumption was unlawful because it failed to show that the drugs were not prescribed and that excess consumption of prescribed drugs is not unlawful. We disagree.

Marijuana, cocaine, morphine, and methamphetamines are controlled substances. ORS 475.005(6). Claimant's mere possession of these substances was unlawful. ORS 475.992(4). The insurer has shown that claimant unlawfully consumed controlled substances. That fact was established by the urine test claimant underwent within an hour of the accident.

However, merely showing that claimant had drugs in her system is insufficient to defeat compensability. The insurer must also demonstrate that claimant's consumption of the drugs was the major contributing cause of the injury.

The Referee found that the insurer failed to meet its burden of proof because "[t]here was no evidence whatsoever that these drugs were negatively impacting claimant's thinking, behavior or operation of the machinery in question." The Referee found that the employer could only prove that claimant was possibly impaired by the presence of those drugs in her system at the time of the accident, and that such impairment might have had some contribution to the accident. We disagree.

Claimant contends that only lay evidence could prove that she was impaired by the drugs at the time of the injury. Because the Referee found, based on lay testimony, that claimant's conduct

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[1] We also stated that ORS 656.005(7)(b)(C) was similar in purpose and effect to the disputed language in ORS 656.273(1).

appeared normal prior to the accident, claimant asserts that the insurer failed to prove that she was impaired. We disagree.

In light of the lay witnesses' limited opportunities to observe claimant's conduct or behavior prior to the accident, we consider such testimony insufficient to establish whether or not claimant was impaired. Although a lay person may be able to recognize if a person is under the influence of drugs, the cause and effect of the use of controlled substances is a medical question requiring competent medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Company, 76 Or App 105 (1985); See Van v. Van, 14 Or App 575 (1973).

The only medical opinion in the record is from Dr. Jacobsen, an expert in addiction medicine.[2] He testified that, based on claimant's age and the results of the urine test, claimant had used the drugs during the week [i.e., ruling out any weekend recreational/social use] and that she was a long-term chronic drug user. Additionally, he testified that cocaine cannot be detected three days after use. Dr. Jacobsen testified that methamphetamine and cocaine are central nervous system stimulants, and the effects of cocaine last 20-30 minutes, with the effects of methamphetamines lasting 18-36 hours. These drugs cause mental impairment in the form of flight of ideas; difficulty paying attention; poor judgment; sleep deprivation; anxiety; impairment of hand-eye coordination and fine motor skills; lack of recognition of mistakes and a tendency to cover up mistakes.

In the present case, claimant had a high level of methamphetamines and cocaine in her system. Dr. Jacobsen conceded that directly equating impairment with urine drug quantitative levels could not be done, because of the drug tolerance that develops. However, he explained that as the dosage increases the toxic effects of the drugs increases and the impairment from the toxicity also increases.

Given claimant's chronic use of the drugs, the high dosage consumed, the toxic effects of the drugs, and claimant's age, Dr. Jacobsen concluded that claimant was impaired by methamphetamines and cocaine at the time of the accident. Therefore, reviewing Dr. Jacobsen's opinion as a whole, we find that claimant's drug consumption, as opposed to any other organic/physical cause, was the major contributing cause of the injury.

Henry Edel, mechanical engineer, testified that OSHA regulations require that the point of application of all machines be guarded to prevent injuries. In this case, the point of application was the saw blade. He concluded that the metal jig fixture attached to the bandsaw properly guarded the saw blade danger zone at the point of application. The jig fixture required the operator's hands to be in a certain position that kept them away from the danger zone.

In light of the safety features on the machine, Mr. Edel's explanation of the proper method for safe operation of the saw, and Dr. Jacobsen's opinion regarding the toxic effects of claimant's drug use, we are persuaded by clear and convincing evidence that claimant's consumption of the controlled substances was the major contributing cause of her injury. Therefore, the insurer has established that the injury is not compensable.

The Referee assessed a 15 percent penalty for the insurer's violation of the discovery rules. However, because we have found that the claim is not compensable, there are no "amounts then due" upon which to assess a penalty under ORS 656.262(10). See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991); Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988).

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[2] The dissenting opinions make much of the fact that claimant was administered marcaine on her admission to the hospital. Since Dr. Jacobsen did not address this "marcaine" issue, the dissenters reason that his opinion should be discredited. Yet, it is uncontested that Dr. Jacobsen conducted a review of claimant's medical record before presenting his testimony. This medical record would necessarily include the hospital reports, as well as urinalysis findings. Such circumstances establish to our satisfaction that Dr. Jacobsen's opinion was rendered with a complete understanding of claimant's medical record, including the "marcaine" injection. Based on a review of the medical record (which would include the hospital report and marcaine injection), Dr. Jacobsen persuasively concluded that: (1) claimant's urine test demonstrated extremely high levels of cocaine and methamphetamines; (2) such levels indicated regular chronic use; and (3) considering the toxic effects of such drugs, claimant was impaired at the time of her injury.

ORDER

The Referee's order dated June 24, 1992 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award and penalty assessment are also reversed.

Board Members Lipton and Kinsley dissenting.

The majority holds that Liberty NW has demonstrated by clear and convincing evidence that the major contributing cause of claimant's injury is an unlawful consumption of a controlled substance. We disagree and dissent.

The evidence that claimant had consumed a controlled substance comes entirely from Dr. Jacobsen. His analysis relies on claimant's medical records, including a drug screen urinalysis from a sample taken at the hospital following claimant's treatment for her injury. The drug screen was interpreted to reveal evidence of methamphetamine, cocaine metabolites and marijuana. Among the drugs claimant admitted consuming in the 30 days prior to the drug test, none of them contained methamphetamine or cocaine. However, probably unknown to claimant, upon her hospital admission for the injury she was administered marcaine. Dr. Jacobsen does not address the issue of marcaine showing up in claimant's urine as the metabolite interpreted as a marker for cocaine use.

With respect to claimant's alleged methamphetamine use, Dr. Jacobsen characterized such use as indicative of long term chronic drug use which would be identified by among other things, avoidance of fluids (although he acknowledged that claimant had a cup of coffee at 5:30 and again at 6)[1] and food (claimant is 5' 7" and weighs 140 pounds).

Dr. Jacobsen dismissed marijuana use as a cause of impairment at the time of injury.

Although Dr. Jacobsen concluded that claimant was a long-term chronic drug abuser who was impaired at the time of injury by the use of cocaine and methamphetamines, in addition to the contradictions and gaps in his testimony identified above, Dr. Jacobsen acknowledged inherent contradictions in concluding that claimant abused both cocaine and methamphetamine, to wit: their use in combination, their cost and the atypical profile for someone of claimant's age. Further, Dr. Jacobson stated that he could not make a direct correlation between the level of drug found in claimant's urine and impairment. (Tr. 138, 139).

These flaws do not allow us to conclude that claimant was, in fact, impaired by unlawful consumption of cocaine and methamphetamine at the time of her injury.

However, even if she were so impaired, we do not find it highly probable that the alleged impairment was the major contributing cause of her injury. Although the safety experts implied that claimant's injury could only result from extreme inattention or a deliberate act, the witnesses who actually work the band saw do not consider it exceptional to hit the blade with the right hand (Tr. pp 22 and 30).

Finally we note that a pre-employment drug test was a condition of claimant's employment. Because there is no evidence in the record of the results of that test, if any, we cannot speculate whether the employer had actual knowledge of claimant's alleged chronic drug abuse.

Liberty NW had the burden of proof. Evidence that is clear and convincing (i.e. "highly probable") must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor v. Tandy Corp., 303 Or 390 (1987). Given the gaps and contradictions in Liberty's evidence, we cannot conclude that it is highly probable that the major cause of claimant's finger amputation is her alleged unlawful consumption of methamphetamine and cocaine.

We would affirm the Referee.

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[1] Claimant's shift began at 7. Her injury was approximately 2 hours later without any intervening breaks.

Board member Hooton concurring in the dissent of Board members Kinsley and Lipton and further dissenting.

I concur in the comments of dissenting members Kinsley and Lipton. I agree that the fact the claimant received marcaine upon admission to the emergency room, and prior to the collection of the urine specimen for drug testing, as well as the fact that claimant's history provides no indication of fluid or food avoidance, substantially diminishes any effect that can be given to the evidence offered by Dr. Jacobsen. In light of these unexplained elements I am also unable to conclude that the majority properly applied a stringent and difficult burden of proof.

In addition, however, there are two additional components of this case which bear comment. The first involves the degree of outright speculation in the testimony of Dr. Jacobsen. On the basis of an extremely limited number of facts, none of which can establish unlawful use, let alone actual contribution to the injury, Dr. Jacobsen engages in a wide ranging speculation regarding claimant's "chronic use". That use is not confirmed, and Dr. Jacobsen's conclusions are, in reality, no more than a quess. I am unable to conclude that the employer offerred any "evidence" which shows unlawful use or contribution, let alone clear and convincing evidence.

Finally, I note that Dr. Jacobsen cannot, and does not, confirm actual use of a controlled substance at a time sufficiently close to the injury that claimant would still have been under the influence of such drugs at the time of injury. The testimony of the toxicology specialist indicates that the urine analysis indicates use within 72 hours of the injury. Dr. Jacobsen argues that the time is more likely within 36 hours of the injury. However, Dr. Jacobsen can get no closer. Nevertheless, Dr. Jacobsen indicates that the toxic effects of the drugs allegedly involved last no longer than 12 hours. Based on that testimony, the reasonable conclusion is that claimant may have been free of any influence for as long as 24 hours prior to the injury.

Dr. Jacobsen argues, however, that we should ignore that fact. He indicates that the impairment related to chronic drug use continues long after the drugs are no longer directly influencing the system. It is these withdrawal impairment phenomena which Dr. Jacobsen argues were the major cause of the injury. The correllary to this reasoning, is that claimant would not have been injured had she actually been under the active influence of methamphetamines or cocaine during the relevant employment exposure, and that claimant had a duty to the employer not to withdraw, but to continue such illegal use, to avoid the possibility of injury. I do not believe that the legislature intended ORS 656.005(7)(b)(C) to accomplish such an absurd result.

I acknowledge that a "hangover" can contribute to an attention deficit, either brief or prolonged, as can the physical discomfort of a tension headache, the distracting influence of family difficulties, or even an overactive imagination. This record does not establish which of a potentially infinite number of variables actually caused claimant's inattention at the time of injury. The statute, however, was designed to eliminate the unsafe conditions that result when a worker is actually under the influence of drugs in the workplace, the one essential fact that this case does not establish.

To briefly summarize, I am unable to conclude that the employer offered any evidence of use of a controlled substance during the relevant time period. I am further unable to conclude that the employer offered any evidence that use during any time period was unlawful. All of the evidence centers upon the impairment experienced by a hypothetical, but unproven, chronic abuser during a period of withdrawal. For these reasons, I would support the conclusion of the referee that the employer has not established a defense to liability in this claim.

In the Matter of the Compensation of
WILLIAM V. WARREN, Claimant
WCB Case No. 92-02016
ORDER ON REVIEW
Brad Larson, Claimant Attorney
Montgomery Cobb, Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of those portions of Referee Hazelett's order which: (1) awarded claimant permanent total disability, whereas an Order on Reconsideration awarded claimant 69 percent (103.5 degrees) scheduled permanent disability for loss of use or function for the right arm and 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the left wrist; and (2) set aside its denial of claimant's bilateral wrist condition. Claimant cross-requests review of those portions of the Referee's order which: (1) upheld the employer's denial of his psychological condition; and (2) declined to assess a penalty and attorney fee for allegedly unreasonable denials. On review, the issues are compensability, permanent total disability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the stipulated facts and the Referee's findings of fact, except his finding that claimant is unable to perform work for which he is qualified by training and experience. We also do not adopt paragraph 3 of the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of bilateral wrist condition

The Referee found that claimant's compensable condition continued to be the major contributing cause of claimant's current bilateral wrist condition. The Referee relied on the medical evidence that claimant's condition had not changed since January 1988, the date of hearing before Referee Hoguet. We affirm and adopt the Referee's conclusions, with the following supplementation.

Claimant began work for the employer in 1980. In 1984, Travelers, the employer's then-responsible carrier, accepted claimant's occupational disease claim for bilateral carpal tunnel syndrome and for a temporary aggravation of preexisting degenerative changes in both wrists. A May 1985 Determination Order closed the claim with an award of time loss only.

Claimant's wrist condition worsened in 1987. Travelers denied claimant's aggravation claim, and CIGNA, the employer's then-responsible carrier, denied claimant's occupational disease claim. Referee Hoguet found that claimant's work activities caused a worsening of claimant's preexisting degenerative arthritic condition as opposed to merely causing an increase in symptoms. He then applied the last injurious exposure rule to hold CIGNA responsible for claimant's current wrist condition. We affirmed that decision. William V. Warren, 41 Van Natta 1221 (1989).

The employer contends that the current condition for which Referee Hoguet found it responsible was the "present" worsening of the underlying degenerative condition and not the preexisting degenerative condition itself. It asserts that the current condition resulting in disability and need for treatment is claimant's preexisting volar instability and degenerative arthritis. Although the Court's holding in Weller v. Union Carbide, 288 Or 27 (1979) and Stupfel v. Edward Hines Lumber Co., 288 Or 39 (1979) (temporary worsening sufficient to establish a compensable occupational disease claim if there was worsening of the underlying disease) lends support to the employer's contention, we nevertheless find that the employer remains responsible for claimant's current wrist condition. In reaching this conclusion, we agree with and adopt the Referee's findings that claimant's current condition is the same since the hearing before Referee Hoguet and that the compensable condition remains the major contributing cause of claimant's bilateral wrist condition. Lizbeth Meeker, 44 Van Natta 2069 (1992).

In Meeker, the insurer accepted the claimant's occupational disease claim for bilateral overuse with tendonitis of both hands. It then attempted to limit compensability under ORS 656.005(7)(a)(B) by asserting that the claimant's preexisting condition was the major contributing cause of her current condition. We disagreed, reasoning that even assuming that ORS 656.005(7)(a)(B) applied to occupational disease claims, the medical evidence established that the claimant's current condition was the same as the accepted condition; i.e., the compensable occupational disease remained the major contributing cause of the disability or need for treatment.

Because we have found that claimant's current condition is the same condition that the employer accepted pursuant to Referee Hoguet's order, claimant's bilateral wrist condition remains compensable. Accordingly, the employer's denial is set aside.

Compensability of claimant's psychological claim

We affirm and adopt the Referee's conclusions that claimant does not have a mental disorder that results in disability or requires treatment. Claimant has therefore failed to establish, under ORS 656.802(3), that his work exposure is the major contributing cause of the claimed psychological condition or that such condition is compensably related to his accepted wrist condition, under ORS 656.005(7)(a)(A).

Penalties and attorney fees

Claimant seeks a penalty under ORS 656.262(10) for an allegedly unreasonable denial of his current bilateral wrist condition. The employer contends that its denial was not unreasonable because it had a legitimate doubt as to its liability based on a plausible interpretation of ORS 656.005(7)(a)(B) and based on medical evidence that claimant's wrist condition had changed. We agree.

A penalty for unreasonable denial may be assessed against an insurer or self-insured employer for unreasonable delay or refusal to pay compensation. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time of the employer's denial, the medical report from First Northwest Health supported the employer's position that claimant's preexisting degenerative condition was the major contributing cause of his current wrist condition. Furthermore, the employer's denial and the Referee's order issued prior to our decision in Meeker, supra. Accordingly, we find that the denial was reasonable and that a penalty is not warranted under these circumstances.

Permanent Total Disability

The Referee found claimant entitled to permanent total disability (PTD) under the odd-lot doctrine. Under that doctrine, PTD may be based upon a combination of medical and nonmedical conditions that render claimant unable to sell his services on a regular basis in a hypothetically normal labor market. The nonmedical factors relate to age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, and labor market conditions. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Claimant must also show that he is willing to seek work and has made reasonable efforts to obtain work, or that such efforts would be futile. ORS 656.206(3); SAIF v. Stephen, 308 Or 41 (1989).

The Referee found that claimant is capable of performing work in the sedentary to light category. The Referee, however, found that claimant could not obtain gainful employment without training, yet formal training programs were inappropriate for claimant. The Referee further found that it would be futile for claimant to seek work that was suitable (within the areas of his experience and training) because claimant was limited to light or medium work, which he had not previously done and which was outside his area of experience and training. He, therefore, concluded that claimant was entitled to PTD. We disagree.

We first address claimant's medical condition as it pertains to his bilateral wrist condition. Claimant's noncompensable psychological condition is not relevant in determining whether he is permanently and totally disabled. See Emmons v. SAIF, 34 Or App 603 (1978). Dr. Weintraub is the only medical expert who supports the view that claimant is permanently totally disabled. Although we generally accord greater weight to the opinion of the treating physician, we find persuasive reasons not to do so in this case. Weiland v. SAIF, 64 Or App 310 (1983). Dr. Weintraub did not perform a closing examination, but felt that claimant's physical condition, with limited usefulness of both hands, as well as a significant depression rendered claimant incapable of working and, therefore, permanently and totally disabled. (Exs. 54-31, 141, 150, 161). Dr. Weintraub, however, admitted that he was having a difficult time assessing claimant's capabilities. (Exs. 150, 151A). Moreover, because we have found claimant's psychological condition not compensable, and because Dr. Weintraub failed to determine whether claimant's wrist condition alone renders him PTD, we find his opinion insufficient to establish that claimant is PTD.

Dr. Nye performed a closing examination on March 14, 1991. He felt that, although claimant did have significant limitations (due to the fusion and instability of the ulna), claimant was magnifying the symptoms in his right upper extremity. Dr. Nye opined that claimant was capable of light work. (Ex. 139).

Dr. Dordevich, specialist in immunology, rheumatology, and internal medicine, (Tr. 96), and Dr. Fuller, orthopedic surgeon, examined claimant and reviewed his entire record. Dr. Dordevich testified that claimant's wrist is fused in a 30 degree dorsiflexion position, which is the optimal functional position to fuse the hand, because it compromises between hand function and power grip. (Tr. 131, 439). The fusion also makes the wrist pain-free, as was found on examination. (Tr. 130, 133). Dr. Dordevich opined that with the right wrist, claimant was limited to 15 to 20 pounds, and probably could not perform work that required fine-tuned ability to position the hand, i.e., repair electrical circuits. (Tr. 134). In regard to the left wrist, claimant should avoid repetitive movement of the left wrist. (Tr. 136).

Dr. Fuller testified that claimant had impairment of his right wrist secondary to his fusion and impairment of his left wrist secondary to a longstanding volar, carpal instability. (Tr. 436-437). He opined that claimant was capable of lifting in the medium category with both wrists, but had limitations on pushing and pulling with the right hand. (Tr. 447, 451).

In addition, claimant's credibility is relevant in assessing claimant's physical condition. The Referee found that claimant was not credible with regard to his hand and wrist condition at the time of his December 1991 independent medical examination with Drs. Dordevich and Fuller.

We agree. Claimant's demonstration at hearing regarding the functional abilities of his hands and wrists were irreconcilably more limited than demonstrated to and observed by Drs. Nye and Fuller. (Tr. 243-248, 444-447; Exs. 139, 163).

Based on a review of the records and on the testimony of Drs. Dordevich and Fuller, we find their opinions and Dr. Nye's opinion to be thorough and well-reasoned. We therefore give greater weight to their opinions than that offered by Dr. Weintraub. Somers v. SAIF, 77 Or App 259 (1986). Relying on their opinions, we find that claimant is capable of performing work in the light to medium category.

Claimant must establish that, but for the compensable injury, he is or would be willing to seek regular gainful employment and has made reasonable efforts to do so, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41, 48 (1989). However, claimant must first prove that he was willing to seek work before establishing that it would be futile for him to seek work. Sinclair v. Champion International Corp., 117 Or App 517, 518 (1992).

The Referee found that claimant was not required to seek work that was suitable because such an effort would be futile. We disagree.

Claimant has not shown that he was willing to seek work. See ORS 656.206(3). Claimant has not worked since April 1987. He has not looked for work since his last wrist surgery in January 1990. (Tr. 352). Claimant admitted that his prior injuries, diabetes, or high blood pressure do not preclude

him from working. (Tr. 334-335, 343-344). Claimant's perception that he is unable to work without use of his hands, (Exs. 128, 159, 178), is not supported by the aforementioned persuasive medical evidence.

Claimant's vocational counselor, Scott Barber, and vocational consultant, Hank Lageman, both felt that claimant had no financial incentive to return to work because he did not want to jeopardize the Social Security, Veteran's Administration, and pension benefits he was receiving. (Exs. 180; Tr. 599-600). Claimant has been uncooperative with vocational rehabilitation. He told his vocational counselor that the counselor was wasting his time and was aggravating him. (Ex. 132). Claimant further advised his counselor that he was unwilling to take a job that was not a comparable wage as what he was previously earning. (Ex. 132). Such jobs are not available without training. Yet, he testified that he would take a job paying $5-$6 an hour. (Tr. 353). Such jobs within claimant's capabilities and skills are available without training. (Tr. 593- 596; Ex. 178). His learning skills are adequate for semi-skilled level jobs. (Tr. 587). Considering the discrepancies in the testimony and written records, we find that claimant lacked motivation to return to work.

Claimant has, therefore, failed to show that he was willing to seek employment. We also conclude that claimant has not shown that it would be futile to seek employment. He is, therefore, not entitled to an award of PTD.

Attorney Fee on Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's denial of his bilateral wrist condition. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review for this issue 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 involved.

ORDER

The Referee's order dated October 7, 1992 is reversed in part and affirmed in part. The Referee's award of permanent total disability and "out-of-compensation" attorney fee payable from this increased compensation is reversed. The Order on Reconsideration is reinstated and affirmed. The remainder of the order is affirmed. For services on Board review concerning the compensability of bilateral wrist condition, claimant's attorney is awarded a fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
MARK D. WINN, Claimant
WCB Case No. 92-03179
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Lipton, Kinsley, and Hooton.

Claimant requests review of Referee Daughtry's order that increased his unscheduled permanent disability award for a low back injury from 23 percent (73.6 degrees), as awarded by Determination Order/Order on Reconsideration, to 24 percent (76.8 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant's low back injury claim was accepted and later closed by Determination Order on October 2, 1991 with an award of 23 percent unscheduled permanent disability benefits. In rating claimant's unscheduled permanent disability, the Department of Insurance and Finance assigned values of 5 for the adaptability factor and 1 for the education factor.

Claimant requested reconsideration of the Determination Order by completing a form prepared by the Department. The Department's reconsideration request form provided that the worker must check a box for each potential issue. On the form, claimant specified that he disagreed with the impairment findings used in rating his disability at the time of claim closure. Claimant checked a box on the form which indicated that he did not object to the age, education or adaptability values used in rating his unscheduled permanent disability.

By Order on Reconsideration dated December 9, 1991, the Department affirmed the Determination Order in its entirety. Claimant requested a hearing, challenging the education and adaptability values used in rating his unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled award by 1 percent, based on an increase in the adaptability value from 5 to 6. The Referee did not disturb the Department's value of 1 for the education factor. On review, claimant contends that the education value should be increased to 4 for an increased scheduled award. We disagree.

Subsequent to the Referee's order, we held that where an issue is not raised on reconsideration, the issue may not subsequently be raised for the first time at hearing or on Board review. Raymond L. Mackey, 45 Van Natta 776 (1993). In Mackey, the claimant specifically indicated on the Department's reconsideration request form that he declined to challenge the adaptability value used in rating his unscheduled permanent disability. The claimant then raised the adaptability value as an issue at hearing. We held that he could not do so. See id.

As in Mackey, claimant in this case raised for the first time at hearing an issue (education value) which he specifically declined to raise on reconsideration before the Department. For the reasons discussed in Mackey, we hold that claimant is precluded from raising the education value as an issue either at hearing or on Board review.

The Referee increased the value for the adaptability factor, which was also not raised by claimant on reconsideration, and awarded additional unscheduled permanent disability benefits on that basis. Nevertheless, because the insurer did not cross-appeal from the Referee's order, we affirm the Referee's award. See Daniel M. Alire, 41 Van Natta 752, 759 (1989).

ORDER

The Referee's order dated June 29, 1992 is affirmed.

Board member Hooton dissenting.

I disagree with the majority resolution of this claim. I am convinced that the Board erroneously decided Raymond L. Mackey, 45 Van Natta 776 (1993), and that there is no necessity to specify issues for reconsideration before those issues can be raised at a subsequent hearing. Further, I am unable to conclude that the Referee properly applied the provisions of OAR 436-35-300(4) in determining the proper value to be awarded for education based on the highest SVP achieved in the preceding ten-year period.

ORS 656.268(4)(e) establishes the requirement for reconsideration prior to a request for hearing from a Determination Order or Notice of Closure. The statute identifies no particular form or method which must be used to request reconsideration, and does not require any party to identify issues for the reconsideration proceeding.

ORS 656.283(3) provides that a request for hearing may be accomplished by any writing which states that a hearing is desired. No particular specification of issues is required to accomplish a request for hearing. Though the Board has established a request for hearing form which identifies issues for hearing, the Board's jurisdiction over an issue is not dependent upon whether a particular issue is identified on that form, or in any other writing. Indeed, the Board freely allows the raising of new issues up to and even during the hearing itself.

It would be incongruous for the Board to conclude that specific pleading rules applied to a pre-hearing dispute resolution forum, when there are no pleading rules at all governing the actual hearing.

In addition, OAR 436-30-050(2) establishes the Department's view of its jurisdiction in the reconsideration proceeding. That rule states that "[d]uring the Reconsideration proceeding, the Determination Order or Notice of Closure will be reconsidered in its entirety." (Emphasis added). Therefore, the Department does not limit its review of the Determination Order or Notice of Closure to those issues specified on a properly completed request form. The form itself, created by the Department in the implementation of the statute, is no more than a guide for the Department, directing it to issues that it might otherwise have missed.

Because the Department may change any portion of the Determination Order or Notice of Closure following a request for reconsideration, regardless of the issues raised on the request form, the Board must have jurisdiction over all of the issues potentially examined, or examinable, by the Department, whether or not memorialized in its Order on Reconsideration. Consequently, our jurisdiction depends only on a valid Order on Reconsideration and is not limited to issues raised on the request form specified by the Department to implement its review proceeding.

Because I conclude that we have jurisdiction to consider the value allowed for education in the Order on Reconsideration, whether or not raised specifically in the Request for Reconsideration, I proceed to that issue.

The Referee found that claimant had been employed as a service writer for a period of one year. The position of service writer is described in the SCODDOT under DOT# 620.261-018, with an SVP value of seven (7). That SVP value correlates to an education value of one (1). The evidence does not support that finding. The evidence does demonstrate that claimant worked as a service writer for a period longer than six months but less that one year.

OAR 436-35-300(4) contains conflicting provisions regarding the education value to be assigned for SVP values of five (5) or higher on the SVP value scale. The pertinent provisions are as follows:

> "(c) An individual has met the SVP for an occupation after remaining in the field long enough to meet the training/skill requirements of that occupation through on-the-job, vocational or apprenticeship training. A worker has also met the SVP by successfully performing the duties and tasks in other similar jobs which have a higher SVP.

"(d) A worker is presumed to have met the SVP for an occupation with a SVP of 5 or higher after performing six months or more with one employer in that job. A worker performing a job with a SVP of 1 - 4 is presumed to meet the SVP after completing employment with one or more employers in the job classification for the maximum period specified in the table below.

"(e) The SVP for each job is obtained from the DOT and SCODDOT. Determine the highest SVP met by the worker and assign a value according to the following table:

SVP	VALUE	TRAINING TIME
1	+4	Short demonstration
2	+4	Short demonstration up to 30 days
3	+3	30+ days - 3 months
4	+3	3+ months - 6 months
5	+2	6+ months - 1 year
6	+2	1+ years - 2 years
7	+1	2+ years - 4 years
8	+1	4+ years - 10 years
9	+1	10+ years

(Emphasis added).

Subsection (c) requires that the worker actually meet the SVP time and training requirements specified in subsection (e). The education value related to SVP is made specifically based on completion of a period time in subsection (e). These two subsections are in apparent conflict with subsection (d) which allows a presumption of completion based on a period of time shorter than the time required by subsection (c) or (e).

We construe administrative rules, as we construe statutes, in a manner that will give effect to the provisions of each. In this case, the apparent conflict is potentially resolvable by construing the presumption in subsection (d) as a rebuttable presumption based on the actual evidence. In this case, claimant proved that he did not meet the actual time requirements for an SVP of seven (7),, as required by OAR 436-35-300(4)(c) & (e). Therefore, the Referee erred as a matter of law in applying the presumption to obtain a igher SVP and a lower education value.

If claimant's employment as a service writer is not considered, claimant's next highest SVP is in the occupation of tune up mechanic/helper (DOT# 620.684-014) with an SVP of three (3) and a rating of three (3). In addition, claimant holds no license or certificate necessary for employment and has an SVP of four (4) or less. Under OAR 436-35-300(5), claimant is entitled to an additional value of one (1) for a total skill award of four (4). On this basis, I would allow an additional 18 percent unscheduled permanent partial disability for a total award of 42 percent unscheduled permanent partial disability.

In the Matter of the Compensation of
CRAIG K. WITT, Claimant
WCB Case No. 92-08129
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of that portion of Referee Tenenbaum's order that directed it to pay temporary disability benefits from January 16, 1991 through the date of claimant's incarceration. Claimant cross-requests review of that portion of the Referee's order that affirmed a Determination Order and Order on Reconsideration which awarded no unscheduled permanent disability. On review, the issues are temporary disability benefits and the validity of the Order on Reconsideration. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Temporary disability benefits

The Referee concluded that, except for the period of time during which claimant was incarcerated, SAIF was required to pay claimant temporary disability benefits as ordered by the Determination Order and the Order on Reconsideration. On review, SAIF argues that it was permitted to stop paying claimant's temporary disability benefits as of January 15, 1991, because claimant's treating physician had not authorized further benefits.

We have previously rejected similar arguments. In Mary A. Lockwood-Pascoe, 45 Van Natta 355 (1993), we concluded that, because the claimant's claim had been closed, the issue was not procedural entitlement to temporary disability, but substantive entitlement. We further concluded that, although a claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. Also see Esther C. Albertson, 44 Van Natta 2058 (1992).

Accordingly, because claimant's claim has been closed, we disagree with SAIF's contention that it was entitled to stop paying claimant's temporary disability benefits, based upon a lack of authorization from the treating physician. Additionally, we agree with the Referee that, because SAIF did not request reconsideration of the Determination Order, it may not challenge claimant's temporary disability award for the first time at hearing. See Mindi M. Miller, 44 Van Natta 1671, on recon 44 Van Natta 2144 (1992); Raymond L. Mackey, 45 Van Natta 776 (1993). We, therefore, affirm the Referee on the issue of temporary disability benefits.

Order on Reconsideration

The Referee concluded that, because claimant escaped from the correctional facility where he was incarcerated, he made himself unavailable for a scheduled medical arbiter examination. Consequently, the Referee concluded that claimant waived his request to be examined by an arbiter.

On review, claimant contends that his failure to appear for the examination was not a waiver. Claimant also argues that, even if he did fail to appear, a medical arbiter was required to conduct a review of the records.

We have previously held that 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. See Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992). Under the statute, an Order on Reconsideration is invalid if the basis for objection is disagreement with the impairment findings, and the Director fails to appoint a medical arbiter or submit the arbiter's findings for reconsideration.

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 a case, the Order on Reconsideration is valid. See Randy M. Mitchell, 44 Van Natta 2304 (1992).

Here, claimant had been scheduled for a medical arbiter examination but claimant subsequently escaped from the institution where the exam was to be performed. At hearing, claimant objected to the Department's refusal to schedule another arbiter exam.

Under the facts of this case, we do not find that the Department was required to schedule a second arbiter exam after claimant failed to appear for the first one. OAR 436-30-050(11)(a) provides that if the worker requests reconsidertion and fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order.

Here, claimant requested reconsideration, was advised of the scheduled arbiter exam, and then (due to his escape from the institution where he was being held) failed to appear for that exam. Furthermore, other than his request for a rescheduled examination at hearing, there is no indication that claimant sought another exam following his failure to appear at the scheduled exam. Accordingly, we agree with the Referee's conclusion that claimant's failure to appear constituted a waiver of his right to a medical arbiter's exam. See also Deborah L. Vilanj, 45 Van Natta 260 (1993) (Claimant's failure to attend a scheduled medical arbiter's examination and her failure to argue at hearing that the Order on Reconsideration was invalid for lack of a medical arbiter's report constituted a waiver of her right to an examination by a medical arbiter).

Finally, claimant argues that the Department's rules provide that claimant's failure to appear at a medical arbiter exam requires a review of the record by an arbiter. Claimant has not provided the citation to such a rule. Moreover, OAR 436-30-050(11)(a) provides only that, if the worker requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order. The rule does not specify that only an arbiter may review the records.

Here, the Order on Reconsideration and attachments to the order provided that a review was being performed based upon "information in the file." After conducting our review of the record, we affirm the Referee's decision that claimant has not established entitlement to a permanent disability award under the Director's disability standards. ORS 656.283(7); 656.295(5).

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of temporary disability benefits. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $500 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of 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 issue of the Order on Reconsideration.

ORDER

The Referee's order dated September 21, 1992 is affirmed. For services on review concerning the issue of temporary disability benefits, claimant's counsel is entitled to an assessed fee of $500, to be paid by the SAIF Corporation.

WORKERS' COMPENSATION CASES

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IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Donna J. England, Claimant.

Donna J. **ENGLAND**, *Petitioner on Review,*
v.
THUNDERBIRD and SAIF Corporation, *Respondents on Review.*
(WCB 90-02863; CA A71117; SC S39346)

In Banc
On review from the Court of Appeals.*
Argued and submitted January 7, 1993.
Edward J. Harri, of Malagon, Moore, Johnson, Jensen & Correll, Eugene, argued the cause and filed the petition for petitioner on review.
Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the response to the petition for review were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
UNIS, J.
The decision of the Court of Appeals is reversed, the order of the Workers' Compensation Board is vacated, and the case is remanded to the Workers' Compensation Board for further proceedings.

* Judicial review of order of Workers' Compensation Board. 112 Or App 324, 827 P2d 208 (1992).

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315 Or 635> Claimant seeks review of a Court of Appeals' decision affirming an order of the Workers' Compensation Board awarding her nine percent unscheduled permanent partial disability (PPD). *England v. Thunderbird,* 112 Or App 324, 827 P2d 208 (1992). We reverse.

Claimant was 49 years old at the time of the hearing. She had been a cocktail server for approximately 15 years. On January 17, 1985, while on the job, she escorted a patron to the lobby to wait for a taxi. The patron grabbed and twisted her head rapidly so that it was against his chest. Claimant developed soreness and general discomfort in her neck, and she received treatment from her family physician and then from other physicians by referral. Claimant was able to continue working.

Claimant applied for permanent partial disability under workers' compensation. *Former* ORS 656.214(5) (1987) provided in part:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. *Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a giuen job."* (Emphasis added.)[1]

Former OAR 436-35-290(2)(a) provided that, "[f]or workers who have returned to their usual and

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[1] ORS 656.214(5) was amended in 1987, Or Laws 1987, ch 884, 36, and in 1990, Or Laws 1990, ch 2, 7. It now provides:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f) [which provides that the criteria for evaluation of disabilities shall be "permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job"]. The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability. For the purpose of this subsection, the value of each degree of disability is $100."

customary work or <315 Or 635/636> accepted a work offer for usual and customary work, the factor of age shall be given no value";[2] *former* OAR 436-35-300(2)(a) was identical with respect to the factor of education;[3] and *former OAR* 436-35-310(2)(a) was identical with respect to the factor of adaptability. [4]

On January 23, 1990, a Determination Order awarded claimant nine percent unscheduled permanent partial disability. On November 30, 1990, a Workers' Compensation Board referee affirmed the Determination Order. The referee, in the "Conclusions of Law and Opinion" section of his Opinion and Order, stated that, "[b]ecause claimant has continued her usual and customary work, I do not rate the factors of age, education, and adaptability. OAR 436-35-290(2); OAR 436-35-300(2)(a); [OAR] 436-35-310(2)(a)."

Claimant sought review. On July 10, 1991, the Workers' Compensation Board affirmed the referee's order. The Order on Review adopted the referee's "Conclusions of Law and Opinion," with the following supplementation:

> "Citing to *former* OAR 436-35-290(2)(a), 436-35300(2)(a) and 436-35-310(2)(a), the Referee did not rate claimant's age, education or adaptability in determining her unscheduled permanent disability. Claimant challenges the validity of those rules, arguing that they are outside the Director's delegated authority and contrary to *former* ORS 656.726(3)(f)(A), which authorizes the Director to adopt 'standards for the evaluation of disabilities' * * *
>
> 315 Or 637> "* * * * *
>
> "If we were to conclude that it is highly probable that claimant's permanent disability resulting from her compensable neck injury is greater than that indicated by application of the 'standards,' then, rather than declaring the rules invalid, we would increase her award pursuant to our authority under former ORS 656.295(5). *Henry L. Szweblik,* 42 Van Natta 1847 (1990). However, we are not persuaded on this record that claimant suffers greater disability than that indicated by the 'standards.' "

Claimant sought review, challenging the validity of the rules that do not rate age, education, and adaptability when claimant continues in her usual work. The Court of Appeals affirmed, citing *Harrison v. Taylor Lumber & Treating, Inc.*, 111 Or App 325, 826 P2d 75 (1992). *England v. Thunderbird, supra,* 112 Or App at 324. In *Harrison v. Taylor Lumber & Treating, Inc., supra,* 111 Or App at 328, the Court of Appeals held that the rules that do not rate age, education, and adaptability when claimant continues in her usual work were adopted under the director's statutory authority and were not inconsistent with *former* ORS 656.214, the statute defining earning capacity.

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[2] OAR 436-35-290(2) now provides:

"For workers, age 40 and above who do not have a physician's release to or have not returned to either their regular work or work requiring greater strength than the job at injury, the factor of age shall be given a value of + 1. For all other workers, a value of 0 shall be given."

[3] OAR 436-35-300(2) now provides:

"For workers who have a physician's release to or returned either to their regular work or work requiring greater strength, the factor of education shall be given a value of 0. For all other workers, the education factor is the sum of the values obtained pursuant to the following subsections of this rule."

[4] OAR 436-35-310(2) now provides:

"For workers who at the time of determination have a physician's release to regular work, or have either returned to or have the RFC for regular work or work requiring greater strength than work performed on the date of injury, the value for factor or adaptability is 0. For all other workers, the adaptability value is calculated according to the following sections of this rule[.]"

The director of the Department of Insurance and Finance has statutory authority to promulgate rules. ORS 656.726(3)(a). In some instances, those rules involve interpretation of statutory terms to assist in evaluating claims and deciding contested cases. In *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980), this court summarized the three classes of statutory terms that delegate rule-making authority to an agency, "each of which conveys a different responsibility for the agency in its initial application of the statute and for the court on review of that application." The three classes of statutory terms are:

> "1.) Terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and judicial review for substantial evidence;
>
> "2.) Inexact terms which require agency interpretation and judicial review for consistency with legislative policy; and
>
> "3.) Terms of delegation which require legislative policy determination by the agency and judicial review of whether that policy is within the delegation." *Id.*

315 Or 638> *See also Tee v. Albertsons, Inc.*, 314 Or 633, 637, 842 P2d 374 (1992) (stating classification of statutory terms).

The term "earning capacity" in *former* ORS 656.214(5) is an inexact term, *i.e.*, the legislature has expressed its meaning completely, but that meaning remains to be spelled out in the agency's rule or order. An inexact term gives the agency interpretive but not legislative responsibility. *See Springfield Education Assn. v. School Dist., supra,* 290 Or at 233 (so holding for terms "employment relations" and "conditions of employment"). With respect to an inexact term, the role of the court is to determine whether the agency "erroneously interpreted a provision of law, " ORS 183.482(8)(a), and the ultimate interpretive responsibility lies with the court in its role as the arbiter of questions of law. *Springfield Education Assn. v. School Dist., supra,* 290 Or at 234.

The court's role in statutory interpretation is to discern and apply the legislature's intent. The best indication of legislative intent is the words of the statute themselves. *State ex rel Juv. Dept. v. Ashley,* 312 Or 169, 174, 818 P2d 1270 (1991). In this case, the legislature has chosen to make the permanent loss of earning capacity due to a compensable injury the criterion for rating a disability. *Former* ORS 656.214(5). *Former* ORS 656.214(5) defined earning capacity as "the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job." Thus, the legislature chose to list the criteria for determining earning capacity and gainful employment by example, but did not use an exhaustive list of factors. The listing of representative factors was a direction to the agency that, in determining a worker's earning capacity, it consider such factors as age, education, impairment and adaptability, and other factors that affect one's earning capacity in a similar way. *See Springfield Education Assn. u. School Dist., supra,* 290 Or at 233 (reaching same conclusion with respect to a different representative list). The legislature directed that the four listed factors must be considered, while allowing that other factors having the same characteristics may be considered as well.

315 Or 639> Further, the legislature has chosen permanent loss of *earning capacity,* rather than loss of *earnings,* as the criterion for rating of disability. The statute goes on to make explicit what the choice of that term implies--that loss of earning *capacity* extends beyond the mere ability to retain the same job or earn the same wage to the "ability to obtain and hold gainful employment in the broad field of general occupations." *Former* ORS 656.214(5). As the Court of Appeals has observed, the fact that one employer has been accommodating and the employee retains the same job or earns the same wage is "no indication that other potential employers would be as accommodating," *Howerton v. SAIF, 70* Or App 99,103, 688 P2d 422 (1984). That is, post-injury employment may establish *earnings,* but it does not necessarily establish earning *capacity:*

> " 'Earning capacity must be considered in connection with a [worker's] handicap in obtaining and holding gainful employment in the broad field of general industrial occupations and not just in relationship to his occupation at any given time. A [worker's] post-injury earnings is evidence which, depending upon the circumstances of an individual case, may be of great, little, or no importance in determining loss of earning capacity.' " *Smith v. SAIF,* 302 Or 396, 401-02, 730 P2d 30 (1986) (quoting *Ford v. SAIF,* 7 Or App 549, 552-53,492 P2d 491 (1972)).

Through statutory directive and historical interpretation, a person's post-injury earnings cannot solely determine the person's earning capacity. By statutory directive, age, education, impairment, adaptability to perform a given job, and factors with similar characteristics are to be considered in determining earning capacity. *Former* OAR 436-35-290(2)(a), *former* OAR 436-35-300(2)(a), and *former* OAR 436-35-310(2)(a) directed that a person's post-injury employment determined whether the key statutory factors in determining earning capacity are considered. That is contrary to the legislative intent; the interpretation is erroneous.

Former OAR 436-35-290(2)(a), *former* OAR 436-35-300(2)(a), and *former* OAR 436-35-310(2)(a) are invalid. Because the decision of the Workers' Compensation Board in this case assumed the validity of and relied on those rules, that decision is erroneous. The Court of Appeals' ruling to the contrary also was error.

315 Or 640 > The decision of the Court of Appeals is reversed, the order of the Workers' Compensation Board is vacated, and the case is remanded to the Workers' Compensation Board for further proceedings.

April 18, 1993 Cite as 316 Or 55 (1993)

IN THE SUPREME COURT OF THE STATE OF OREGON
In re Complaint as to the Conduct of

Rex Q. **SMITH**, *Accused.*
(OSB 90-42; SC S39426)

In Banc
On review from the Disciplinary Board ofthe Oregon State Bar.
Argued and submitted March 1, 1993.
Mary A. Cooper, Assistant Disciplinary Counsel, Lake Oswego, argued the cause and filed the brief for the Oregon State Bar Lia Saroyan, Assistant Disciplinary Counsel, filed a reply brlef.
Rex Q. Smith, Portland, argued the cause and filed a brief *in propria persona.*
PER CURIAM
The accused is suspended from the practice of law for 35 days, effective on issuance of the appellate judgment.

PER CURIAM

316 Or 57 > This is a lawyer disciplinary proceeding. The Oregon State Bar charges that the accused engaged in conduct prejudicial to the administration of justice, in violation of DR 1-102(A)(4).[1] The trial panel found the accused not guilty. The Bar sought review by this court pursuant to BR 10.1, BR 10.3, and ORS 9.536(1). We review the record *de novo.* ORS 9.536(3). The Bar has the burden of establishing ethical misconduct by clear and convincing evidence. BR 5.2. We find the accused guilty of violating DR 1-102(A)(4) and suspend him for 35 days.

FINDINGS OF FACT

The accused was admitted to practice law in Oregon in 1974. A significant part of his practice has consisted of the representation of workers' compensation claimants. In January 1987, the accused undertook to represent Landers, a claimant who was contending that a previous work-related injury had worsened, entitling him to additional benefits.

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[1] DR 1-102(A)(4) provides:

"It is professional misconduct for a lawyer to:

"* * * * *

"(4) Engage in conduct that is prejudicial to the administration of justice.

The employer's workers' compensation insurer scheduled an independent medical examination for Landers at Kaiser Permanente Medical Center, to be conducted by the doctor who had treated Landers' original injury. The doctor was expected to prepare a written report on Landers' current condition, which would be submitted, if necessary, to the Workers' Compensation Board. The accused prepared a letter for Landers to give to the doctor at the examination. The letter stated in pertinent part:

> "Landers has been ordered by [the insurer] to undergo a defense medical exam conducted by you.
>
> "I have enclosed [reports from Landers' chiropractor].
>
> "As you will observe, [Landers' chiropractor] has opined that Landers has had a * * * worsening of his injury * * *
>
> "If you agree with [Landers' chiropractor], fine.
>
> **316 Or 58>** "If not, you need to be extremely specific and detailed * * * .
>
> " * * * Landers has a simple choice in that he can either have time loss income from [the insurer], or if no time loss income then risk hurting himself worse by trying to work; his other choice is simply to be destitute. Therefore, I just want you to be aware of what the consequences are if you tell [the insurer] that [Landers' ch*opractor] is wrong. If any of your opinions result in Landers getting cut off of time loss and hurting himself by trying to work, then he will sue you and Kaiser."

At the time of the scheduled examination, Landers gave the letter to the doctor, who conducted a brief examination. Later, the doctor informed the insurer:

> "I am withdrawing from this examination for the following reasons. When Mr. Landers came into my office to be examined, he brought with him a letter from his attorney, [the accused]. Specifically, part of the letter states that if my opinion differs from those of his present treating chiropractor then I could be sued. I refuse to put myself in jeopardy or put my Organization in jeopardy by taking this risk."

The insurer arranged for Landers to be examined by other doctors.

The Disciplinary Board trial panel concluded that, because Landers' workers' compensation claim was ultimately adjudicated despite the original doctor's withdrawal from the case, the Bar failed to show by clear and convincing evidence that the conduct of the accused "prejudiced" the administration of justice in either of the ways described by this court in *In re Haws*, 310 Or 741, 801 P2d 818 (1990). Accordingly, the trial panel found the accused not guilty of violating DR 1-102(A)(4).

DR 1-102(A)(4)

In *In re Haws, supra,* this court established a threepart test for finding a violation of DR 1-102(A)(4), the rule proscribing conduct that is prejudicial to the administration of justice.

First, the accused must have engaged in *"conduct,"* that is, performed, or failed to perform, some act. *Id.* at 746.

316 Or 59> Second, that conduct must have occurred in the context of the "administration *of justice,"* that is, during the course of some judicial proceeding or a matter directly related thereto. *Id.* at 746. The conduct may relate to the "procedural functioning of the proceeding" or to the "substantive interest of a party in the proceeding." *Id.* at 747.

Third, the conduct must have been *"prejudicial"* in nature--it must have caused, or had the potential to cause, harm or injury. *Id.* at 747. The amount of harm caused, or having the potential to be caused, however, must be more than minimal. *Id.* at 747-48. The court concluded that more than minimal harm can result either from "[r]epeated conduct causing some harm to the administration of justice" or from a "single act causing substantial harm to the administration of justice." *Id.* at 748.

We apply that test to the facts found here.

First, it is undisputed that the accused prepared, and caused to be delivered to the insurer's doctor, the letter quoted in part above. The accused thereby engaged in *"conduct."*

Second, the accused prepared the letter in the course of representing a claimant in a workers' compensation proceeding, and the letter pertained to a report to be submitted to a party in a workers' compensation case and potentially to be submitted to the Workers' Compensation Board in the course of adjudicating the claim. The performance of medical examinations by doctors for the use of parties in workers' compensation proceedings is part of the process of adjudication. The relevant conduct thus occurred in the context of the *"administration of justice."* In this case, the conduct affected the "procedural functioning of the proceeding," by causing the doctor, who was a prospective witness, to withdraw from the process of evaluating Landers' condition, thereby delaying that process. *See In re White,* 311 Or 573, 815 P2d 1257 (1991) (conduct resulting in waste of time for courts, lawyers, and litigants violated DR 1-102(A)(4)); *In re Paauwe,* 294 Or 171, 174, 654 P2d 1117 (1982) (conduct that caused delays in litigation was prejudicial to the administration of justice). In addition, the conduct affected the substantive interest of a **<316 Or 59/60>** party to the proceeding, the insurer, by potentially denying that party evidence related to the claim.

Finally, we consider whether the conduct of the accused, although not "repeated," caused, or had the potential to cause, "substantial" harm to the administration of justice. The letter prepared by the accused threatened litigation if the doctor expressed aparticular medical opinion in the course of the workers' compensation proceeding. That threat was improper, because what a witness says in a legal proceeding is absolutely privileged. In *Ramstead v. Morgan,* 219 Or 383, 347 P2d 594 (1959), this court held that a lawyer could not maintain an action for libel based on statements in a former client's letter to the chair of a county grievance committee of the Oregon State Bar. The court wrote:

> "The absolute immunity attaches to statements made in the course of, or incident to a judicial proceeding. And so, statements made by parties, witnesses, and affiants are included within the privilege.
>
> "The rule of absolute privilege is applicable not only to judicial proceedings but to quasi- judicial proceedings as well.
>
> "Statements made before various administrative boards and commissions have been recognized as absolutely privileged." 219 at 388 (citations omitted).

A workers' compensation proceeding to adjudicate a claim is a quasi-judicial administrative proceeding. *See* ORS 656.260 to 656.390 (procedure for obtaining compensation and recovering attorney fees). The report of an examining physician is an integral part of that proceeding. *See* ORS 656.325 (providing for independent medical examinations on request of the insurer); OAR 436-10-100(1) (the insurer may obtain independent medical examinations of the claimant). Therefore, absolute immunity applied to the doctor's report.

The fact that this particular workers' compensation claim was ultimately adjudicated is irrelevant. Improperly threatening a witness in a legal proceeding is substantially harmful to the administration of justice without regard to the timing or outcome of the particular case. *See* ORS 162.285 (tampering with a witness includes knowingly inducing, or attempting to induce, the witness to withhold testimony in **<316 Or 60/61>** any official proceeding; witness tampering is a Class C felony). The conduct of the accused was, therefore, *"prejudicial." See In re Boothe,* 303 Or 643, 740 P2d 786 (1987) ("an attempt to induce a witness not to testify, even if unsuccessful, is prejudicial to the administration of justice").

We conclude that the accused violated DR 1-102 (A)(4).

SANCTION

In deciding on the appropriate sanction, this court refers for guidance to the American Bar Association Standards for Imposing Lawyer Sanctions (ABA Standards). *In re White, supra,* 311 Or at 591. ABA Standard 3.0 sets out the factors to consider in imposing sanctions: the duty violated, the lawyer's mental state, the actual or potential injury caused by the misconduct, and the existence of aggravating or mitigating factors.

The accused violated his duty to the legal system during his pursuit of Landers' workers' compensation claim by communicating improperly with a witness in a judicial proceeding. ABA Standard 6.3.

The accused acted intentionally. We find that he had the conscious purpose of interfering with the doctor's independent medical judgment, by causing the doctor either to agree with Landers' chiropractor or to withdraw from the case. *See* ABA Standards at 7 (June 17, 1992) (a lawyer acts intentionally when he or she acts with the conscious purpose to acheive a particular result).

The accused asserts that his purpose in preparing the letter was to fulfill his "ethical duty to zealously represent" Landers and that his conduct was proper in view of Landers' constitutional right under Article I, section 8, of the Oregon Constitution, to express his concern about the consequences of the doctor's examination. Even assuming that Landers was constitutionally privileged to make the same comments and that Landers induced the accused to prepare the letter, the conduct of the accused was not justified. *See* ABA Standard 9.4(b) (agreeing to a client's demand for improper conduct is neither an aggravating nor a mitigating factor).

316 Or 62> Under the ABA Standards, where a lawyer influences or attempts to influence a witness' testimony, the extent of the resulting injury is measured by evaluating the level of interference or potential interference with the administration of justice. *See* ABA Standards at 8 (stating that principle). In this case, the conduct of the accused potentially interfered with the timely disposition of Landers' claim and potentially interfered with the outcome of the claim, by depriving the insurer of the opinion of the doctor who had originally treated Landers.

The ABA Standards suggest that the appropriate sanction when a lawyer acts intentionally in these circumstances ranges as high as disbarment. *See* ABA Standard 6.31 (disbarment is appropriate when a lawyer intentionally tampers with a witness and causes serious or potentially serious injury to a party, or causes significant or potentially significant interference with the outcome of the legal proceeding); ABA Standard 6.32 (suspension is appropriate when a lawyer engages in communication with an individual in the legal system and the lawyer knows that such communication is improper, and causes injury or potential injury to a party or causes interference or potential interference with the outcome of the legal proceeding).

We next consider pertinent aggravating and mitigating factors.

As an aggravating factor, the accused had substantial experience in the practice of law. ABA Standard 9.22(i).

In mitigation, the accused has no prior disciplinary record, ABA Standard 9.32(a); he made a full disclosure to the trial panel of the facts and circumstances of his conduct, ABA Standard 9.32(e); and there was a delay in initiating the disciplinary proceedings, ABA Standard 9.32(j).

The mitigating factors outweigh the aggravating factor in this case. We conclude that a suspension of 35 days is the appropriate sanction.

The accused is suspended from the practice of law for 35 days, effective on issuance of the appellate judgment.

May 6, 1993 Cite as 316 Or 180 (1993)

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald R. Buddenberg, Claimant.

Ronald R. **BUDDENBERG**, *Petitioner on Review,*
v.
SOUTHCOAST LUMBER and SAIF Corporation, *Respondents on Review.*
(WCB 89-19242; CA A68896; SC S39328)

In Banc
On review from the Court of Appeals.*
Argued and submitted January 7, 1993.
Jon C. Correl, Eugene, argued the cause for petitioner on review. Edward J. Harri, of Malagon, Moore, Johnson, Jensen & Correll, Eugene, filed the petition for petitioner on review.
Steve Cotton, Special Assistant Attorney General, Salem, argued the cause and filed the response for respondents 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 Workers' Compensation Board. 112 Or App 148, 826 P2d 1062 (1992).

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316 Or 182> In this workers' compensation case, the issue is whether the Director of the Department of Insurance and Finance (the Director) exceeded his statutory authority in the adoption of certain standards for the evaluation of permanent partial disability. We conclude that the Director did not exceed his authority in the manner urged by claimant.

Before 1987, the rating of extent of disability under the workers' compensation laws was carried out on an *ad hoc* basis. The Director had promulgated "guidelines" for the rating of the extent of various kinds of disability, but the Court of Appeals had held (and this court had agreed) that the "guidelines" were just that--guidelines. They were not a substitute for evidence as to what the extent of a claimant's disability actually might be. *See Fraijo v. Fred N. Bay News Co.*, 59 Or App 260, 268-69, 650 P2d 1019 (1982) (Court of Appeals employed the guidelines "merely as a tool"); *accord Harwell v. Argonaut Insurance Co.*, 296 Or 505,510,678 P2d 1202 (1984) ("use of the guidelines is not a substitute for a 'fair assessment' of the percentage of disability").

The uncertainty inherent in the foregoing situation changed when, in 1987, the legislature amended ORS 656.283(7) to provide in part:

> "Except as otherwise provided in this section and rules of procedure established by the board, the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. *The referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726."*

Or Laws 1987, ch 884, 11 (emphasis supplied).

The Director adopted the standards authorized by the 1987 act. They are found at OAR 436-35-001 *et seq.* The standards were intended "to reflect the criteria for rating outlined in legislation adopted by the 1987 legislature." *Former* OAR 436-35-002. The standards replaced the guidelines and "applied to all claims closed after July 1, 1988." *Former* OAR 436-35-003.

316 Or 183> Claimant suffered a compensable injury to his feet on June 6, 1981. In December 1982, and presumably under the guidelines for the evaluation of disability then in effect, that claim was closed with an award of compensation for 60 percent scheduled permanent partial disability (PPD) in each foot.

In 1987, claimant filed a new claim for aggravation,[1] contending that the condition of his feet had worsened. His condition became medically stationary in August 1989. In September 1989, a determination order awarded claimant compensation for temporary total disability from November 1987 through August 1989, but denied him any additional compensation for scheduled PPD. Claimant requested a hearing, and a referee affirmed the denial of additional scheduled PPD.

On review from the referee's order, the Workers' Compensation Board also denied additional scheduled PPD benefits. The Board determined that, under the standards for evaluation of disability that were in effect on the date of the September 1989 determination order, the extent of claimant's scheduled permanent partial disability was 28 percent. Under the version of the Workers' Compensation Law then applicable to this case, a party dissatisfied with his or her rating under the standards was permitted to attempt to "establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726." ORS 656.283(7), 656.295(5) (1989).[2] Claimant attempted to meet that burden. **<316 Or 183/184>** The Board found, however, that, while claimant had established by clear and convincing evidence that the actual extent of his scheduled permanent partial disability was greater than the 28 percent indicated by the standards, he had not demonstrated that his actual permanent disability under the 1989 standards exceeded the 60 percent scheduled PPD previously awarded under the guidelines. The Board therefore ruled that claimant was not entitled to additional scheduled PPD benefits.

On judicial review in the Court of Appeals, claimant argued that, by finding that his condition had worsened since the last arrangement of compensation but then refusing to award him additional scheduled PPD benefits, the Board had denied him his statutory right to "additional compensation" under ORS 656.273(1), set out *infra*. The Court of Appeals disagreed and affirmed the Board's decision, holding that " [a] worker is entitled to additional compensation under ORS 656.273(1) only if the worsened condition increases the extent of disability as defined by the standards." *Buddenburg v. Southcoast Lumber*, 112 Or App 148, 152, 826 P2d 1062 (1992). We allowed review and now affirm the decision of the Court of Appeals.

Claimant does not argue to this court that the Board erred in applyingthe standards, rather than the guidelines, to his aggravation claim. It is clear that, by their own terms, the standards applied. Neither does claimant argue that the Board miscalculated when it determined the extent of his disability under those standards. Claimant's argument is that, by adopting standards that had the effect of denying him a greater award of PPD *benefits* despite the worsening of his *condition*, the Director exceeded his statutory authority by limiting claimant's right to "additional compensation" under ORS 656.273(1). Essentially, claimant's argument is that, because of an injured worker's right to "additional compensation" under ORS 656.273(1), the standards must provide a special "tacking" procedure for evaluating the extent of disability on aggravation claims. By not promulgating standards that included such a procedure, claimant argues, the Director exceeded his statutory authority. For the reasons that follow, we reject claimant's argument.

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[1] Although a claim for aggravation is based on the prior adjudicated claim, we call a claim for aggravation "new" for two reasons. First, a claim for aggravation independently fits the definition of a "claim." See ORS 656.005(6) (" 'Claim' means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."). Second, the statute that authorizes claims for aggravation, ORS 656.273, clearly treats such a claim as independent of the prior adjudicated claim. For example, ORS 656.273(2) requires a separate filing of a claim for aggravation, ORS 656.273(3) allows a physician's report to serve as a claim for aggravation, and ORS 656.273(4) provides a separate statute of limitations for a claim for aggravation (generally, five years from last arrangement of compensation).

[2] That pronsion was rewritten in 1990, however. Or Laws 1990, ch 2, 20,22. Presently, the law allows a party to establish "by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied." ORS 656.283(7), 656.295(5). This case does not involve any issue concerning the quantum of proof that claimant was required to produce under the statute.

316 Or 185> Claimant bases his argument on ORS 656.273(1), which states, 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." (Emphasis supplied.) According to claimant, once he proves a worsening of his condition,[3] he is entitled as a matter of right under ORS 656.273(1) to additional compensation in the form of "a greater award of disability." Claimant concludes that, by adopting standards that permitted denial of such an award, the Director must have exceeded his statutory authority.

Our recitation of the procedural, statutory, and regulatory history of the standards demonstrates that the Director's promulgation of them did not violate any right of claimant to compensation under ORS 656.723(1). First, claimant's right to "additional compensation" was not compromised. He did, in fact, receive compensation on his aggravation claim. Under the Workers' Compensation Law, " '[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 selfinsured employer pursuant to this chapter." ORS 656.005(8). Thus, "compensation" encompasses benefits paid for death, ORS 656.204, permanent total disability, ORS 656.206, temporary total disability, ORS 656.210, temporary partial disability, ORS 656.212, and permanent partial disability, ORS 656.214, as well as medical services, ORS 656.245. In this case, claimant received benefits for temporary total disability from November 23,1987, through August 21, 1989, as well as medical services for surgery and treatment of his feet. Consequently, claimant actually received "additional compensation" for his claim of a worsened condition.

Second, to the extent that claimant is arguing that ORS 656.723(1) entitled him to one particular *type* of additional compensation--*i.e.*, additional scheduled PPD benefits--we disagree. By itself, ORS 656.273(1) does not entitle <316 Or 185/186> an injured worker to any particular type of additional compensation. The type of additional compensation (if any) to which an injured worker is entitled under the statute depends on how the claimant's circumstances fit within the provisions of the Workers' Compensation Law governing that particular claim.

The present case illustrates the principle. To qualify for compensation for permanent partial disability, an injured worker must show apermanent loss of use, either complete or partial, of a part of the body.[4] Next, as explained above, the extent of the worker's disability must be determined under the standards adopted by the Director. In this case, claimant established a permanent partial disability by showing a partial loss of use of his feet. As required by the statutes, the Board rated the extent of that permanent partial disability according to the standards. The extent of claimant's disability, as determined under the standards (28 percent), was less than the extent of the disability for which claimant previously had been compensated (60 percent) under a former claim that had been decided under the guidelines. Claimant was unable to prove, by clear and convincing evidence, that the extent of his disability exceeded the 60 percent disability for which he already had been compensated. Accordingly, claimant was not entitled to any further PPD benefits, despite the fact that his condition had worsened.

The way in which claimant could receive additional PPD under the present facts would be if the Director had promulgated a rule that created a "bridge" between the old (guidelines) and the new (standards) disability ratings. Such a rule would have to direct that, for workers whose original injuries were rated under the old system, the facts no longer mattered. But we do not discern from ORS 656.273(1), nor from any other source, a legislative requirement that the Director adopt as part of the standards the procedure that claimant proposes. As explained above, ORS 656.273(1) allows "additional compensation" to an injured worker who <316 Or 186/187> proves a worsened condition resulting

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[3] In this case, neither the referee nor the Board made an express finding that claimant's condition had, in fact, worsened. Nevertheless, such a finding was implicit in the orders in this case, and no party has raised any argument on that point. For purposes of this opinion, we will assume that claimant proved a physical worsening of his condition as a matter of fact.

[4] ORS 656.214 governs permanent partial disability. Under that statute " '[p]ermanent partial disability' means the loss of either one arm, one hand, one leg, one foot, loss of hearing in one or both ears, loss of one eye, one or more fingers, or any other injury known in surgery to be permanent partial disability." ORS 656.214(1)(b). " 'Loss' includes permanent and complete or partial loss of use." ORS 656.214(1)(a).

from the original injury. However, the statute does not guarantee any particular type of compensation, such as scheduled PPD benefits, nor does the statute even purport to prescribe how the extent of disability should be determined on an aggravation claim. Because ORS 656.273(1) does not compel the evaluation procedure advocated by claimant, the Director did not compromise any right guaranteed to claimant by that statute in adopting standards that did not include that procedure.

In addition to noting that there is no textual justification in the statute or rules for his position, we note also that claimant's argument is inconsistent with his own acknowledgment of the applicability of the 1987 standards to his case. Under the old guidelines, a particular level of physical impairment (or "loss of use") was rated as a greater extent of disability than the same level of impairment now is rated under the standards. The effect of claimant's argument would be that a worker who was hurt initially during the reign of the guidelines system would be entitled, after proof of a compensable aggravation claim, to an even higher rating of permanent partial disability, while a worker who is making a claim under the standards for a new injury would be entitled to a much lower rating of PPD, *in spite of the fact that both workers are physically impaired to precisely the same extent.* The accurate way to portray claimant's situation is to say that, because he received his original injury when the earlier system was in place, he received a higher disability rating at that time than he would receive now, even with the further aggravation of his injury. That earlier disability rating is unassailable, but the legislature was not required to further the disparate treatment of our two hypothetical workers by granting the earlier-injured worker even more benefits now.

We hold that the Director did not exceed his statutory authority in the manner claimant urges. It follows that the Board committed no error in applying the standards to the new aggravation claim, and the Court of Appeals was correct in affirming the Board's decision.

The decision of the Court of Appeals is affirmed.

May 6, 1993 Cite as 316 Or 188 (1993)

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Keith T. Johnson, Claimant.

Keith T. **JOHNSON**, *Petitioner on Review*
v.
HELI-JET CORPORATION and SAIF Corporation, *Respondents on Review.*
(WCB 90-12901; CA A70738, SC S39347)

In Banc
On review from Court of Appeals.*
Argued and submitted January 7, 1993.
Jon C. Correll, of Malagon, Moore, Johnson, Jensen & Correll, Eugene, argued the cause and filed the petition for petitioner on review.
Steve Cotton, Special Assistant Attorney General, Salem, argued the cause and filed the response for respondents 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 Workers' Compensation Board. 112 Or App 323, 827 P2d 209 (1992).

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316 Or 190> In this workers' compensation case, claimant seeks review of an order of the Workers' Compensation Board that denied him additional permanent partial disability benefits on his aggravation claim. The Court of Appeals affirmed the Board's denial. *Johnson v. Heli-Jet Corp.*, 112 Or App 323, 827 P2d 209 (1992). We also affirm.

Claimant suffered a compensable injury to his right knee on December 10, 1983. In March 1986, under the guidelines for evaluation of disability then in effect, claimant was awarded compensation for 30 percent scheduled permanent partial disability (PPD). In April 1988, the parties stipulated to an additional award of 15 percent PPD, for a total of 45 percent scheduled PPD.

In July 1989, claimant filed a claim for aggravation, contending that the condition of his right leg had worsened. His condition became medically stationary in May 1990, and the following month the employer's workers' compensation insurance carrier sent to claimant a notice of closure awarding claimant temporary total disability benefits and temporary partial disability benefits but no additional scheduled PPD benefits. Claimant requested a hearing.

A referee affirmed the denial of additional scheduled PPD benefits. The referee found that claimant's condition had, in fact, worsened since April 1988. Nevertheless, applying the standards for evaluation of disability in effect when the notice of closure issued, the referee determined that the extent of claimant's right leg disability was 17 percent. Because that disability rating did not exceed the 45 percent determined earlier under the guidelines, the referee held that claimant was not entitled to increased compensation.

On review of the referee's order, the Workers' Compensation Board affirmed without further comment or analysis. On judicial review of the Board's order, the Court of Appeals affirmed *per curiam,* citing *Buddenberg v. Southcoast Lumber,* 112 Or App 148, 826 P2d 1062 (1992). *Johnson v. Heli-Jet Corporation, supra,* 112 Or App at 323. We allowed review in this case and in *Buddenberg* to address the argument that the Director of the Department of Insurance and Finance (the Director) exceeded his statutory authority in **<316 Or 190/191>** adopting the standards for the evaluation of disability applied in these cases.

Claimant argues that, because he proved that he now suffers from a worsened condition resulting from his original injury, he has a statutory right under ORS 656.273(1) to additional compensation.[1] According to claimant, the Director exceeded his statutory authority in adopting evaluation standards that compromised this right by denying claimant additional scheduled PPD benefits. In *Buddenberg v. Southcoast Lumber,* 316 Or 180, ___ P2d ___ (1993), we confronted an identical argument. In that case we held that ORS 656.723(1) alone does not entitle an injured worker to any particular *type* of compensation, such as PPD benefits. We further held that ORS 656.273(1) does not require the Director to adopt, and that the Director did not exceed his statutory authority by not adopting standards that included a special procedure for evaluating aggravation claims that treated any earlier PPD award as a "baseline." Those holdings are dispositive here.

The decision of the Court of Appeals is affirmed.

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[1] In part, 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."

March 17, 1993 Cite as 118 Or App 602 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Doris A. Pace, Claimant.

STANLEY SMITH SECURITY, *Petitioner,*
v.
Doris A. **PACE**, *Respondent.*
(90-08372; CA A72660)

In Banc*
Judicial Review from Workers' Compensation Board.
Argued and submitted June 17, 1992.
Darren L. Otto, Portland, argued the cause for petitioner. With him on the brief was Scheminski & Lyons, Portland.
David C. Force, Salem, argued the cause for respondent. With him on the brief was Vick & Gutzler, Salem.
DEITS, J.
Remanded to the Board for modification of its award of interim compensation not inconsistent with this opinion; otherwise affirmed.
Richardson, C. J., dissenting.

*Durham, J., not participating.

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118 Or App 604> Employer seeks review of an order of the Workers' Compensation Board awarding claimant interim compensation under ORS 656.273(6) on her aggravation claim that was eventually determined to be noncompensable.[1] We affirm.

In January, 1990, claimant experienced what she regarded as an aggravation of a compensable injury involving her head, upper back and right arm and shoulder. The original claim had been closed by a determination order in December, 1989. The aggravation claim consisted of a report from claimant's treating chiropractor. Employer received the report on January 18, 1989, but did not deny or accept the claim. On April 16, 1990, claimant requested a hearing alleging a *de facto* denial. The referee found that the report submitted by claimant's treating chiropractor constituted an aggravation *clazm,* but concluded that claimant failed to prove that her claim was compensable. The referee, however, did award claimant interim compensation under ORS 656.273(6), because employer did not deny or accept her claim within 14 days of the notice of the claim.

Both parties sought Board review. Employer requested review of the referee's award of interim compensation to claimant. The Board held that claimant was entitled to interim compensation from January 18, 1990, through July 11, 1990, the date that claimant returned to regular work.

Employer assigns error to the Board's determination that claimant was entitled to interim compensation. It first argues that the Board was wrong in concluding that the chiropractor's report constituted an aggravation claim. Employer argues that the report was insufficient to constitute an aggravation claim, because it summarized claimant's subjective complaints of pain but was not supported by objective medical findings.

The Board held, and the parties agree, that the claim is subject to the amendments by Oregon Laws 1990 (Special Session), chapter 2, section 18. *See Carlson v. Valley Mechanical,* 115 Or App 371, 838 P2d 637 (1992), *rev den* 315 Or 311 **<118 Or App 604/605>** (1993). As amended, ORS 656.273(3) states that: "A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation." (Or Laws 1990, ch 2, 18.) The chiropractor's report stated:

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[1] Claimant has not contested the referee's determination that the claim is not compensable.

"[Claimant's] condition has deteriorated markedly since her IME of November 7, 1989. Since that examination, the [claimant] has experienced increases in her headaches, she also has increased pain in her right arm with numbness in her right fingers and increased pain in her right shoulder. She is still having headaches and dizziness and I feel that this [claimant] is unable to return to her previous job as a security guard.

"[Claimant] cannot use her right hand at this time, as her right hand is not only painful, but her right forearm is in a splint at this time to minimize her pain. "

In *Georgia-Pacific Corp. v. Ferrer,* 114 Or App 471, 835 P2d 949 (1992), we discussed the legislature's intent when it added the requirement that medical evidence be supported by objective findings before it would be sufficient to establish a compensable injury. We agreed with the Board's conclusion that, in adding the term "objective findings,"

" 'the legislature did not intend to exclude those findings based on an injured worker's subjective complaints. Rather, we believe that the intent was to require a determination by a physician, based on examination of the injured worker, that an injured worker has a disability or need for medical services. *Such a finding* may be based on a physically verifiable impairment, but, as stated by the committee members, *may also be based on the physician's evaluation of the worker's description of the pain that she is experiencing.' "* 114 Or App at 474. (Emphasis in original.)

We see no reason to interpret the term "objective findings" differently for aggravation claims than for compensable injuries. We conclude that the chiropractor's report was an aggravation claim. The chiropractor examined claimant and, on the basis of that examination and his evaluation of her subjective complaints, he determined that her underlying condition had worsened and that she was unable to perform her regular work.

Employer next argues that the Board erred in awarding claimant interim compensation, because her aggravation **<118 Or App 605/606>** claim was ultimately found to be noncompensable. According to employer, the amendments to ORS 626.273 added the requirement that an aggravation claim be compensable before there is any obligation to pay interim compensation.

As amended, ORS 656.273 provides, in part:

"(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. A *worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable.* * * *

"* * * * *

"(3) A *physicians's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation.*

"* * * * *

"(6) 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 installment of compensation 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 a *compensable worsening under subsection (1) or (8) of this section.*

" * * * * *

" (8) If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, 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." (Emphasized language added by Or Laws 1990, ch 2, 18.)

Employer argues that the addition of the word "compensable" to ORS 656.273(6) and changing the reference in that subsection from ORS 656.262(4) to a general reference to ORS 656.262 made interim compensation for aggravation claims dependent on a determination of compensability. The Board, sitting *in banc,* held that these changes to ORS **<118 Or App 606/607>** 656.273(6) did not limit the availability of interim compensation only to compensable aggravation claims. It explained:

> "We have held that to constitute an aggravation claim under ORS 656.273(3) as amended, the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has worsened from a medical standpoint. * * * We interpret the minor language change at issue here as having a similar purpose, i.e., to require the medical report to constitute prima facie evidence of all applicable elements provided in ORS 656.273(1) or (8) for establishing a compensable worsening.
>
> "We do not believe the legislation *[sic]* intended, by the addition of a single word, to leave injured workers without any maintenance or support pending the carrier's acceptance or denial of the aggravation claim. The employer has not provided, and we are not aware of, any legislative history which would suggest that, after notice of an initial injury claim, the employer is required to pay claimant interim compensation, but in the case of an aggravation claim, the employer is required to give the worker no support until the claim is accepted or proven compensable at hearing. Absent plain and unambiguous statutory direction for such a fundamental change of legislative policy, we conclude that ORS 656.273(6) required the employer to pay claimant interim compensation no later than the 14th day after it received medical verification of an inability to work as documented in a medical report which constitutes prima facie evidence of a compensable worsening."

Reading the statute in its entirety and in the context of the changes made by the 1990 legislature, we agree with the Board's conclusion that interim compensation continues to be available for aggravation claims. Before ORS 656.273(6) was amended, it provided:

> "A claim submitted in accordance with this section shall be processed by the * * * 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."* (Emphasis supplied.)

118 Or App 608> Under that statute, aggravation claims were processed under ORS 656.262, which has been construed to include the requirement that interim compensation be paid under certain circumstances. *Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977). If the employer accepted or denied the claim within 14 days, it had no duty to pay interim compensation. ORS 656.262(2), (4); *Georgia-Pacific v. Hughes,* 305 Or 286, 293, 751 P2d 775 (1988). However, if the employer delayed responding to the claim longer than that, ORS 656.262 required the employer to pay interim compensation:

> "The compensation due under this chapter shall be paid periodically, promptly and d*ectly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, *except where the right to compensation is denied by the insurer or self-insured employer."* ORS 656.262(2). (Emphasis supplied.)

In Jones v. Emanuel Hospital, supra, 280 Or at 151, the Supreme Court explained why ORS 656.262 required the payment of interim compensation:

> "In the context of ORS 656.262, the word 'compensation' includes what we have called interim compensation. Any other interpretation does violence to the intent of the statute. ORS 656.262 gives the employer two choices: deny the claim or make interim payments. To interpret the word 'compensation' as the employer would have us do would give the employer a third choice: to delay acceptance or denial of the claim while making no interim payments. This third choice would delay the worker's appeal from an

adverse decision since the worker cannot appeal until he or she receives the notice of denial. ORS 656.262(6). During this time, the worker would receive no benefits; thus, the employer would be able to gamble on the ultimate outcome of the case and at the same time delay that outcome."

ORS 656.273(6), as amended, continues to require that aggravation claims be processed in accordance with ORS 656.262. It provides:

"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 installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the **<118 Or App 608/609>** subject employer *has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (I) or (8) of this section."* (Emphasis supplied.)

Employer's interpretation of ORS 656.273(6) would, in effect, give the employer a third choice: to delay acceptance or denial of the claim, thus delaying the outcome of the claimant's case, while making no interim payments. As the Supreme Court said in *Jones v. Emanuel Hospital, supra,* that result is directly contrary to the statutory scheme for the processing of claims.

The 1990 legislature did not add only the word "compensable," it added "a compensable worsening *under subsection (1)* or (8)[.]" (Emphasis supplied.) At that same time, the legislature also amended subsection (1) and added subsection (8). The Board concluded that the legislature added the phrase "a compensable worsening under subsection (1) or (8)" in order to clarify that the duty to pay interim compensation is not triggered unless the *notice* that the employer receives conforms to the requirements for compensability in subsections (1) or (8), as amended. Subsection (1) was amended to require "medical evidence supported by objective findings" and subsection (8) requires that:

"If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated."

As the Board concluded, it is apparent that the legislature added the phrase "a compensable worsening under subsection (1) or (8)" in order to clarify that the new definition of an aggravation claim and the requirement that the worker establish that the worsening is more than waxing and waning must be met before the employer is obligated to pay interim compensation.

The legislative history also supports our conclusion that interim compensation continues to be available for aggravation claims. There was no discussion of eliminating interim compensation for aggravation claims that are supported by objective medical findings. The executive summary **<118 Or App 609/610>** of the changes to ORS 656.273(6), prepared by the Governor's Workers' Compensation Labor Management Advisory Committee, does not even discuss interim compensation for aggravation claims.

Finally, employer argues that even if claimant was entitled to interim compensation, the Board erred in ordering it to pay it through July 11, 1990. It contends that because claimant requested a hearing on April 16, 1990, raising the issue of her entitlement to those benefits, its duty to pay interim compensation ended on that date. Employer argues alternatively, that its duty to pay interim compensation ended on April 17, 1990, when claimant was released for regular work by her attending physician.

Interim compensation benefits are temporary total disability benefits. *See Bono v. SAIF,* 298 Or 405,692 P2d 606 (1984). ORS 656.268(3) governs the termination of temporary total disability benefits. It 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 attendingphysician gives the worker a written release to return to regular employment; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Under the above statute, claimant's request for a hearing is not a basis to terminate benefits.[2] *See International Paper Co. v. Huntley,* 106 Or App 107, 806 P2d 188 (1991). Glaimant, however, allegedly was released by her attending physician for regular work on April 17,1990, which under the statute does terminate benefits. However, the Board did not make factual findings regardingwhether claimant was actually released by her attending physician for regular work on that date. Accordingly, we remand to the Board for appropriate findings.

118 Or App 611> Remanded to the Board for modification of its award of interim compensation not inconsistent with this opinion; otherwise affirmed.

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[2] If the employer had denied the claim its obligation to pay interim compensation would have ended pursuant to ORS 656.262(2).

RICHARDSON, C. J., dissenting.

I agree with the majority that the Board correctly concluded that the chiropractor's report constituted a claim for aggravation under the 1991 amendments to ORS 656.273(3). I disagree with its holding that employer was required to pay interim compensation on the claim that was ultimately found to be noncompensable. The issue on which we disagree is whether the 1991 amendments to ORS 656.273 changed the law about interim compensation. The majority says they did not.

As amended, ORS 656.273 prondes, in part:

"(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. *A worsened condition resulting from the original injury is established by medical evidence supported by objectiue findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable.* * * *

"* * * * *

"(3) A physician's report *establishing the worsened condition by written medical evidence supported by objective findings is* a claim for aggravation.

"* * * * *

"(6) 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 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 *a compensable worsening under subsection (1) or (8) of this section.*

"* * * * *

> *"(8) If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the* **<118 Or App 611/612>** *condition contemplated by the preuious permanent disability award."* (Emphasized language added by Or Laws 1990, Special Session, ch 2, 18.)

In *Jones v. Emanuel Hospital,* 280 Or 147, 151, 570 P2d 70 (1977), the court coined the term "interim compensation" to describe time loss benefits payable to a claimant pursuant to ORS 656.262(2), (4) and (5) between the time when the employer first has knowledge of the claim and when the claim is either accepted or denied. Before it was amended, ORS 656.273(6) required an employer to begin payment of compensation on an aggravation claim "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."* (Emphasis supplied.) Relying on that language and the statute's reference to ORS 656.262(4), which, in 1979, required payment of benefits no later than the 14th day after the employer had notice or knowledge of an injury claim, we held in *Silsby v. SAIF,* 39 Or App 555, 592 P2d 1074 (1979), that a worker making an aggravation claim may be entitled to interim compensation.

The new language in ORS 656.273(6) requires that compensation be paid no later than the 14th day after employer has notice of a medically verified inability to work resulting from *"a compensable worsening* under subsection *(1) or (8)"* of ORS 656.273. (Emphasis supplied.) The statute now speaks of compensable worsening, not just a worsened condition, as the trigger for an employer's obligation to begin paying benefits.

As we said in *Silsby v. SAIF, supra,* ORS 656.273 is a procedural statute and relates only to "when compensation payments must actually be made, not to what period of time the payments must cover." 39 Or App at 562. The question here is whether ORS 656.273 still requires an employer to begin making payment of benefits for time loss from the 14th day after it has notice of an aggravation claim, even if the claim has not been accepted or ordered accepted. The Board held that it does; the majority takes comfort by quoting the Board's opinion.

I do not agree with the Board's or the majority's analysis. In the first place, the legislative changes involve much more than the addition of a "single word." There are **<118 Or App 612/613>** many changes, and the statute must be read in its entirety to determine what they mean.

A compensable worsening is only established by "medical evidence supported by objective findings" showing a worsened condition resulting from the original injury. ORS 656.273(1); *Smith v. SAIF,* 302 Or 396, 730 P2d 30 (1986). A claim is compensable either if the employer accepts it or if it is otherwise determined to be compensable under the standards in the statute. Only after compensability is established is an employer required to begin paying any compensation.

I reject the Board's conclusion that the legislature intended that a medical report that satisfies the requirements of ORS 656.273(3) as an aggravation claim necessarily is sufficient to trigger the obligation to begin paying benefits. If the legislature had intended that, it could have straightforwardly said so. Instead, it clearly added a critical word to the equation that supports my analysis. The Board (and the majority) would attach no significance to words that are virtually terms of art in compensation law. If the legislature had intended what the majority says, it could have left out the phrase "compensable worsening" and left in the phrase "worsened condition." The referee concluded that claimant has not established a compensable worsening of her condition, and she does not challenge that. She is, therefore, not entitled to any benefits for time loss.

March 17, 1993 Cite as 118 Or App 640 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joel O. Sandoval, Claimant.

Joel O. **SANDOVAL**, *Petitioner*,
v.
CRYSTAL PINE and Liberty Northwest Insurance Corporation, *Respondents*.
(90-01081; CAA74626)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 16, 1992.
Edward J. Harri, Salem, argued the cause for petitioner. On the brief were Stanley F. Fields and Law Office of Michael B. Dye, Salem.
Alexander D. Libmann, Portland, argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Rossman and Edmonds. Judges.
EDMONDS, J.
Affirmed.

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118 Or App 642> Claimant seeks review of an order of the Workers' Compensation Board. He argues that the Board erred when it held that employer was not required to pay temporary total disability (TTD) after November 5, 1990, and that employer was not liable for attorney fees or penalties. ORS 656.262(4)(b). We affirm.

The Board found that claimant, a tree planter, injured his back in a fall on October 19, 1989. Employer accepted the claim and began paying TTD. In October, 1990, employer requested verification of claimant's inability to work from claimant's attending physician. The physician responded by letter dated November 5, 1990:

> "[Claimant] was last seen on 10-23-90[.] At this time the [doctor's] physical examination sees minimal tenderness on lumbar sacral area, negative tension signs, M/S intact, DTR are within normal limits. Patient is [recommended] to obtain a second opinion for further management since he suffers lumbar back pain for over one year. Patient has been released to go back to work on 6-26-90 and returned to us on 7-11-90 for a check up and then on 7-31-90 when he couldn't return to work because of [too] much pain so he was put on disability again by Dr. Song. [Claimant] returned on 8-14-90 for a check up then released again on 8-27-90. On 10-23-90 he returned stating he couldn't work so doctor Haeff M.D. (general [practitioner]) referred him back to Dr. Song (orthopedic) and at that time is what I mentioned in the above beginning paragraph. At this time Dr. Song would like if you would set up [claimant] with one of your medical doctors to be [evaluated] for this condition."

Based on the letter, employer had claimant undergo a medical examination by a different physician, who reported that claimant was capable of returning to work without restriction. Employer then stopped paying TTD as of December 18, 1990. The Board held that TTD was not due and payable after November 5, 1990, because claimant's attending physician was unable to verify claimant's inability to work.

Claimant argues that the authority to terminate TTD exists exclusively under ORS 656.268(3)[1]

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[1] ORS 656.268(3) 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; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

when ongoing **<118 Or App 642/643>** payments are being made, and that ORS 656.262(4)[2] does not authorize employer to stop TTD payments under these circumstances. He asserts that, once claimant's entitlement to TTD is established, it continues until one of the three statutory events in ORS 656.268(3) occurs, none of which happened here. Claimant misconstrues ORS 656.262(4).

Statutes that are part of the same act should be construed together to give effect to the legislature's intent and to give meaning to each provision of the act, if possible. *Davis v. Wasco IED*, 286 Or 261, 593 P2d 1152 (1979). ORS 656.268 provides for termination of TTD and claim closure. The only means for an employer to unilaterally "terminate" TTD is pursuant to ORS 656.268(3); the entitlement to those **<118 Or App 643/644>** benefits continues until the requirements of the statute are met. *See Northrup King & Co. v. Fisher, 91* Or App 602, 757 P2d 855, *rev den* 307 Or 77 (1988) (construing an earlier version of ORS 656.268).

ORS 656.262(4)(a) contemplates that TTD benefits are being paid and describes when they are payable to a claimant. ORS 656.262(4)(b) provides that TTD is not "due and payable" when the attending physician is unable to verify the claimant's inability to work. In essence, it permits an insurer or self-insured employer to "suspend" the payment of TTD until such verification is obtained. However, the suspension of benefits pursuant to ORS 656.262(4)(b) does not terminate claimant's entitlement to TTD under ORS 656.268. To read ORS 656.262(4)(b) as claimant suggests would read it out of existence. We hold that the Board was correct when it held that TTD was not due and payable after November 5, 1990.

Affirmed.

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[2] ORS 656.262(4) provides:

"(a) The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Thereafter, compensation shall be paid at least once each two weeks, except where the director determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

"(b) Temporary disability compensation is not due and payable for any period of time for which the insurer or self- insured employer has requested from the workers' attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.

"(c) If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment.

"(d) If the insurer or self-insured employer has requested and failed to receive from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician are not compenssble until the attending physician submits such verification."

March 31, 1993 Cite as 119 Or App 17 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY AND HEALTH DIVISION, *Petitioner,*
v.
PGE COMPANY, *Respondent.*
(SH-91194; CA A73575)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 16, 1992.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Robin Tompkins, Assistant General Counsel, Portland, argued the cause for respondent. With her on the brief was Ann L. Fisher, Assistant General Counsel, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration.

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119 Or App 19> Petitioner, Oregon Occupational Safety & Health Division (OR-OSHA), seeks review of an order of the Workers' Compensation Board in a contested case proceeding. ORS 654.290(2)(b); ORS 183.482(8)(a). We reverse.

The facts were stipulated. Respondent Portland General Electric Company (PGE) is an electric utility that operates a facility in Salem, Oregon, which is

> "a limited access building under the exclusive control of [PGE. It] contains vehicles for fabrication and repairs, air compressor, welding equipment, metal shop equipment, vehicle servicing and repair equipment, vehicle hoist and pits, and miscellaneous electrical installation and repair equipment. The premises are used to store electrical equipment and to fabricate metal for use in electrical distribution systems.

On August 1, 1991, OR-OSHA cited and fined PGE for violating a lockout/tagout rule relating to the control of hazardous energy. OAR 437-02-1910.147(c)(5)(ii) provides, in part:

> "Lockout devices and tagout devices shall be singularly identified; shall be the only devices(s) *[sic]* used for controlling energy; shall not be used for other purposes[.]"[1]

OR-OSHA alleged that PGE had violated that rule because

> "[l]ockout devices and tagout devices were utilized for other purposes than controlling energy:
>
> "(a) The lockout device was not under exclusive control of the authorized employee performing the servicing or maintenance.

On PGE's appeal, the Board dismissed the citation, concluding that PGE's Salem facility was not subject to that rule. OR-OSHA contends that the Board erred in so ruling. We agree.

The rule on which the Board relied in concluding that the facility was not subject to OAR 437-02-1910.147 **<119 Or App 19/20>** (c)(5)(ii) is OAR 437-02-1910.147(a)(1)(ii), which provides, in part:

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[1] That rule is part of the standard adopted by the Oregon Department of Insurance and Finance as minimum performance requirements for controlling hazardous energy in order to prevent unexpected injury to employees. ORS 654.025(2); OAR 437-02-1910.147(a)(1)(i).

> "This standard [governing the lockout/tagout requirements for controlling hazardous energy, including the rule that was allegedly violated by PGE] does not cover the following:
>
> "* * * * *
>
> "(B) Installations under the exclusive control of electric utilities for the purpose of power generation, transmission and distribution, including related equipment for communication or metering[.]"

Conceding that the facility in question was "under exclusive control" of PGE, OR-OSHA nonetheless contends that it is not an installation "for the purpose of power generation, transmission and distribution." OR-OSHA interprets the phrase "for the purpose" to mean that the facility must itself generate, transmit and distribute power. PGE counters that the phrase means that, as long as the facility is used in some way, albeit indirectly, for power generation, transmission or distribution, it is not covered by the lockout/tagout rules as provided by OAR 437-02-1910.147.[2] Because either argument is tenable, we resort to the context in which the Oregon "lockout/tagout" standard was adopted. *Cf. Royer v. Miles Laboratory, Inc.*, 107 OrApp 112,115,811 P2d 644 (1991). Our review is to determine which interpretation is more reasonably consistent with the rule and the underlying statute. ORS 183.482(8)(a); *Beverly Enterprises, Inc. v. Senior Seruices Div.*, 106 Or App 739, 745, 809 P2d 1360 (1991).

The Oregon lockout/tagout standard for controlling hazardous energy is almost identical to its federal counterpart, which was issued by the Occupational Safety and Health Administration (OSHA) on September 1, 1989. 54 Fed Reg 36,644. OAR 437-02-1910.147(a)(1)(ii)(B), the rule in question, was taken verbatim from 29 CFR 1910.147(a)(1) (ii)(B). ORS 654.003(6) provides:

> **119 Or App 21>** "Oregon assumes fullest responsibility, in accord with the federal Occupational Safety and Health Act of 1970 (Public Law 91-596), for the development, administration and enforcement of safety and health laws and standards."

Because Oregon adopted the federal rules governing the lockout/tagout standard, we look to the federal purpose to assist in discerning the Oregon purpose. *See, e.g., McKean-Coffman v. Employment Div.*, 312 Or 543, 550, 824 P2d 410, *on remand* 314 Or 645, 842 P2d 380 (1992). In issuing its final rule governing the lockout/tagout standard for the purpose of controlling hazardous energy, OSHA commented:

> "OSHA has determined that certain installations under the exclusive control of electric utilities, as defined in [29 CFR 1910.147] paragraph (a)(l)(ii)(B), are not to be covered by this rule [concerning the lockout/tagout requirements]. These installations are intended to be covered separately by a new section, 1910.269, 'Electric Power Generation, Transmission and Distribution,' which OSHA proposed on January 31, 1988 (54 FR 4974). Because of the nature of these electrical utility operations, 1910.269 will tailor the key provisions of this standard on lockout or tagout to meet the special safety needs of that industry. " 54 Fed Reg at 36,660.

That comment makes it clear that certain installations are not subject to the lockout/tagout standard as provided, because they are to be addressed specifically by a separate section proposed in 29 CFR 1910.269. In proposing that section, OSHA intended it to be applied to "electric power generation, transmission, and distribution facilities":

> "Proposed 1910.269 would apply to the parts of an electric utility operation that are directly involved with the generation, transmission, or distribution of electric power. Installation in buildings not used for one of these purposes would not be covered by the standard. For example, office buildings, warehouses, machine shops, and other installations which are not an integral part of generating plant, substation, or control center would not be covered by proposed 1910.269. Work performed in these installations would not be of a type addressed by the proposal. " 54 Fed Reg 4,974; 4,980.

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[2] Specifically, PGE argues that its Salem facility is not subject to the lockout/tagout standard, because its "primary purpose is to provide a central control center for crews and trucks to be dispersed into the field in order to *distribute* power to PGE customers." (Emphasis supplied.)

Although the proposed rule has not been finally adopted, it sheds light on OSHA's intent in promulgating 29 <119 Or App 21/22> CFR 1910.147(a)(1)(ii)(B). That intent is that only the facilities that directly generate, transmit or distribute electric power are not subject to the lockout/tagout standard as provided in 29 CFR 1910.147. Because PGE's facility is not such a facility, it is subject to the standard in the Oregon counterpart of the federal rule. The Board erred in holding otherwise.

Reversed and remanded for reconsideration.

March 31, 1993 Cite as 119 Or App 69 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DOUGLAS COUNTY FARMER'S CO-OP, *Petitioner,*

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and Department of Insurance and Finance, *Respondents.*

(90-07-017; CAA72093)

Judicial Review from Department of Insurance and Finance.

Argued and submitted July 17, 1992.

Inge D. White, Roseburg, argued the cause for petitioner. With her on the brief was Dole, Coalwell & Clark, P.C., Roseburg.

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.

Michael D. Reynolds, Assistant Solicitor General, Salem waived appearance for respondent Department of Insurance and Finance.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

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119 Or App 71> Petitioner seeks review of a final order of the Department of Insurance and Finance (DIF), which upheld the National Council on Compensation Insurance's (NCCI) classification of petitioner's hardware and feed department employees. We affirm.

Petitioner owns and manages a farmer's co-op that operates a fertilizer plant, a pump department, a feed department and a hardware department. The hardware and feed departments are located in the same building, although each has its own street address and a separate entrance. The two departments share the same management and accounting personnel, shipping and receiving clerks, a conveyor belt for transporting merchandise, telephone numbers, utility and telephone bills, sales invoice forms and advertising. Clerks assigned to work in one department do not work in the other department and, although the departments are essentially physically separate, a narrow stairway, for employee use only, connects them. Approximately 70 percent of the gross sales from the building come from feed, tack and veterinary materials, fencing and miscellaneous merchandise.

NCCI is a licensed rating organization for workers' compensation insurance. Its classifications and rates have been approved by DIF and are used to determine the premiums that individual businesses are charged. *See OAR* 83642-020; OAR 836-42-045. The classifications used by NCCI are included in a publication entitled *Scopes of Basic Manual Classifications* (Scopes). NCCI also publishes a manual that includes rules that guide its interpretation and application of the Scopes' classifications. It is called *Workers Compensation and Employers Liability* (Manual).

Following an inspection of petitioner's business, NCCI determined that petitioner's hardware and feed departments were in the same building and, therefore, were operating at the same location for purposes of rule IV-D-9 of the Manual. It then classified both the hardware and feed departments' employees at that location within classification 8215 --Hay, Grain or Feed Dealer & Local Managers, Drivers. The underwriting guide to the Manual states that a store that "sells several types of merchandise, each of which may be <119 Or App 71/72> subject to a different classification, * * * [is to] be assigned on the basis of the principal category of merchandise sold. The term 'principal' means more than 50 percent of the gross receipts." Because over 50 percent of petitioner's gross sales receipts from the operations at that location came from merchandise described under classification 8215, that classification was given to employees in both departments.

Petitioner's position is that its hardware personnel should be classified under Scopes Code 8010--Store: Hardware. It first sought review of the classification with the Oregon Classification and Rating Committee of NCCI (OC&R). OC&R affirmed the classification. Petitioner then requested review of the classification with DIF pursuant to ORS 737.505. DIF also affirmed the classification.

Petitioner agrees that rule IV-D-9 of the Manual applies, because its operation is a mercantile business. That rule provides:

> "For mercantile businesses, such as stores or dealers, the classification is determined separately for each location."

Petitioner contends, however, that DIF erred in concluding that businesses operated in the same building are at the same "location" for purposes of Manual Rule IV-D-9. Petitioner asserts that, in defining "location" as the same building or site, NCCI and DIF have acted in a manner that is "arbitrary, inconsistent with NCCI's manual rules and bears no relationship to the risks being incurred by the employees."

As a general rule, the NCCI rating system classifies the business of the employer as a whole and does not apply separate classifications for separate employments, occupations or operations within the business. Manual Rule IV-A; *Mr. Lustre Car Care v. Nat'l Council on Comp. Ins.*, 99 Or App 654, 783 P2d 1032 (1989). However, as petitioner points out, there are exceptions to this general rule. For example, Manual Rule IV-B-2 allows a separate classification for clerical workers if they are "physically separated" from the other operations. Petitioner asserts that, because that exception only requires "physical separation," the exception for the classification of mercantile businesses must be based on the same test. We disagree. The fact that some classifications are made on the basis of physical separation of the workers does **<119 Or App 72/73>** not compel the agency to make all classifications on that basis. Further, the classification by location of mercantile business is not arbitrary. As explained in the hearings officer's order, the purpose of Manual Rule IV-D-9 is to allow entities opening mercantile businesses to have some control over their premium rates by operating different businesses at different locations:

> "NCCI understood that each legal entity preferred that its mercantile business be classified within the lowest-rated category of any merchandise sold by the business as a whole. By doing so, the NCCI established an equitable rule which allows any legal entity to establish as many locations as it may choose, determine the merchandise categories it offers for sale at each location, and maintain some control of the workers' compensation premium rate at each location."

We also do not agree that NCCI and DIF's application of the rule is unfairly discriminatory. DIF's rules provide:

> "Premiums are unfairly discriminatory if differentials between insureds fail to reasonably reflect the differences in expected losses and expenses to the insurer attributable to the insureds. Workers' compensation insurance rates, rating plans or rating systems are not unfairly discriminatory when different premiums result or different rates apply to insureds if:
>
> "(a) Differences in loss exposures, expense factors or investment income opportunity to an insurer can be attributed to the insureds; and
>
> "(b) The differences are reasonably reflected by the rates, rating plan or rating system." OAR 836-42-025(3).

Petitioner has offered no evidence that NCCI treats similarly situated employers differently. All mercantile businesses that sell a variety of merchandise in the same building are charged the premium applicable to that category of merchandise producing over 50 percent of the business's gross receipts. We conclude that DIF did not err in upholding NCCI's classification of petitioner's hardware and feed department's employees.

Affirmed.

April 14, 1993 Cite as 119 Or App 202 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Kathleen C. **McQUIGGIN**, *Appellant*,
v.
Julie G. **BURR** and Washington County, *Respondents*.
(A8805-02846; CA A61122)

Appeal from Circuit Court, Multnomah County.
Samuel J. Imperati, Judge pro tempore.
Argued and submitted January 22,1993.
Bradley C. Berry, Newberg, argued the cause for appellant. With him on the brief were Donald O. Tarlow and Brown, Tarlow & Berry, P.C., Newberg.
Lisa E. Lear, Portland, argued the cause for respondents. With her on the brief were Douglas R. Andres and Bullivant, Houser, Balley, Pendergrass & Hoffman, Portland.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
EDMONDS, J.
Reversed and remanded.

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119 Or App 204> Plaintiff appeals the trial court's judgment for defendant, dismissing plalntiff's tort action after a bifurcated trial, on the ground that defendants are immune from liability because plaintiff's claim was covered under workers' compensation law. *See* ORS 30.265(3)(a).[1] We reverse, because plaintiff is an independent contractor, not an employee.

On review, we are bound by the trial court's findings if they are supported by any evidence in the record. *Illingworth v. Bushong*, 297 Or 675, 694, 688 P2d 379 (1984). Based on those facts, we review to determine if the trial court erred as a matter of law in reaching its conclusion.

Plaintiff began her relationship with Milwaukie Floral in January of 1985. Her job was to care for plants at businesses that contracted with Milwaukie Floral for such services. In May, 1986, she was injured when her car was hit from the rear by defendant Burr, an employee of defendant Washington County. At the time of the accident, she was en route to the next location designated by Milwaukie Floral.

The trial court found:

> "[T]he written contracts require the plaintiff to `service and maintain plants' and that the `satisfactory performance' of this task will be established by a task log that provides store identification, date, job performed and endorsement. It is obvious that the plaintiff and [her supervisor] saw their working relationship as result-oriented. Milwaukie Floral was only concerned about the presentability of the plants. However, the presentability of the plants could only be maintained by the services performed by the plaintiff. This was a service-oriented business by its nature and required **labor** in order to accomplish the end product marketed by Milwaukie Floral."

119 Or App 205> The trial court outlined the agreement between plaintiff and Milwaukie Floral:

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[1] ORS 30.265(3)(a) provides:

"Every public body and its officers, employees and agents acting within the scope of their employment or duties, or while operating a motor vehicle in a ridesharing arrangement **** are immune from liability for:

"(a) Any claim for injury to or death of any person covered by the workers' compensation law."

> "The contracts establish that Milwaukie Floral's payments to the plaintiff were predicated upon the plaintiff's servicing and maintaining plants at the various described locations on a twice-monthly basis of no less than 12 days apart, during described hours and maintaining a task log of her activities.
>
> "* * * * *
>
> "The contract provided compensation at the rate of $15.00 per location. At the time of the accident, payment was definitely by the piece. Ultimately, the compensation formula was changed and a portion of the monies paid was characterized as mileage reimbursement for tax and accounting purposes.
>
> "* * * * *
>
> "[T]he contract sets forth that either party may terminate the agreement with thirty-days' notice. They essentially renewed their relationship on a monthly basis. [Plaintiff's supervisor] didn't feel he had a `moral right' to terminate her as long as she was doing her job. He was not sure what his rights were under the contract."

The trial court described how the contract provisions were carried out:

> "I find that the plaintiff could determine her own working hours and days. A contractual requirement that her visits were to be at least 12 days apart and during the time Milwaukie Floral customers were open does not defeat the fact that she had total control over when she worked.
>
> "* * * * *
>
> "The contract provides that Milwaukie Floral will supply garden supplies and equipment. [Plaintiff's supervisor] testified that he would have given her tools, but he is not sure he had done so. He does remember paying for some fertilizer but recognizes that she may have also purchased some on her own. The question here is primarily whether the plaintiff provided the major tools of the trade. Here, the major `tool' was plaintifFs automobile which she used while performing her duties. She paid for the fuel, maintenance and insurance.
>
> "* * * * *
>
> "While Milwaukie Floral provided or made available some supplies, the plaintiff also purchased a large number of her <119 Or App 205/206> own supplies and equipment. *** While a good number of the supplies were inexpensive, they were nevertheless furnished by the plaintiff who also provided her car which was the tool most indispensable to the performance of the job."

Furthermore, the trial court found that the management style of Milwaukie Floral was virtually "non-existent," that Milwaukie Floral seldom interfered with plaintifFs performance, and that "the only thing Milwaukie Floral cared about was whether or not the plants were maintained in a presentable condition. Plaintiff had the discretion to choose the method of maintenance." PlaintifFs supervisor testified that "he did not care who went to the job site locations." Occasionally, plaintiff had friends assist her, and her supervisor did not object. The trial court found that plaintiff's supervisor provided

> "some *initial* instruction and direction concerning plant maintenance; [however,] it is clear that he discontinued the requirement of her to complete the task logs and, at best, consulted with her concerning plant care versus supervising her in the skills of the trade. It is clear that day-to-day decisions concerning the timing and manner of care, along with routes selected, were left solely to plaintiff's discretion. Milwaukie Floral was only concerned with whether the plants remained in a presentable condition. [Plaintiff's supervisor] did not feel he could require the plaintiff to deliver *** gifts during the holiday season and he was unsure whether he could make the plaintiff take on new customers."

There is evidence to support the trial court's findings. The inquiry is whether, on those facts, plaintiff is an independent contractor or an employee of Milwaukie Floral.[2] An employee is covered by the Workers' Compensation Act if she is "subject to the direction and control of an employer." ORS 656.005(27).[3] An employer under ORS chapter 656 is one who has "the right to direct and control the services of any person. ORS 656.005(13). To test whether Milwaukie **<119 Or App 206/207>** Floral had the right to control plaintiff, we apply the traditional "right to control" analysis and also consider the "nature of the work." *Woody v. Waibel,* 276 Or 189,196,554 P2d 492(1976).

The principal factors in 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).

Although the contract listed the locations where plaintiff was to perform her services, plaintiff had flexibility in scheduling when she worked. Under her contract, she was required to go to each location two times a month and to make the visits at least 12 days apart. Those circumstances are not indicative of "employee" status. *See Jenkins v. AAA Heating & Cooling Inc.,* 245 Or 382,386,421 P2d 971(1966). Also, the parties expressly refer to plaintiff in the contract as an independent contractor. Although that fact is not controlling, it is not to be disregarded, and "in a close case, it may swing the balance." *Henn v. SAIF,* 60 Or App 587, 592, 654 P2d 1129(1982), *rev den* 294 Or 536(1983).

Similarly, although the fact that plaintiff was paid by the visit is not conclusive evidence of her status, it does suggest that Milwaukie Floral's interest was in the results that she achieved. *See Carlile v. Greeninger,* 35 Or App 51,54, 580 P2d 588, *rev den* 283 Or 235(1978). Likewise, the facts that plaintiff furnished the major "tool" of the business, her car, and was not reimbursed for her transportation expenses, weigh against the conclusion that she was an employee. In regard to the "right to fire" factor, the contract provides that *either* party could terminate the contract after giving 30 days notice. That provision also could be indicative of an independent contractor relationship. *Henn v. SAIF, supra,* 60 Or App at 593.

Moreover, certain evidence about the nature of plaintiff's work and Milwaukie Floral's business suggests that she was an independent contractor. Plaintiff worked part time and decided when she would visit each store. The day-to-day decisions were left to her discretion. Her work did not require her to contact her supervisor on a regular basis, nor did her **<119 Or App 207/208>** supervisor routinely check her work. She furnished some of her own supplies for her work. Plant maintenance was not, as far as the record shows, an integral part of Milwaukie Floral's business.

Based on all the evidence, we conclude that, under the "right to control" and the "nature of the work" tests, plaintiff was an independent contractor. Therefore, the trial court erred in holding that defendants were immune from liability under ORS 30.265(3)(a).

Reversed and remanded.

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[2] The 1989 amendments to the statutes relating to independent contractors are not applicable to this case. Or Laws 1989, ch 762, § 1; former ORS 701.025 (renumbered ORS 670.600 in 1991).

[3] ORS 656.005(27) has since been renumbered subsection (28). Or Laws 1990, ch 2, §3.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arthur L. Ennis, Claimant.

KIEWIT PACIFIC and Standard Fire Insurance, *Petitioners,*
v.
Arthur L. **ENNIS**, *Respondent.*
(90-02644; CA A70803)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 13, 1992.
Darren L. Otto, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Eileen G. Simpson, Eugene, argued the cause for respondent. With her on the brief was Martin J. McKeown, Eugene.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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119 Or App 125> Employer seeks review of a Workers' Compensation Board order holding that claimant's injury is compensable. The issue is whether the injury is work-related. We affirm.

Claimant worked for employer on a road construction job. Employer provided employee parking at an off-road, graded area on the side of Highway 42, about 20 miles west of Roseburg. The parking lot facilitated employer's transportation of employees to the work site. Claimant drove to work on Highway 42 and slowed almost to a stop to negotiate the right turn into the parking area. There were other routes to the parking area, but none as direct. The Board's order states:

> "When turning into the parking area, claimant was required to slow down, almost to a stop, before entering the parking area. Thus, claimant was exposed to the greater hazard of potentially being hit from behind than was the general public which would continue down the road, without slowing down to turn. Accordingly, we conclude that, by requiring claimant to park in this specific area, claimant was exposed to hazards peculiar to his employment and not experienced by traveling members of the common public."

When claimant's vehicle turned into the driveway, it stalled. The rear portion that extended into the roadway was struck from behind by a log truck. The Board held that claimant's resulting injury was compensable, because his employment exposed him to a greater hazard than that encountered by the general public.

Employer first argues that the Board's order is inadequate for review under the rule stated in *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975):

> "If there is to be meaningful judicial scrutiny of the activities of an administrative agency--not for the purpose of substituting judicial judgment for administrative judgment but for the purpose of requiringthe administrative agency to demonstrate that it has applied the criteria prescribed by statute and by its own regulations and has not acted arbitrarily or on an ad hoc basis--we must require that its order clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes."

Employer contends that the Board did not explain why it concluded that slowing down to turn into the parking area **<119 Or App 125/126>** created a hazard peculiar to the employment, because all people slowing down to turn off busy roads are subject to potential rear-end collisions. We reject that argument. The Board found that stopping and turning into *this* parking area at employer's direction created a peculiar hazard, because members of the general public would not stop and turn at that place. Only employees were required to encounter that risk. The order is adequate for review.

Employer next assigns error to the Board's conclusion that the injury was compensable. It argues that the Board misapplied the "going and coming" rule, that the hazard to claimant was the same experienced by all motorists when they stall on or turn from a highway, and that the collision occurred on the highway before claimant had entered employer's premises.

As a general rule, injuries sustained while the employee is going to or coming from work are not compensable, because they do not arise out of and in the course of employment. *See SAIF v. Reel,* 303 Or 210, 216, 735 P2d 364 (1987). The rule has several exceptions. In *Nelson v. Douglas FirPlywood Co.,* 260 Or 53,57,488 P2d 795 (1971), the court held that,

> "[i]f the employee's employment requires him to use an entrance or exit to or from his work which exposes him to hazards in a greater degree than the common public, he is regarded as being within the course of his employment."

In *Nelson,* the worker was injured while driving to work. As she turned onto a company-owned road, a company-owned truck collided with her car. The road was primarily used by employees and was the only way to reach the work site. The court held that turning onto the private road into the face of employer-generated truck traffic exposed her to hazards "peculiar to her employment and not experienced by traveling members of the general public." 260 Or at 57.

The Board correctly followed the rule in *Nelson.* Employer required claimant to use the designated employee parking lot for its convenience. The entrance was constructed so that entering employees were required to come to a virtual stop in the traffic lane in order to negotiate the turn. That exposed employees to a risk of rear-end collision. The risk to **<119 Or App 126/127>** employees was greater than that to which the general public was exposed. Traveling members of the general public did not encounter the risk. They did not slow down to enter the lot because they did not use it. Substantial evidence supports the Board's finding that the injury had a sufficient work relationship because employer's requirement that claimant use the parking lot exposed him to a hazard peculiar to his employment and not experienced by traveling members of the public.

Employer seeks to distinguish *Nelson u. Douglas Fir Plywood Co., supra,* by arguing that, in *Nelson,* a private road was the sole means of ingress and egress by automobile to employer's premises, and the claimant was struck by an employer-operated vehicle. Thus, the "claimant was held captive to the hazard of collisions with the employer's own vehicles while the general public was not."

> The public nature of Highway 42 is not controlling. As the court said in *Nelson:*
>
> "It is immaterial whether the road the employee is required to travel in order to reach the plant is public or private if the employee is exposed to hazards in a greater degree than the common public." 260 Or at 57.

Under *Nelson,* the injury is work-related if the employee is using the employer-created hazardous work entrance. The evidence supports the Board's finding that the accident occurred while claimant was using the driveway provided by employer.

Cope v. West American Ins. Co., 309 Or 232, 785 P2d 1050 (1990), requires us to focus on the presence of employercreated hazards in determining whether an injury occurring on public property had sufficient work relationship. In *Cope,* an employee had parked her car in an employee parking lot and was struck by a car driven by another employee as she stood on a sidewalk, intending to cross the street to go to work. The court concluded that the injury was not compensable, because the employer had not made the public sidewalk hazardous for employees:

> "When an employee is injured on a public sidewalk over which the employer has no control, and on which there are no employer-created hazards, the connection between the **<119 Or App 127/128>** injury and the employment is insufficient to make the injury compensable." 309 Or at 240.

The presence of an employer-created hazard here supports the Board's conclusion that the injury was connected to employment.

The facts also distinguish this case from *Adamson v. The Dalles Cherry Growers, Inc.*, 54 Or App 52, 633 P2d 1316 (1981), on which employer relies. In *Adamson,* the claimant was injured when she slipped on an icy public street. It was near the work site, and employees frequently used it. It was the only route that the claimant could take to work that day. We affirmed the Board's order denying compensability because, among other things, the street was not a part of the employer's premises, and the employer did not exercise control over street traffic. Nothingin the facts suggested that the claimant should be excepted from the going and coming rule. Here, employer required claimant to use a particular lot for its convenience. The entrance exposed claimant to greater risks than those faced by the general public. Claimant was injured as he encountered that risk by turning into the driveway. The Board correctly concluded that he was not excluded by the going and coming rule and, that under *Nelson,* the injury occurred within the course of his employment.[1]

Affirmed.

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[1] Claimant testified that employer paid him for travel time. The testimony was not rebutted. The referee found that employee was not paid for travel time. The Board rejected that finding, but made no finding of its own regarding pay for travel time. If the Board intended its action to be a finding of fact on the issue, it should say so. In *Bernards v. Wright,* 93 Or App 192, 196, 760 P2d 1388 (1988), we said:

> "An employee is generally not within the [going and coming] rule if he is compensated by the employer for 'travel time.'"

April 14, 1993 Cite as 119 Or App 194 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Charles E. Condon, Claimant.

SAIF CORPORATION and Gilchrist Timber Company, *Petitioners,*
v.
Charles E. **CONDON**, *Respondent.*
(91-00585; CA A74780)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 14, 1992.
Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Geoffrey G. Wren, Portland, argued the cause for respondent. With him on the brief was Royce, Swanson & Thomas, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
RIGGS, J.
Reversed.

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119 Or App 196> SAIF seeks judicial review of a Workers' Compensation Board order awarding attorney's fees under ORS 656.382(1). We reverse.

On November 30, 1989, claimant began treatment for depression resulting from a compensable injury to his lower back. SAIF was notified of the treatment on December 21, 1989. However, SAIF did not issue an acceptance within 90 days of notification. In an August 13, 1990, telephone conversation, SAIF advised claimant's psychiatrist that psychiatric treatment was a part of the accepted low back claim. SAIF paid all the bills for that treatment.

Claimant requested a hearing, which convened on April 1, 1991. On that date, SAIF accepted the claim, which was more than a year late. The referee held that the acceptance rendered the issue of compensability moot and refused to award any insurer-paid penalties or attorney fees. On appeal, the

Board affirmed in part and reversed in part the referee's order and awarded claimant an insurer-paid attorney fee of $1700 under ORS 656.386(1)[1] and $300 under ORS 656.382(1).

SAIF assigns error only to the award of attorney fees under ORS 656.382(1).

> "If an insurer or self-insured employer * * * 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 * * *."

An insurer cannot unreasonably resist the payment of compensation that has been paid. *Aetna Casualty Co. v. Jackson,* 108 Or App 253, 257, 815 P2d 713 (1991). The award of attorney fees pursuant to ORS 656.382(1) was wrong as a matter of law.

Reversed.

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[1] ORS 656.386(1) permits recovery of penalties and attorney fees "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held."

April 21, 1993 Cite as 119 Or App 252 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gregory L. Potts, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and KOIN TV, Inc., *Petitioners,*
v.
Gregory L. **POTTS**, *Respondent.*
(WCB 90-05167; CA A70348)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1992.

M. Kathryn Olney, Senior Trial Counsel, Liberty Northwest Insurance Corporation, Portland, argued the cause and filed the brief for petitioners.

Martin L. Alvey, Portland, argued the cause for respondent. With him on the brief was William H. Skalak, Portland.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

RICHARDSON, C. J.

Affirmed.

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119 Or App 254> Liberty Northwest Insurance Corporation (Liberty), employer's insurerj seeks review of a decision by the Workers' Compensation Board that claimant's injury is compensable. Liberty argues that claimant was an independent contractor under ORS 701.025,[1] not an employee, at the time of the injury. The Board determined that subsection (1) of ORS 701.025 had not been satisfied, because claimant was not free from the direction and control of employer and, consequently, he was not an independent contractor. We affirm.

Claimant is a "grip" in the film production industry. A grip's main tasks involve setting up and moving cameras and lighting equipment. Grips are skilled workers paid by the job. They furnish some of their own tools.

Claimant worked under a "key" or lead grip and a director. The director supervised the key grip who, in turn, hired grips and gave them directions based on the director's instructions. Generally, claimant had little control in determiningthe hours he worked or the way in which he completed his work. He was told when to be on the set and when to take breaks. More specifically, he was told how to set up lighting and where to place lights, cameras and related equipment. He was instructed where and when to move the equipment. At the time he was injured, the key grip had told him to get some equipment from a company truck. Substantial evidence supports the Board's finding that he was not free from the direction and control of employer at the time of his injury.

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[1] ORS 701.025 was renumbered ORS 670.600 in 1991.

Liberty argues that, even if the Board's finding is supported by substantial evidence, it erred in not making findings on all eight factors listed in ORS 701.025. The statute defines "independent contractor" by reference to eight standards. Although the statute does not explicitly state that each of the eight standards must be met to establish status as an independent contractor, its language indicates that that was the legislature's intent. The introductory paragraph states that an individual is an independent contractor "if the *standards* of this section are met." Moreover, each of the eight standards is joined by the conjunctive "and." **<119 Or App 254/255>** Because the statute requires that all eight standards be met before a claimant is considered an independent contractor, the failure to meet the criteria in subsection (1) was dispositive. The Board was not required to address the other factors.[2]

Affirmed.

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[2] Liberty relies on *Timberline Lodge u. Kyle*, 97 Or App 239, 775 P2d 899 (1989).That case is distinguishable. There, the issue was whether the evidence in the record supported the Board's determination that the claimant's injury was work-related. We remanded the case, because the Board had not made specific findings as to some of the required factors. We could not affirm the compensability of the claim when the necessary requirements were not supported by findings. In contrast, we do not need further findings here, because the failure to meet even one requirement means that the statutory definition of an independent contractor is not satisfied.

April 21,1993 Cite as 119 Or App 282 (1993)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Nancy P. Magnuson, Claimant.

CNA INSURANCE COMPANIES and Litton Industries, *Petitioners,*
v.
Nancy P. **MAGNUSON**, *Respondent.*
(WCB 90-21930; CA A72359)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 18, 1992.
Charles L. Lisle, McMinnville, argued the cause for petitioners. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Charles H. Seagraves, Jr., Grants Pass, argued the cause for respondent. With him on the brief was Myrick, Seagraves, Adams and Davis, Grants Pass.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
RICHARDSON, C. J.
Affirmed.

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119 Or App 284> Employer petitions for review of an order of the Workers' Compensation Board holding that its retroactive denial of claimant's previously accepted claim was improper. It argues that the Board erroneously interpreted and applied ORS 656.262(6). We affirm.

Claimant filed a claim for compensation in January, 1989, asserting that exposure to soldering fumes at work caused her to have respiratory problems. Two physicians, Sinclair and Montanaro, examined claimant. Neither physician could state, to a medical probability, that claimant's work exposure was the major contributing cause of her respiratory conditions. Nevertheless, after receiving both doctors' reports, employer accepted claimant's claim for "lung irritant exposure" on June 28, 1989. One year later, in June, 1990, the claim was closed by determination order with an award of unscheduled permanent partial disability.

In May, 1990, ORS 656.262 was amended to allow previously accepted claims to be denied under certain circumstances. The amendments became effective July 1, 1990. In October, 1990, employer sought and obtained a letter from Sinclair regarding claimant's condition. On the basis of that letter, it issued a denial of the claim pursuant to ORS 656.262(6).

Claimant requested a hearing on the denial. The referee found that the "back-up" denial was improper under ORS 656.262(6) and imposed penalties pursuant to ORS 656.262(10). The Board affirmed and adopted the referee's decision regarding the propriety of the denial but reversed, in part, the referee's assessment of penalties.

Employer assigns error to the Board's interpretation and application of ORS 656.262(6), which provides, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. *However, if the insurer or selfinsured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or euidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two* **<119 Or App 284/285>** *years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. How*ever, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible for the claim. " (Emphasis supplied.)

Employer argues that Sinclair's letter confirming his earlier report, in the light of new case law about the standards for determining occupational diseases, constitutes the "later obtain[ed] evidence" required by the statute. The Board interpreted the statute's requirement for later obtained evidence to mean *new* material obtained *"after* the acceptance of the claim." The Board found that Sinclair's October letter did not meet that requirement, because it essentially expressed the same opinion given in the earlier report. The Board also rejected employer's argument that new interpretations of the law constitute new material warranting a back-up denial under ORS 656.262(6).

The amendment allowing back-up denials specifically sought to change the law articulated in *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). Tape recording, Joint House and Senate Committee, 1990 Special Legislative Session, May 3, 1990, Tape 1, Side B at 275. In *Bauman,* the court held that a retroactive denial was proper only in cases of fraud, misrepresentation or other illegal activity by the claimant. Because the burden for justifying retroactive denials was high, the drafters believed that insurers had a tendency to deny claims from the outset:

> "So what has happened is a number of insurers and selfinsured employers have denied claims because they know they can never turn around and deny them if evidence comes in at a later date." Tape Recording, Joint House and Senate Committee, 1990 Special Legislative Session, May 3, 1990, Tape 1, Side B at 275.

An integral part of the legislature's concern about "nervous denials" was that evidence substantiating a denial might develop after an acceptance of the claim, because the time for accepting or denying claims was relatively short.

Given the legislative history, the Board's interpretation of the statute is consistent with the legislative policies **<119 Or App 285/286>** underlying the amendment. The legislature intended that evidence warranting a retroactive denial "come about" after the insurer's original acceptance. We agree with the Board's interpretation that the statute requires new material, *i.e.,* something other than the evidence that the insurer had at the time of the initial acceptance. The letter that employer offers as new evidence merely repeats the doctor's earlier report that he was unable to determine whether the work environment was the major contributing cause of claimant's respiratory problems.

We also agree with the Board's rejection of employer's contention about new interpretations of the law. Employer's argument is, essentially, that it properly accepted the claim on the basis of the medical reports under then existing interpretations of the burden of proving an occupational disease. When that interpretation was changed, the existing medical reports take on new significance. However, a reevaluation of known evidence, for whatever reason, is not "later obtain[ed] evidence" under ORS 656.262(6).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gerald W. Senters, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Bohemia, Inc., *Petitioners,*
v.
Gerald W. **SENTERS**, B.J. Equipment and SAIF Corporation, *Respondents.*
(91-00042; CA A75719)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 29, 1993.
David O. Wilson, Eugene, argued the cause and filed the brief for petitioners.
Edward Harri, Eugene, argued the cause for respondent Gerald W. Senters. On the brief were Christine Jensen and Malagon, Moore, Johnson, Jensen & Correll, Eugene.
Steven Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents B.J. Equipment and SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General and Virginia L. Linder, Solicitor General, Salem.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P. J..
Affirmed.

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119 Or App 316> Liberty Northwest Insurance Corporation (Liberty) seeks review of an order ofthe Workers' Compensation Board determining that it is responsible for claimant's right shoulder and low back condition.

Claimant sustained a low back injury while working for Liberty's insured in March, 1988. Dr. Hockey performed a lumbar laminectomy at L5-S1. Liberty accepted the claim and, by stipulation, awarded claimant 7.5 percent unscheduled permanent partial disability. In August, 1989, claimant began working for SAIF's insured. In October, 1990, he began to feel pain in the low back and right leg. The symptoms were identical to those he had experienced after the 1988 injury.

Hockey treated claimant for a recurrent herniated disc at L5-S1, and performed a second laminectomy on October 29, 1990. Claimant had a third surgery on November 5, 1990, to remove two large disc fragments impairing the right S1 nerve root. After the surgery, claimant had pain in his right shoulder as a result of the way in which he had been positioned on the operatin~ table.

Liberty denied responsibility for claimant's right shoulder and back condition and requested the designation of a paying agent under ORS 656.307. Claimant filed a claim for his low back condition with SAIF, which denied responsibility for both the low back and the right shoulder. It later denied the compensability of the claim. A referee designated Liberty as the PaYin~ a~ent.

The Board, in affirming the referee, found that claimant had suffered an aggravation of his low back condition after the closure of his claim. It found, further, that the 1988 injury is the major contributing cause of the disability and need for treatment for the back. It found that the shoulder condition is "intrinsically related" to the disc herniation, "the treatment for which is the major contributing cause of the development of the shoulder condition." Those findings are supported by substantial evidence.

The Board held that the low back condition is compensable. It analyzed the question of responsibility under **<119 Or App 316/317>** ORS 656.308, which provides:

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

> "(2) * * * Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease."

The Board held that, in light of subsection (2) of the statute, which refers repeatedly to the claim for "injury or disease," the term "compensable injury," as used in subsection (1), is intended to encompass occupational disease claims. We agree.

The Board held that, in order for Liberty to shift responsibility for claimant's back condition to SAIF, it would have to establish that, during the employment with SAIF's insured, claimant experienced a new compensable injury or occupational disease. We agree with that analysis. *See SAIF v. Drews,* 117 Or App 596,845 P2d 217 (1993). Additionally, the Board reasoned that proof of a new compensable occupational disease would require Liberty to establish that employment conditions at SAIF's insured were the major contributing cause of claimant's disease or its worsening. That is the standard of proof for the establishment of an occupational disease, ORS 656.802(2), and we agree with the Board that that is what Liberty must show in order to shift responsibility for claimant's back condition to SAIF. The Board found that claimant did not develop an occupational disease during his employment with SAIF's insured, and concluded that responsibility remains with Liberty. The Board's findings are supported by substantial evidence, and we affirm its determination that Liberty remains responsible for claimant's low back condition.

119 Or App 318> Liberty does not contend that the Board erred in assigning it responsibility for the shoulder condition; accordingly, we do not address that condition separately.

Affirmed.

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