In the Matter of the Compensation of
STEVEN B. MATTHEWS, Claimant
WCB Case No. 92-01353
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Crumme's order that: (1) set aside an Order on Reconsideration on the grounds that it was invalidly issued; (2) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD); and (3) dismissed claimant's hearing request. On review, the issue is the validity of the Order on Reconsideration and, if the Order on Reconsideration is valid, the authority of the Hearings Division or the Board to promulgate a temporary rule pursuant to ORS 656.726 addressing claimant's permanent disability and the extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

We take administrative notice of the fact that on June 17, 1992, subsequent to the Referee's June 1, 1992 order and prior to the Referee's August 10, 1992 Order on Reconsideration, the Department of Insurance and Finance (Department) abated and withdrew its January 15, 1992 Order on Reconsideration and issued a revised Order on Reconsideration on June 22, 1992, which allowed an additional value of 5 percent for claimant's chondromalacia condition, pursuant to (temp.) OAR 436-35-230(13).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Department subsequently withdrew its Order on Reconsideration and issued a revised Order on Reconsideration which reconsidered claimant's impairment in light of the promulgation of OAR 436-35-230(13). We have previously held that the fact that the Department abates and withdraws an Order on Reconsideration while Board review is pending, does not render the issue raised on review moot. Marvin L. Thrasher, 45 Van Natta 565 (1993); Kenneth G. Moore, 45 Van Natta 16 (1993). Consequently, claimant's request for review concerning the extent of his permanent disability is properly before the Board and we consider the issues raised in the request.

The Referee found that the Director had failed to complete the mandatory reconsideration process under ORS 656.268(5). The Referee specifically found that the Director had failed to follow the mandatory procedures outlined in ORS 656.726(3)(f)(C) for adopting temporary rules and analogized the failure to adopt temporary rules to a failure to follow the mandatory medical arbiter requirement set out in ORS 656.268(7). On this basis, the Referee set aside the Order on Reconsideration as invalid, found that jurisdiction over this matter remained with the Department and dismissed claimant's hearing request.

On review, claimant first argues that since the statutory time period for the reconsideration process had expired, the Referee acquired jurisdiction to issue a temporary rule pursuant to ORS 656.726(3)(f)(C). We disagree.

ORS 656.726(3)(f)(C) provides that when it is found that the worker's disability is not addressed by the standards, the Director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment. In Gary D. Gallino, 44 Van Natta 2506 (1992), we held that ORS 656.726(3)(f)(C) reserves to the Director the authority to make findings concerning whether or not the worker's disability is addressed by the standards and, if not, to stay further proceedings and adopt temporary rules amending the standards to accommodate the worker's impairment. We further held that neither the Hearings Division nor the Board has authority to adopt standards or to require the Director to enact rules for evaluating disability.

Applying the holding in Gallino to this case, we conclude that regardless of whether the statutory time limits for the reconsideration process had expired, the Referee was without statutory authority to enact temporary rules addressing claimant's permanent disability. Accordingly, we reject

claimant's arguments that the Referee had authority to enact temporary rules addressing claimant's chondromalacia.

Finally, we disagree with the Referee's conclusion that the Director failed to complete the mandatory reconsideration process under ORS 656.268(5). The mandatory provisions of ORS 656.726(3)(f)(C) which require the Director to stay further proceedings and adopt temporary rules only become operative if the Director makes a finding that the standards do not address a worker's disability. Here, the Director did not make a finding in the January 15, 1992 Order on Reconsideration that the standards did not address claimant's impairment. Absent such a finding, the mandatory portions of ORS 656.726(3)(f)(C) did not apply and the Referee should not have declared the January 15, 1992 Order on Reconsideration invalid.[1] Accordingly, we reinstate claimant's hearing request and address the extent of claimant's permanent disability under the standards.

Extent of Scheduled Permanent Disability

The applicable standards are those in effect on October 2, 1991, the date the Determination Order issued. WCD Admin. Orders 2-1991 and 7-1991.

In rating the extent of claimant's scheduled permanent disability, we note that Exhibit 18A, which is a questionnaire concerning claimant's impairment due to the left knee injury, incorrectly refers to the "right" knee as the injured body part. We interpret Dr. Jones' remarks concerning claimant's impairment in Exhibit 18A to refer to the injured left knee, rather than the right knee.

Claimant has 135 degrees flexion in the left knee compared to 145 degrees in the uninjured contralateral right knee joint. Former OAR 436-35-007(16) provides, in relevant part: "The range of motion or laxity in the injured joint shall be compared to the contralateral joint except when the contralateral joint has a history of injury or disease. In such a case, the injured joint impairment shall be valued proportionately to the full motion of the contralateral joint, unless the contralateral joint motion exceeds the normals established under these rules * * *." When claimant's lost range of motion in the left knee is compared to that of the uninjured right knee using the formula in former OAR 436-35-007(16) and the values in former OAR 436-35-220(1), claimant has a 4 percent impairment due to lost range of motion in the left knee.

Dr. Jones, claimant's attending physician has opined that claimant has a chronic condition which causes him to be unable to repetitively use his injured knee. Accordingly, we find that claimant is entitled to a 5 percent award for a chronic condition limiting repetitive use of the left knee. Former OAR 436-35-010(6).

Here, Dr. Jones has indicated that claimant has chondromalacia. Although there was no administrative rule specifically addressing impairment due to chondromalacia at the time this claim was closed and reconsidered, the Director has since promulgated a rule which provides for impairment due to chondromalacia where the injured worker has grade IV chondromalacia, secondary strength loss, chronic effusion, varus or valgus deformity, or a chronic condition. At the same time the Department adopted the rule addressing chondromalacia, the Department also amended OAR 436-35-003. Subsection (2) now provides:

> "(2) For claims in which the worker was medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268, disability rating standards in effect on the date of issuance of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C) shall apply."

Therefore, in addition to the standards in effect on the date of closure, temporary rule OAR 436-35-230(13) also applies to the rating of claimant's permanent disability. OAR 436-35-230(13) provides:

> "(13)(a) Except as provided in subsection (b) of this section: for chondromalacia, arthritis, or degenerative joint disease of the knee, the rating shall be determined pursuant to the chronic condition rule, if the criteria of OAR 436-35-010(6) are met.

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[1] Board Member Gunn although signatory to this order, directs the parties to his dissent in Gallino, supra.

"(b) A value of 5% of the leg shall be combined with other impairment values, including chronic condition as in (a) above, if there is diagnosis of more extensive chondromalacia, arthritis, or degenerative joint disease and one or more of the following:

"(A) Grade IV Chondromalacia;

"(B) Secondary Strength Loss;

"(C) Chronic Effusion; or,

"(D) Varus or valgus deformity less than that specified in subsection (4) of this rule."

OAR 436-35-230(4) provides:

"(4) When injury in the knee results in angulation, impairment values shall be determined accordingly. Varus deformity of the knee greater than 15 degrees is rated at 10 percent of the leg. Valgus deformity of the knee greater than 20 degrees is rated at 10 percent of the leg."

Here, Dr. Jones has indicated that claimant has 5 degrees varus deformity and 5 degrees valgus deformity. Accordingly, claimant has a varus or valgus deformity less than that specified in subsection 4 of OAR 436-35-230 and is therefore entitled to a 5 percent impairment for chondromalacia in addition to the other impairment values. The 5 percent value for chondromalacia is combined with the 5 percent value for a chronic condition and the 4 percent value for lost range of motion to equal 14 percent (21 degrees) scheduled disability for the left leg.

ORDER

The Referee's order dated June 1, 1992, as reconsidered August 10, 1992, is reversed. Claimant's hearing request is reinstated. The January 15, 1992 Order on Reconsideration is reinstated and modified. In addition to the Reconsideration Order award, claimant is awarded 5 percent (7.5 degrees) for a total scheduled award to date of 14 percent (21 degrees) for a left knee injury. Claimant's counsel is awarded 25 percent of the increased compensation awarded by this order not to exceed $3,800.

July 1, 1993 Cite as 45 Van Natta 1437 (1993)

In the Matter of the Compensation of
DONALD J. BIDNEY, Claimant
Own Motion No. 91-0187M
OWN MOTION ORDER ON RECONSIDERATION
Richard Sly, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's June 18, 1993 Own Motion Order in which we found that we were not authorized to reopen claimant's claim for Own Motion relief because claimant had failed to establish that the proposed cervical surgery was compensable. Claimant notes that the Board made an incorrect assumption that the Director's Order was not appealed and requests that our June 18, 1993 order be withdrawn pending final disposition of the case by decision of the Court of Appeals and/or the Supreme Court of the State of Oregon.

This case involves prior orders by Referees Knapp and Menashe, both of which were appealed to the Board. The Board's decisions were adverse to claimant in both cases, and claimant has appealed both Board orders to the Court of Appeals.

On January 24, 1991, claimant requested a hearing raising the issue of the SAIF Corporation's "de facto" denials of surgery requests made on August 28, 1989 and August 17, 1990. On April 26, 1991, Referee Knapp issued an Opinion and Order in which he concluded that the Hearings Division had jurisdiction to decide the issue of whether the proposed surgery was reasonable and necessary. Referee Knapp also found that the proposed surgery was reasonable and necessary. SAIF requested

Board Review of Referee Knapp's order. On March 18, 1992, the Board vacated the Referee Knapp's order on the ground that the Hearings Division lacked original jurisdiction over the issue of the appropriateness of the proposed surgery. On April 14, 1992, claimant appealed that Board order to the Court of Appeals.

In the meantime, in April 1991, SAIF sought Director review of this dispute. On August 28, 1991, the Director issued a Proposed and Final Order concluding that claimant's proposed medical treatment was not appropriate. Claimant appealed that order and, on November 26, 1991, Referee Menashe issued an Opinion and Order in which he found that the Director did not have jurisdiction over this medical services dispute and vacated the Director's order. SAIF appealed Referee Menashe's order. On August 27, 1992, the Board reversed Referee Menashe's order, finding that the Director had original jurisdiction over the medical services dispute and affirming the Director's order. On September 10, 1992, claimant appealed that Board order to the Court of Appeals.

In order to establish entitlement to medical services for the compensable low back injury, claimant must prove both a causal relationship between the medical services and the compensable injury and the reasonableness and necessity of the medical services. See ORS 656.245. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985); Douglas A. Eichensehr, 44 Van Natta 1755 (1992). Here, there is no dispute regarding the causal relationship between the proposed surgery and the compensable injury. However, currently, claimant has failed to prove that the proposed surgery is reasonable and necessary. Therefore, he has failed to prove that the proposed surgery is compensable. Without a compensable hospitalization or surgery, there is no basis to reopen his claim for Own Motion relief. Therefore, we continue to conclude that we are not authorized to reopen claimant's claim.

We acknowledge that claimant has appealed the reasonableness and necessity issue to the Court of Appeals. Nevertheless, it is the Board's practice not to postpone action regarding own motion matters on the basis of an appeal pending before the Court of Appeals. However, if the Court of Appeals rules in claimant's favor, he may request reconsideration of this matter. OAR 438-12-065(2). Alternatively, claimant could file a new request for own motion relief.

Accordingly, we withdraw our June 18, 1993 order. On reconsideration, as supplemented herein, we adhere to our June 18, 1993 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL P. ROAM, Claimant
Own Motion No. 92-0675M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests that the Board reconsider its December 18, 1992 Own Motion Order. In that order we denied claimant's request for own motion relief on the ground that he had not met his burden of proving that he was in the work force at the time of disability. Based on his attorney's statements, claimant contends that he was in the work force at the time of disability.

As a preliminary matter, we consider whether claimant has timely filed his request for reconsideration. Pursuant to OAR 438-12-065(2), claimant had 30 days from the mailing date of the order to request reconsideration. The only exceptions are when a request is filed within 60 days from mailing date of the order and good cause has been established or if extraordinary circumstances are deemed to have existed. OAR 438-12-065(2). Here, the own motion order was mailed on December 18, 1992. The request for reconsideration is dated May 18, 1993 and was received on May 19, 1993. Thus, claimant did not file his request for reconsideration until more than 60 days after the mailing date of our order and beyond the date allowed for consideration of "good cause" factors. Therefore, unless extraordinary circumstances are deemed to exist, claimant's request for reconsideration is untimely.

Claimant's attorney notes that he was not sent a copy of the December 18, 1992 order, although claimant has been represented by his firm for more than 12 years. As proof of claimant's long term representation by his firm, claimant's attorney submits copies of retainer agreements dated January 12, 1981 and February 18, 1989. However, although claimant apparently was represented by an attorney, there was no evidence in the own motion record submitted by the SAIF Corporation indicating that claimant was represented. To the contrary, SAIF indicated on its recommendation form that claimant was not represented by an attorney.

Given SAIF's mistaken indication that claimant was not represented which resulted in claimant's attorney not being sent a copy of the December 18, 1992 Own Motion Order, we find that extraordinary circumstances exist in this case which permit an extension of the time limit to request reconsideration. OAR 438-12-065(2). Accordingly, we proceed with our reconsideration.

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.

On reconsideration, claimant contends that his condition worsened in 1989 because Dr. Butters, treating orthopedic surgeon, had recommended surgery at that time, although he opined that claimant was in need of psychiatric treatment "as a condition precedent to that surgery." However, the first evidence in the record regarding a surgery request is a report from Dr. Butters dated February 12, 1992. On that date, Dr. Butters requested authorization for removal of a broken silastic prosthesis at claimant's right elbow and "curettage of the bone with localized synovectomy." On the basis of Dr. Butters recommendation, we find that claimant's condition worsened in February 1992. Therefore, the relevant date as to whether claimant was in the work force is February 12, 1992. 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 his compensable injury as of February 12, 1992. Claimant did not respond to SAIF's request for information regarding his work force status.

In his request for reconsideration, claimant's attorney states that claimant has been unable to work since 1989, has been involved in several self-employment schemes, has actively looked for work with little success, and is willing to work but for his industrial injury. Claimant's attorney states that claimant would be willing to supply an affidavit to that effect. However, claimant has submitted no evidence of any work search, "self-employment schemes," or any other evidence regarding the work force issue. 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. Larry R. Ruecker, 45 Van Natta 933 (1993).

In addition, the record fails to establish that claimant was in the work force in February 1992. There is no evidence that claimant is unable to work due to his industrial injury. In his February 12, 1992 report, Dr. Butters stated that claimant had "not been employed since I have seen him." Dr. Butters does not indicate when he began treating claimant. However, Dr. Gardner, examining psychiatrist, noted that claimant saw Dr. Butters in 1988 or 1989. (Letter dated June 17, 1992 from Dr. Gardner, page 1).

On June 5, 1992, claimant was examined by Dr. Baker, examining orthopedist. Dr. Baker noted that claimant was last employed in 1989 when he worked at a gas station. Following an independent psychiatric examination in June 1992, Dr. Gardner issued a report dated June 17, 1992. Dr. Gardner

reported a history received from claimant that, since the industrial injury, claimant's work situation has been odd jobs consisting of mechanical work and lawn work which he continues to do. (Letter dated June 17, 1992 from Dr. Gardner, pages 4 & 6).

Although Dr. Gardner's report indicates that claimant might have been working at odd jobs at the time of his worsening in February 1992, Drs. Butters and Baker both indicate that claimant was not in the work force at that time and has not worked for several years. Given these inconsistencies, we find that claimant has not met his burden of proving that he was in the work force at the time of his worsening in February 1992.

Accordingly, as supplemented herein, we adhere to and republish our December 18, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

July 1, 1993 Cite as 45 Van Natta 1440 (1993)

In the Matter of the Compensation
LARRY R. RUECKER, Claimant
Own Motion No. 92-0492M
OWN MOTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our May 19, 1993 Own Motion Order in which we declined to reopen his claim for Own Motion relief on the ground that he had not established that he was in the work force at the time of his disability. With his request for reconsideration, claimant submits additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our May 19, 1993 order and granted the SAIF Corporation an opportunity to respond to the motion. SAIF's response has been received. After further consideration, we issue the following order.

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).

According to the reports and chart notes of Dr. Stewart, treating orthopedist, claimant was able to perform light duty work with restrictions until October 27, 1992. On that date, Dr. Stewart opined that claimant was unable to perform any gainful employment due to his work injury. Thus, we conclude that claimant's condition worsened as of October 27, 1992. The issue presented is whether claimant remained in the work force as of the date of his disability in October 1992. Weyerhaeuser v. Kepford, supra.

Claimant has not worked since June 11, 1991. However, he received unemployment benefits from December 30, 1991 through July 22, 1992. Thus, for that period of time, claimant remained in the work force. In addition, with his request for reconsideration, claimant submits an affidavit stating that he looked for work both before and after his unemployment benefits. He states that, after his unemployment benefits ended, he expanded his work search in that he was willing to take any work that would not cause additional injury to his shoulder. Furthermore, he lists 16 specific businesses he contacted for employment and states that he also contacted many more. He also states that his brother attempted to find work for him at his brother's place of business but he was unable to carry the heavy materials involved. Claimant, his wife, and his mother share a household. His wife and mother also submitted affidavits which describe claimant's work search efforts following the termination of his unemployment benefits.

We find that the record establishes that, although not employed, claimant remained willing to work and made reasonable efforts to find work. Thus, we conclude that claimant remained in the work force at the time of his disability.

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

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

IT IS SO ORDERED.

July 7, 1993 Cite as 45 Van Natta 1441 (1993)

In the Matter of the Compensation of
DOUGLAS FREDINBURG, Claimant
WCB Case Nos. 92-05032 & 92-05033
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Claimant has requested reconsideration of our June 17, 1993 Order on Review that reinstated the Department of Insurance and Finance's order declaring claimant to be a non-subject worker. Specifically, claimant contends that the Board lacked jurisdiction over this matter.

In order to allow us sufficient time to consider claimant's motion, we withdraw our June 17, 1993 order. The Department of Insurance and Finance and Farmers Insurance Group may submit a response. In order to be considered, the responses 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
STEVEN E. KEYSER, Claimant
WCB Case No. C3-01484
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Andrew H. Josephson, Claimant Attorney
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On June 2, 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 have received the insurer's June 30, 1993 letter and a copy of Dr. Rosenbaum's June 15, 1993 report. The insurer's letter states that it believes the CDA is now inappropriate as it was based on claimant's inability to return to his job-at-injury, and Dr. Rosenbaum has now indicated that claimant has returned to that job. We construe the insurer's letter as a motion to set aside the proposed CDA, pursuant to ORS 656.236(1)(6).

Because a copy of this letter was not sent to claimant's counsel, we find that the insurer's motion is not properly before us. See OAR 438-05-046(2)(a). Pursuant to OAR 438-05-046(2)(a), we hereby provide copies of the insurer's letter and Dr. Rosenbaum's report to claimant's attorney. Nevertheless, even if a copy of the letter and report had properly been sent to claimant's counsel, we would not find that the insurer has established an intentional misrepresentation of a material fact such that there would be grounds for disapproval of the agreement. ORS 656.236(1)(b); see Bob A. Taylor, 44 Van Natta 97 (1992).

Although the CDA provides that claimant was unable to return to regular work at the time he entered into the CDA on May 24, 1993, the insurer has not shown, through its submission of a subsequent medical report, that claimant intentionally misrepresented his ability to return to his job at injury. Consequently, we decline to disapprove the CDA on that basis.

Therefore, upon review of the document as a whole, the agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES V. COMPTON, Claimant
Own Motion No. 92-0359M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider & DeNorch, Claimant Attorneys
Saif Legal Department, Defense Attorney

On June 3, 1993, the Board received claimant's request for review of the SAIF Corporation's April 29, 1993 Notice of Closure which closed his claim with an award of temporary disability compensation from June 29, 1992 through September 1, 1992. SAIF declared claimant medically stationary as of September 1, 1992. On June 8, 1993, the Board notified SAIF of its receipt of claimant's request and granted SAIF 15 days to provide all materials it considered in closing claimant's claim. On June 25, 1993, the Board received the materials from SAIF. Finally, on June 29, 1993, the Board received claimant's response to the submitted materials from SAIF.

Claimant contends that he is entitled to additional benefits as he is not medically stationary. We agree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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). Claim closure was premature if claimant's compensable psychiatric condition was not yet medically stationary when the Notice of Closure issued on April 29, 1993. Rogers v. Tri-Met, 75 Or App 470 (1985); Paul E. Voeller, on recon, 42 Van Natta 1962 (1990).

Here, the only evidence in the record regarding claimant's psychiatric medically stationary status is provided by Dr. Glass, psychiatrist. Dr. Glass performed a record review on September 1, 1992 and opined that claimant's psychiatric condition was not related to the 1975 work injury. He also opined that claimant's psychiatric condition was medically stationary.

The Board does not find Dr. Glass' opinion persuasive because it is against the law of the case. Specifically, on September 25, 1992, SAIF issued a denial which denied the compensability of claimant's current psychiatric condition alleging that it was unrelated to the 1975 work injury. Claimant requested a hearing on that denial. On February 22, 1993, Referee Lipton issued an order which found that claimant's current psychiatric condition was compensably related to the work injury. Referee Lipton concluded that claimant's psychiatric condition had not changed since found compensable by two previous referees. Referee Lipton also concluded that Dr. Glass' opinion that claimant's current condition was not related to the work injury was not persuasive because Dr. Glass was unaware of the legal effect of the prior litigation which had found the psychiatric condition compensable. Referee Lipton also found that claimant's emergency hospitalization for depression from June 29, 1992 through July 6, 1992 was compensable.

SAIF requested Board review of Referee Lipton's order. However, subsequently, SAIF withdrew its request. Therefore, Referee Lipton's order bacame final by operation of law. Meanwhile, the Board had postponed action on claimant's request for own motion relief pending resolution of the current condition denial. On April 15, 1993, based on Referee Lipton's findings, the Board concluded that claimant's compensable psychiatric condition had worsened requiring hospitalization. On that basis, the Board reopened claimant's claim for own motion relief. The April 15, 1993 Own Motion Order was not appealed and has become final by operation of law. Thus, by both Referee Lipton's order and the April 15, 1993 Own Motion Order, it is the law of the case that claimant's compensable psychiatric condition worsened.

On April 29, 1993, SAIF closed claimant's claim in reliance on Dr. Glass' September 1, 1992 record review. This was the same report by Dr. Glass that SAIF relied on in issuing its September 25, 1992 current condition denial. Dr. Glass stated that claimant's "psychiatric condition is unchanged over many years and I would consider him medically stationary." However, as noted above, it is the law of the case that claimant's psychiatric condition had changed by worsening in late June 1992. Thus, Dr. Glass' opinion regarding claimant's medically stationary status is not persuasive because it is based on his opinion that claimant's condition had remained unchanged for years, an opinion which is against the law of the case. Kuhn v. SAIF, 73 Or App 768 (1985); Robert P. Roth, 43 Van Natta 2492 (1991).

In addition, Dr. Glass' opinion is internally inconsistent. Dr. Glass opined that he had no specific treatment to recommend and noted that no treatment had been particularly successful. However, he also noted that "the use of a combination of low doses of antidepressants and neuroleptics is probably the most effective." Dr. Glass concluded that claimant needed psychiatric treatment and management but such treatment was not related to the compensable injury. Thus, Dr. Glass apparently does recommend further psychiatric treatment. Furthermore, Dr. Glass' opinion that claimant's need for psychiatric treatment is not related to the work injury is against the law of the case because claimant's current psychiatric condition is compensable.

Based on the above reasoning, we do not find Dr. Glass' opinion regarding claimant's medically stationary status persuasive. There is no other opinion in the record regarding the medically stationary issue. Thus, there is no persuasive medical opinion that claimant was medically stationary at the time his claim was closed in April 1993. In other words, SAIF had no basis for its Notice of Closure. Therefore, we set aside SAIF's April 29, 1993 Notice of Closure and direct it to resume payment of temporary disability compensation commencing from September 1, 1992. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

Claimant also requests penalties, contending that SAIF's actions in closing the claim were unreasonable. 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 actions must be gauged based upon the information available to the carrier at the time of its action. Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

Here, at the time SAIF issued the Notice of Closure, it had withdrawn its request for review of Referee Lipton's order and that order had become final by operation of law. As discussed above, Referee Lipton had found that Dr. Glass' opinion was not persuasive because it went against the law of the case. Also, as found by Referee Lipton and our April 15, 1993 Own Motion Order, claimant's compensable psychiatric condition had worsened requiring hospitalization. Thus, it was unreasonable for SAIF to rely on Dr. Glass' opinion that claimant was medically stationary based on his conclusion that claimant's condition had not worsened. Furthermore, as noted above, Dr. Glass recommended further psychiatric treatment which he mistakenly concluded was not related to the compensable injury. Therefore, we find that it was unreasonable for SAIF to rely on Dr. Glass' opinion in deciding that claimant's psychological condition was medically stationary.

Based on the above reasoning, we conclude that SAIF's Notice of Closure, which was based solely on Dr. Glass' September 1, 1992 report, amounted to unreasonable resistance to the payment of compensation. Accordingly, we assess a penalty equal to 25 percent of the temporary disability benefits "then due" from September 1, 1992 through April 29, 1993, the date of the Notice of Closure, with one-half of the penalty payable to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER ON RECONSIDERATION
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. On May 12, 1993, we withdrew our order for reconsideration and allowed SAIF an opportunity to respond. SAIF's response has been received. After further consideration, we issue the following order.

"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 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. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Dr. Mulchin, treating urologist, first began treating claimant in April 1990. In letters dated January 11, 1993, February 16, 1993, and May 14, 1993, Dr. Mulchin requested approval for a surgical procedure to augment claimant's bladder. He noted that claimant's neurogenic bladder condition resulted from the work-related back injury. He opined that claimant is essentially a urological cripple due to severe bladder irritability that forces him to frequently catheterize himself which, in turn, has resulted in infections and several hospitalizations. He also opined that the proposed surgery would decrease the need for such frequent catheterizations and ultimately could improve claimant's quality of life and possibly allow him to do some sort of sedentary job.

In a letter dated June 1, 1993, Dr. Mulchin noted that the primary physician treating claimant's back condition was contacted in October 1992 regarding claimant's back status and he found no further treatment was available for claimant's back condition. However, Dr. Mulchin stated that he was not contacted at that time regarding the status of claimant's neurogenic bladder condition which was caused by the back condition. Dr. Mulchin stated that, if he had been contacted at that time, he would have informed SAIF that further medical treatment was available in the form of a surgical bladder augmentation which he considered to be an option at that point.

Based on Dr. Mulchin's reports, we find that claimant's claim was prematurely closed. In order to be medically stationary, all of the compensable conditions must be medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985). Here, at the time of claim closure, claimant's compensable back condition was medically stationary. However, claimant's treating urologist was not consulted regarding the medically stationary status of the compensable bladder condition. Furthermore, at the time the claim was closed, Dr. Mulchin was recommending surgery for claimant's bladder condition. Thus, there was a reasonable expectation of further material improvement of the bladder condition with medical treatment. Therefore, claimant was not medically stationary when his claim was closed.

Accordingly, the employer's October 13, 1992 Notice of Closure is set aside. The parties rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT F. NELSON, Claimant
WCB Case No. C3-01115
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Gatti, Gatti, et al., Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On April 23, 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 438-15-052. 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 $1,752.40. The agreement further provides that an overpayment in the amount of $1,182.85 exists and that amount will be deducted from the settlement proceeds. Accordingly, the agreement proceeds that remain after deduction of the overpayment would be $569.55.

The CDA, however, indicates that claimant's attorney will receive a fee of $438.10 based on the total amount of consideration, prior to deducting the overpayment amount. We have previously held that, where an overpayment has apparently been made pursuant to prior claims processing obligations, the overpayment cannot qualify as "proceeds" of the parties' CDA. See Raymond E. Clonkey, 43 Van Natta 1897 (1991). Thus, the proposed attorney fee in the amount of $438.10 (from actual consideration of $569.55) exceeds the limitations of OAR 438-15-052. Furthermore, no extraordinary circumstances have been cited to support such a fee.

Consequently, by letter dated May 10, 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.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On June 17, 1993, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable left above-the-knee amputation injury. SAIF recommends reopening the claim under our own motion to provide medical services for a hip dislocation.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b).

In a June 9, 1993 Own Motion Order, we denied authorization of payment for medical services related to claimant's right hip dislocation because we lacked evidence that the requested medical services were causally related to claimant's compensable injury. The record indicated that claimant had dislocated his right hip on January 22, 1993 during a skiing accident. Claimant has neither requested reconsideration of that order nor submitted any evidence relating the need for the medical treatment to his compensable injury.

Currently, SAIF submits a $30.00 invoice from Dr. McCullough, claimant's treating orthopedist, which notes that service was provided on May 3, 1993 and indicates a diagnosis of "hip dislocation." SAIF also submits an April 29, 1993 letter from Dr. McCullough in which he states that claimant previously had a total hip replacement as the result of the 1955 work injury. Dr. McCullough also states that the "principal cause" of claimant's hip dislocation was the skiing accident. Although he notes that there was a "significant predisposition" towards hip dislocation due to the prior total hip replacement, Dr. McCullough concludes that the skiing injury caused the hip dislocation.

There is no evidence in the record that the right hip dislocation, which occurred during a January 1993 skiing accident, is a direct or primary consequence of the 1955 work injury. Instead, any relationship between the initial injury and the current right hip dislocation is indirect or "consequential." Accordingly, ORS 656.005(7)(a)(A) applies to this case. Therefore, claimant must prove that his 1955 compensable injury is the major contributing cause of his current right hip dislocation. See Julie K. Gasperino, 44 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 76 Or App 422 (1992).

The issue of whether claimant's compensable injury is the major contributing cause of his current right hip dislocation is a complex medical question, the resolution of which turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 113 Or App 105, 109 (1985). Dr. McCullough

provides the only medical evidence regarding the cause of claimant's right hip dislocation. He opines that the principal cause was the skiing accident. On this record, claimant has failed to prove that the 1955 injury was the major contributing cause of his right hip dislocation. Accordingly, we deny authorization of payment for the above medical services. See OAR 438-12-037(1)(c).

However, claimant's claim shall remain open pursuant to our October 1, 1992 Own Motion Order to provide medical services to maintain and monitor the status of the prosthetic device for claimant's left above-the-knee amputation. After those medical services are provided, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

July 9, 1993 Cite as 45 Van Natta 1447 (1993)

In the Matter of the Compensation of
MARILEE K. KANE, Claimant
WCB Case No. 92-10352
ORDER OF DISMISSAL
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Claimant's former counsel requests review of Referee Baker's order which modified an Order on Reconsideration awarding an approved attorney fee. On review, the issue is attorney fees. We dismiss the request for review.

Pursuant to ORS 656.283(1), "any party or the director may at any time request a hearing on any question concerning a claim." Similarly, any party to a Referee's order may seek Board review of that order. ORS 656.289(3); 656.295(1). "Party" is defined as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(20). Under this provision, "party" does not include attorneys representing a claimant, whether former or not. William G. Rice, 44 Van Natta 182 (1992); Frank F. Pucher, Jr., 41 Van Natta 794 (1989).

Here, claimant's former counsel is no longer representing claimant. As an attorney, claimant's former counsel does not qualify as a "party" and, therefore, cannot request a hearing under ORS 656.283(1) or seek Board review under ORS 656.289(3). Thus, the Board lacks jurisdiction to consider this request for attorney fees. Moreover, considering claimant's termination of his services, claimant's former attorney did not have authority to appeal the Referee's order. ORS 656.005(20); Raymond L. Rasmussen, 44 Van Natta 1704 (1992; Wendy S. Reyes, 43 Van Natta 1249 (1991).

Accordingly, we dismiss this request for Board review.

IT IS SO ORDERED.

July 9, 1993 Cite as 45 Van Natta 1447 (1993)

In the Matter of the Compensation of
ROBERT A. KNUDSON, Claimant
WCB Case No. 92-10111
ORDER ON REVIEW
Schouboe & Furniss, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Menashe's order which: (1) upheld the insurer's denial of claimant's ruptured spleen injury claim; and (2) declined to award a penalty and attorney fee for allegedly unreasonable claim processing. On review, the issues are compensability and penalties and attorney fees.

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

Although claimant's injury occurred on the employer's premises, it did not arise out of his employment. Rather, the "fight" was purely personal in nature, between friends/fellow employees participating in a "birthday beating" ritual that was specifically forbidden by the employer. See Robinson v. Felts, 23 Or App 126 (9175); Oliver S. Brown, 35 Van Natta 1646 (1983).

ORDER

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

In the Matter of the Compensation of
ROBERT D. PRICE, Claimant
WCB Case No. 91-15047
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Mongrain's order which granted permanent total disability, whereas an Order on Reconsideration had awarded claimant 39 percent (124.8 degrees) unscheduled permanent disability for a low back injury and 9 percent (13.5 degrees) for loss of use or function of the left leg. On review, the issue is permanent total disability.

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

The Referee found that claimant was 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 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. ORS 656.206(3); 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 had no transferable skills, that no available job had been identified that claimant could presently regularly perform, and that he required vocational assistance to return to work, but no assistance was provided. The Referee further found that claimant had a limited labor market, that he possessed few interview skills to use to seek employment, and that his compensable somatoform pain disorder (manifested by hostility and irritability) impacted his employability. The Referee concluded that claimant was permanently and totally disabled.

We agree with the Referee's finding that claimant was presently unable to obtain and perform any work at a gainful and suitable occupation. Gettman v. SAIF, 289 Or 609 (1980). We further find that, although claimant made minimal effort to seek work by filling out a few applications at the unemployment office, such efforts were reasonable considering claimant's lack of transferable skills, lack of vocational assistance to return to work, and limited labor market. See SAIF v. Simpson, 88 Or App 638 (1987). We base this conclusion on the following reasoning.

Vocational counselor Lynch reported that claimant is physically precluded from performing his prior job and that some employment options might be feasible with vocational assistance. Such assistance never materialized. The insurer contends that such efforts were not forthcoming because of claimant's previous negative attitude regarding vocational assistance. These previous unsuccessful efforts do not cause us to conclude that claimant's current efforts to seek work (in light of no vocational assistance) were not reasonable.

Although claimant's earlier vocational assistance was terminated for his failure to cooperate, claimant had been subsequently recommended as eligible for vocational assistance. However, none was provided. Furthermore, vocational consultant Potocki persuasively testified that claimant is limited, by his physical capabilities, to about 5 percent of the job market. (Tr. 55). Accordingly, we conclude that claimant was willing to seek work and had made reasonable efforts to do so. Claimant has therefore established that he is permanently and totally disabled.

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 $1,000, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated August 11, 1992 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
BILLY J. SLACK, Claimant
WCB Case No. 92-09512
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Quillinan's order that upheld the SAIF Corporation's denial of his current bilateral carpal tunnel syndrome condition. On review, the issue is compensability.

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

On review, claimant contends that the Referee should have relied upon the opinion of Dr. Warren, his treating physician. We disagree. Because this case involves expert medical analysis rather than expert observation, we give no particular deference to the opinion of Dr. Warren. See Hammons v. Perini Corp., 43 Or App 299 (1979). Moreover, like the Referee, we are not convinced that claimant's treating physician had an accurate description of his work activities.

Claimant was released to a quality control position on February 11, 1992. On February 19, 1992, claimant informed Dr. Warren that his wrist problems had increased. Claimant told Dr. Warren that his job consisted of pulling metal from bark, fiften to twenty times per hour. However, claimant's job description provided that metal pieces were removed approximately six to eight times per shift. At hearing, claimant testified that in an average day, he pulled out metal pieces approximately nine to ten times per day. Consequently, we conclude that Dr. Warren's opinion was based upon an inaccurate history, and the Referee correctly declined to defer to the treating doctor's opinion. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Finally, claimant argues that if he does have functional overlay, it is related to the compensable condition. We disagree. Claimant was examined by Dr. Glass, psychiatrist, on June 30, 1992. Dr. Glass was unable to identify a specific psychiatric condition. His impression was that claimant's functional behavior and preoccupation with his physical symptoms were major factors in his subjective complaints, however, Dr. Glass recommended further psychological testing. Although Dr. Glass noted a possible history of overfocusing on physical symptoms, he did not relate claimant's functional behavior to his compensable injury. Under the circumstances, we disagree with claimant's contention that his functional overlay condition is related to his compensable condition.

ORDER

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

In the Matter of the Compensation of
JOSEPH C. HACKLER, Claimant
WCB Case Nos. 91-18196, 91-18195, 91-08763, 91-14052, 92-01876, 91-18197 & 91-04880
ORDER OF DISMISSAL (REMANDING)
Westmoreland & Shebley, Claimant Attorneys
Saif Legal Department, Defense Attorney
Davis & Bostwick, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys
Williams, et al., Defense Attorneys
Pam Schultz, Defense Attorney
Scheminske & Lyons, Defense Attorneys
Sandra K. Haynes, Defense Attorney

Kemper Insurance Company has requested Board review of Referee Quillinan's May 5, 1993 "Order of Dismissal," which dismissed all carriers except Kemper as parties to an upcoming and rescheduled hearing. We have reviewed the request to determine whether we have authority to consider this matter. Because we conclude that the Referee's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

Claimant requested a hearing contesting denials of his claim issued by Kemper Insurance, the SAIF Corporation (on behalf of two employers), and Liberty Northwest Insurance Company (on behalf of four employers). Prior to the scheduled hearing, claimant moved to dismiss all of the carriers as parties to the hearing (with the exception of Kemper). Claimant contended that Kemper's responsibility disclaimers (which preceded the other carriers' denials and claimant's subsequent hearing requests) were untimely.

On May 5, 1993, Referee Quillinan issued an "Order of Dismissal." Finding that Kemper's responsibility disclaimers were untimely issued, the Referee reasoned that the disclaimers were invalid. Determining that claimant had no obligation to join the other carriers to the proceeding and that Kemper had waived its entitlement to disclaim responsibility under ORS 656.308(2), the Referee dismissed the other carriers from the proceeding. In addition, the Referee directed that claimant's hearing with Kemper be rescheduled. The Referee's order contained a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3).

Within 30 days of the Referee's order, Kemper filed a request for Board review.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the Referee's May 5, 1993 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, notwithstanding the dismissal of several carriers from the proceeding and the inclusion of a statement explaining the parties' rights of appeal, the order was preliminary in nature. In effect, the other carriers were notified that their presence at a rescheduled hearing involving claimant and Kemper would not be required. See Shirley J. Davis, 44 Van Natta 762 (1992).

In reaching this conclusion, we recognize that the Referee expressly dismissed claimant's hearing requests from six separate responsibility disclaimers. Since each request was assigned a separate WCB Case Number, it could be argued that the Referee finally disposed of claimant's claim insofar as it pertained to those carriers. Nevertheless, the Referee neither finally disposed of, nor allowed, claimant's claim concerning Kemper. Moreover, the Referee's order specifically deferred action regarding that claim pending a rescheduling for hearing.

Inasmuch as the Referee's order pertained to pre-hearing matters and since the order expressly directed the rescheduling of a hearing regarding Kemper's disclaimer, we hold that the order was not final. Not only is this decision consistent with case precedent, but to reach any other conclusion would present several procedural and administrative problems.

It is the Board's policy and preference to avoid piecemeal review of multiple issues arising from the same claim. Here, the Referee's order would contravene that policy. See Maria Martinez, 40 Van Natta 57 (1988); Harris E. Jackson, 35 Van Natta 1674, 1676 (1983). Furthermore, despite the potential effect the Referee's ruling may have on its responsibility for the claim, it is unclear whether Kemper would have "standing" to request review from a Referee's order which dismissed claimant's hearing requests from other carriers and did not finally resolve claimant's hearing request regarding Kemper. See Timothy D. Herrman, 43 Van Natta 266 (1991) (One insurer lacked standing to request a hearing from another insurer's denial of a claim).

To avoid this potential for piecemeal review, we reiterate that the appropriate procedure for responding to such procedural motions is to do so by means of an interim order. See Shirley J. Davis, supra. In that way, the parties can be notified of the Referee's pre-hearing ruling, as well as be advised that the carriers' formal dismissal as parties to the proceeding would be incorporated into the Referee's eventual final, appealable order.

Although not framed as an "interim" order, we interpret the Referee's order as interim in nature. In short, as a result of the Referee's order, further proceedings will be required to determine claimant's entitlement to and/or the amount of, compensation. Under such circumstances, we conclude that, notwithstanding the statement regarding the parties' rights of appeal, the Referee's order is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF; Maria Martinez, supra.

Therefore, we currently lack jurisdiction to consider Kemper's request for Board review. Consideration of the issues raised by Kemper's request must await the eventual issuance of the Referee's final, appealable order determining claimant's entitlement to and/or the amount of compensation (assuming that Board review is subsequently timely requested).

Finally, for the reasons already discussed, we would find a remand appropriate and necessary even assuming the Referee's decision constituted a final, appealable order. In other words, the present record (based on the bifurcated cases which involve inter-related issues) is no properly, completely, or sufficiently developed. ORS 656.295(5).

Accordingly, this case is returned to Referee Quillinan for further action consistent with this order and the Referee's May 5, 1993 order. In other words, the scheduling of a hearing involving claimant and Kemper Insurance.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL E. HUNTER, Claimant
WCB Case No. C3-01542
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Parker & Bush, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On June 9, 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.

Here, the summary page of the proposed agreement initially provided that the total due claimant is $5,488.75 and the total due claimant's attorney is $1,406.25, for a total consideration in the amount of $6,895. However, the body of the CDA provided for a total consideration in the amount of $6,875, with an attorney fee of $1,406.25. On June 16, 1993, the Board requested that the parties clarify the matter by addendum.

By a June 22, 1993 addendum, the parties provided that the total due claimant should be $5,468.75, for a total consideration of $6,875. Because the original summary page contained a mathematical error, we find that it has always been the parties' intent to settle this matter for a total consideration of $6,875, and an attorney fee of $1,406.25 as evidenced by the body of the original CDA. Therefore, because the addendum did not alter the bargain underlying the exchange of consideration, we find this case to be distinguishable from Mary A. Smith, 45 Van Natta 1014 on recon 45 Van Natta 1072 (1993) (Parties' revision of CDA resulted in less consideration to claimant. Such revised agreements substantially alter the bargain underlying the exchange of consideration and will be treated as a new submission, with claimant's statutory 30-days to request disapproval running from new acknowledgement date.)

Upon review of the CDA, as clarified by the parties' addendum, we approve the proposed agreement for a total consideration of $6,875 with an attorney fee provided out of the total consideration in the amount of $1,406.25.

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

IT IS SO ORDERED.

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

The SAIF Corporation requested reconsideration of our April 7, 1993, Order on Review, as corrected on 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 claimant had established that he was unable to repetitively use his right knee due to a chronic and permanent medical condition that had become symptomatic and disabling as a result of his compensable injury. On reconsideration, SAIF asserts that we erred in affirming an award for an alleged chronic condition involving claimant's right knee.

In order to fully consider the matter, we abated our prior orders on May 7, 1993, and granted claimant an opportunity to respond. After receiving claimant's response, we proceed with our reconsideration.

The sole issue on reconsideration is whether claimant is entitled to a 5 percent award for a scheduled chronic condition impairment. After reconsidering the matter, we conclude that claimant has failed to prove that he is entitled to a chronic condition award.

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 condition as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow, and arm."

Claimant relies on the medical opinion of the medical arbiter, Dr. Baker, who stated that claimant has a "permanent and chronic condition limiting repetitive use of his right knee due to traumatic arthritis." (Ex. 17-4). Dr. Baker did not state, however, that claimant is unable to repetitively

use the knee, nor did he make findings from which we can conclude that claimant is unable to do so. In his examination, Dr. Baker reported complaints of pinching pain and grinding in the knee. (Ex. 17-1). He noted that claimant walked with a slight limp, was able to do 75 percent of a squat and rise, ran in place poorly and declined to hop on the right side. (Ex. 17-2).

At the same time, though, Dr. Baker reported that claimant walks on tiptoes and heels "quite well" and has "quite good" overall alignment, no knee joint instability and full leg strength. Although claimant testified to his difficulty walking on inclines or for any distance, lay testimony alone is insufficient to establish "impairment" under the standards. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

We recognize that, before the current chronic condition rule was adopted, former OAR 436-35-010(7) allowed a 5 percent award for "[c]hronic conditions limiting repetitive use" of the injured body part. See WCD Admin. Order 15-1990 (Temp.) In our view, by changing the language of the rule from "limiting repetitive use" to "unable to repetitively use," the Director did not intend to require a total loss of ability to repetitively use the body part. Rather, the Director intended to clarify the standard of proof required to receive a chronic condition award. As clarified, the rule requires medical evidence of, at least, a partial loss of ability to repetitively use the body part. Here, however, Dr. Baker provides no medical opinion or findings to prove a partial loss of claimant's ability to repetitively use the right knee.

Based on this record, therefore, we conclude that claimant has not sustained his burden of proving that his chronic knee condition prevents him from repetitively using the knee. Accordingly, claimant is not entitled to a 5 percent chronic condition award. See ORS 656.266.

The Referee's order dated July 31, 1992 is reversed. In lieu of the 13 percent (19.5 degrees) scheduled permanent disability awarded by the Notice of Closure/Order on Reconsideration, claimant is awarded 8 percent (12 degrees) scheduled permanent disability for the loss of use or function of the right leg (knee). The assessed fees awarded by the Referee and the Board are also reversed.

Accordingly, as amended herein, we adhere to and republish our April 7, 1993 order, as corrected on April 8, 1993. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Neidig specially concurring.

I agree with the majority that claimant has not sustained his burden of proving entitlement to a 5 percent chronic condition award. I write separately, however, because I disagree with the majority's interpretation of the change in the Director's chronic condition rule.

The majority states that, by changing the language of the chronic condition rule from "limiting repetitive use" to "unable to repetitively use," the Director intended merely to clarify that a partial loss of repetitive use of the injured body part is sufficient for entitlement to the chronic condition award. That interpretation does not account for the rather substantial change made to the rule.

As noted by the majority, former OAR 436-35-010(7) provided that a chronic condition award could be made for those conditions "limiting repetitive use of a scheduled body part." (Emphasis added). Dr. Baker apparently referred directly to this former rule when offering his medical arbiter's opinion, for the wording of his opinion is identical to the wording of the rule.

Effective October 1, 1990, however, the Director changed the rule to its current form. WCD Admin. Order 15-1990. OAR 436-35-010(6) now provides that a chronic condition award may be made when the worker is "unable to repetitively use a body part due to a chronic and permanent condition . . ." (Emphasis added). Thus, whereas the former rule was phrased in terms of limitations, the current version specifically refers to an inability of use.

There is no language in the current rule allowing a chronic condition award for anything less than a total inability to repetitively use the body part. Unlike the majority, I would not insert language ("partial") where the rule is clear on its face.

I further note that at the same time the current OAR 436-35-010(6) was promulgated, the Director added former OAR 436-35-010(8)(a), which provided that where impairment in a body part was equal to or greater than 5 percent, the worker was not entitled to a separate award for a chronic condition. Thus, under the former rules, the worker was not allowed compensation for both a chronic condition and other impairments.

Since the promulgation of both rules, however, the latter one has been eliminated. In my view, the Director's intent in eliminating that rule was to thereafter allow for a chronic condition award in addition to awards for other impairments, but only if the worker meets the burden of establishing a total inability to repetitively use a scheduled body part, rather than a mere limitation of its use. If he does, he is entitled to an award separate and distinct from that he has received for such limitations as reduced range of motion.

This case provides a good illustration of what I believe the Director had in mind in changing the applicable rules. Claimant has received an 8 percent award for lost range of motion which, in my view, has resulted in a "limitation" of the use of his right knee. Under the Director's former OAR 436-35-010(8), claimant would be precluded from receiving an additional award for a chronic condition simply because his remaining award exceeds 5 percent. Under the current rules, however, the Director recognizes that claimant may have both a "limitation" of use resulting from lost range of motion or other impairment, and an "inability" to repetitively use the injured member. However, because claimant has already been compensated for his "limitation" by the 8 percent award, the current rule contemplates that he must bear an additional burden to get an additional award; that is, he must demonstrate a total inability to repetitively use his right knee.

In sum, I believe the Director, by changing the chronic condition rule, intended to restrict the award to only those conditions which render claimant totally unable to repetitively use the injured body part. Because the majority's interpretation conflicts with what I believe the Director intended, I specially concur.

In the Matter of the Compensation of
JOHN L. DESMOND, Claimant
WCB Case No. 92-03191
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Menashe's order which: (1) awarded claimant temporary disability compensation from January 24, 1992 to March 23, 1992; and (2) assessed a penalty in the amount of 25 percent of the temporary disability compensation ordered, payable by the SAIF Corporation, one half to claimant and one half to his attorney. On review, the issues are temporary disability, penalty and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

In January 1992, claimant's treating chiropractor released him for modified work, and by letter dated January 16, 1992, advised SAIF that the restrictions were for both the thoracic and lumbar spine conditions. (Exs. 11, 11A). When SAIF stopped paying temporary disability compensation on January 23, 1992, claimant had not returned to work, nor had he received a written offer of modified employment. (See Tr. 11-12).

CONCLUSIONS OF LAW AND OPINION

The sole issue in the "show cause" hearing, conducted pursuant to OAR 438-06-075, was the propriety of SAIF's unilateral termination of temporary disability benefits on January 23, 1992. The Referee held that SAIF unilaterally terminated temporary disability compensation on an open, accepted claim without statutory authority for doing so, and that its conduct was unreasonable, warranting the imposition of a penalty under ORS 656.262(10). We agree.

First, we address SAIF's argument that the Referee exceeded his authority in the "show cause" hearing by addressing the merits and validity of SAIF's partial denial. OAR 438-06-075 provides, in relevant part:

> "(1) If it is alleged that the self-insured employer or insurer has terminated temporary disability compensation without the attending physician's written release for the worker's return to his regular employment; or the injured worker's actual return to regular or modified employment; or the attending physician's written release to return to modified employment, when such employment has been offered in writing to the worker and the worker fails to begin such employment; or the issuance of a determination order or notice of closure; or authorization of the Board or Evaluation or Compliance, the claimant may file with the Hearings Division with copies to the insurer, a motion supported by affidavit asserting the failure to receive such compensation.
>
> "* * * * *
>
> "(3) Immediately upon the conclusion of the hearing or expiration of the fifteen (15) days, the referee shall enter an Order denying or granting temporary disability compensation and awarding penalties and attorney fees when appropriate."

Claimant alleged that he was not paid temporary disability benefits after January 23, 1992. The Referee properly considered whether any of the conditions identified in OAR 438-06-075 had occurred by January 23, 1992. In addition, since SAIF relied on its partial denial based on ORS 656.005(7)(a)(B) as authority for unilaterally terminating benefits, we find that the Referee properly considered the denial for that limited purpose. Following the hearing, the Referee issued an order awarding temporary disability benefits, penalties and attorney fees, as authorized by OAR 438-06-075(3). We find that the Referee did not address the merits of the denial. Accordingly, we conclude that the Referee did not exceed his authority in the "show cause" hearing conducted pursuant to OAR 438-06-075.

Claimant had an accepted, open claim for a thoracic strain condition arising out of an October 24, 1991 work injury. (Ex. 9). The Referee found that none of the events identified in ORS 656.268(3) or ORS 656.262(4)(b) had occurred at the time SAIF stopped paying temporary disability compensation. Therefore, SAIF was obliged to pay temporary disability compensation until the claim was properly closed under ORS 656.268. See Esther C. Albertson, 44 Van Natta 521 (1992).

SAIF contends, however, that its partial denial of claimant's lumbar strain condition authorized it to terminate temporary disability compensation. We disagree.

SAIF partially denied claimant's lumbar strain condition pursuant to ORS 656.005(7)(a)(B), but it simultaneously accepted a thoracic strain condition. (Exs. 9, 10). We recently held that ORS 656.005(7)(a)(B) is not a basis for terminating temporary disability benefits on an open claim. Nancy G. Brown, 45 Van Natta 548 (1993). In Nancy G. Brown, we reasoned that ORS 656.005(7)(a)(B) is a definitional statute that determines a worker's substantive rights to disability and medical treatment, unlike ORS 656.268(3), which is a claims processing statute. The latter statute provides grounds for procedurally terminating temporary disability benefits; the former does not. Therefore, notwithstanding the denial, a carrier remains responsible for temporary disability benefits being paid on an open, accepted claim.

Here, SAIF accepted claimant's thoracic strain condition. The Referee correctly found that none of the conditions in ORS 656.268(3) had been met at the time SAIF stopped paying temporary disability benefits on January 23, 1992. Nor does SAIF contend that it failed to receive verification of an inability to work due to the thoracic strain, so that it was authorized to "suspend" temporary disability benefits pursuant to ORS 656.262(4)(b). See Sandoval v. Crystal Pine, 118 Or App 640 (1993); Nancy G. Brown, supra. There is no contention that termination of temporary disability benefits was authorized by the Board, the Evaluation Section or the Compliance Section. See OAR 438-06-075. Accordingly, we agree with the Referee's determination that SAIF was not authorized to terminate temporary disability benefits on the accepted, open thoracic strain claim.

Because the Referee found that SAIF was obliged to continue paying temporary disability compensation until proper closure of the accepted claim, he awarded claimant temporary disability compensation from January 24, 1992 until March 23, 1992, the date SAIF issued a Notice of Closure.

The Notice of Closure awarded claimant a period of temporary total disability ending January 23, 1992, and determined that claimant was medically stationary on February 11, 1992. (Ex. 15).

Subsequent to the Referee's order, the Court of Appeals held in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), that we may not impose a "procedural" overpayment by ordering a carrier to pay temporary disability benefits beyond a claimant's substantive entitlement to those benefits. There, the employer had refused to pay temporary disability benefits on an open aggravation claim. The claimant requested a hearing. While the hearing request was pending, the claim was closed by Determination Order. On Board review, we ordered the employer to pay temporary disability benefits through the date of claim closure. Recognizing that there would be an overpayment of temporary disability benefits in the amount paid from the medically stationary date through the closure date, we authorized the employer to offset that overpayment against future awards of permanent disability.

The court reversed. Noting the undisputed finding that the claimant was substantively entitled to temporary disability benefits through the medically stationary date, the court reasoned that the payment of temporary disability benefits beyond the medically stationary date, until the closure date, would create a "procedural" overpayment. The court concluded that the Board has no authority to impose that overpayment, and reversed the award of temporary disability benefits beyond the medically stationary date. Id. at 654.

Here, SAIF's Notice of Closure indicates that claimant became medically stationary on February 11, 1992, but it awarded temporary disability benefits only through January 23, 1992. Because the Notice of Closure determines claimant's substantive entitlement to temporary disability benefits, and the closure notice is not subject to our review in this case, we are without jurisdiction to review claimant's substantive entitlement to those benefits. See Galvin C. Yoakum, 44 Van Natta 2403, 2404, recon 44 Van Natta 2492 (1992); Ralph E. Fritz, 44 Van Natta 1168 (1992). Rather, our jurisdiction in this case is limited to claimant's procedural entitlement to temporary disability benefits, i.e., temporary disability benefits payable prior to claim closure. See Galvin C. Yoakum, supra; Steven V. Bischof, 44 Van Natta 255, recon 44 Van Natta 433 (1992), aff'd mem Freightliner Corporation v. Bischof, 115 Or App 758 (1992).

Inasmuch as claimant's substantive entitlement has been determined by Notice of Closure to end as of January 23, 1992, we are without authority to impose a procedural overpayment by awarding temporary disability benefits beyond that date.[1] See Lebanon Plywood v. Seiber, supra. Therefore, we reverse the Referee's award of temporary disability compensation after January 23, 1992.

On the penalty issue, however, we agree with the Referee's determination that SAIF's failure to pay temporary disability benefits on an open, accepted claim through the date of claim closure was unreasonable. Lebanon Plywood v. Seiber, supra; Pascual Zaragosa, 45 Van Natta 1221 (1993). Therefore, we affirm the Referee's assessment of a penalty in the amount of 25 percent of the temporary disability compensation that was due from January 24, 1992 until March 23, 1992, the closure date. ORS 656.262(10)(a).

Inasmuch as the compensation awarded to claimant by the Referee was disallowed and penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an assessed attorney fee for services on review. ORS 656.382(2); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 1, 1992 is reversed in part and affirmed in part. That portion of the order which awarded claimant temporary disability compensation from January 24, 1992 to March 23, 1992 and an attorney fee payable out of the increased compensation is reversed. The remainder of the Referee's order is affirmed.

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[1] We wish to emphasize that our order in this case addresses only claimant's procedural entitlement to temporary disability benefits and does not preclude claimant from establishing a greater substantive entitlement to those benefits by directly appealing from the Notice of Closure.

In the Matter of the Compensation of
JUDITH L. DUNCAN, Claimant
WCB Case No. 91-10737
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Lipton's order that: (1) directed it to pay temporary disability benefits as awarded pursuant to a Determination Order; (2) assessed a penalty and related attorney fee for unreasonable resistance to the payment of compensation; and (3) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. In its brief, the insurer also contends that the Referee erred in dismissing, for lack of jurisdiction, its cross-request for hearing on the Determination Order/Order on Reconsideration award of scheduled permanent disability benefits for the right forearm (wrist). On review, the issues are jurisdiction, extent of scheduled permanent disability, temporary disability compensation, penalties and attorney fees, and rate of scheduled permanent disability. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the first paragraph on page 3. We also supplement the Referee's findings with the following:

Claimant's injury claim was closed by Determination Order on February 12, 1991, with awards of temporary disability benefits, 4 percent scheduled permanent disability for the left forearm (wrist) and 11 percent scheduled permanent disability for the right forearm (wrist). Claimant requested reconsideration of the Determination Order, contending that: (1) the insurer did not pay her all temporary disability benefits awarded by Determination Order; (2) she is entitled to additional awards of permanent disability for each arm; and (3) she is entitled to payment of permanent disability awards at the rate of $305 per degree. The Department received claimant's request for reconsideration on June 28, 1991. The insurer did not request reconsideration of the Determination Order.

By Order on Reconsideration dated August 6, 1991, the Department increased claimant's scheduled permanent disability award for the right forearm (wrist) from 11 percent to 33 percent. On August 12, 1991, claimant filed a request for hearing, raising the issues of temporary disability, permanent disability, rate of scheduled permanent disability and penalties and attorney fees. In its response to the request for hearing, the insurer denied each of claimant's pleading allegations. Subsequently, claimant amended her hearing request to include the issue of the insurer's alleged failure to pay temporary disability awarded by Determination Order.

On November 5, 1991, the insurer filed a cross-request for hearing, requesting that claimant's 33 percent scheduled permanent disability award for the right forearm be disallowed and that the award be declared an overpayment of compensation to be offset against future awards of permanent disability.

At hearing, claimant withdrew all previously-asserted issues, with the exception of: (1) the rate of scheduled permanent disability; (2) the insurer's failure to pay temporary disability awarded by the Determination Order; and (3) penalties and attorney fees for the insurer's allegedly unreasonable refusal to pay compensation awarded by Determination Order. Claimant also moved to dismiss the insurer's cross-request of the Order on Reconsideration on the ground that the cross-request had been untimely filed.

The Referee dismissed the insurer's cross-request on the ground that the insurer had failed to request reconsideration of the Determination Order prior to filing its cross-request for hearing. He also found the cross-request to have been untimely filed. (Tr. 10).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer contends that, under ORS 656.268(6)(b) and (9), the Referee had jurisdiction to consider its cross-request regarding claimant's entitlement to temporary and permanent partial disability benefits granted by Determination Order. The insurer argues that a claimant's withdrawal of a specific issue at hearing does not limit the Board's jurisdiction over a Determination Order.

As a preliminary matter, we find that the Referee properly had subject matter jurisdiction to review the Determination Order and Order on Reconsideration in this case. Because the dispute involves a matter concerning a claim, the Referee had the authority under ORS 656.708 and 656.704(3) to decide the issue in dispute. See SAIF v. Roles, 111 Or App 597, 601-602, rev den 314 Or 391 (1992).

We find, however, that the Referee erroneously exercised his authority in dismissing the insurer's cross-request for hearing on the Determination Order/Order on Reconsideration. ORS 656.268(6)(b) provides:

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

OAR 436-30-050(3) provides:

> "The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing. The 180 day time limit will be tolled upon receipt of the request for reconsideration until the date the reconsideration order is issued."

ORS 656.319(4) provides:

> "With respect to objections to a reconsideration order under ORS 656.268, a hearing on such objections shall not be granted unless a request for hearing is filed within 180 days after the copies of the determination or notice of closure were mailed to the parties."

In this case, the Determination Order was mailed on February 12, 1991. Claimant filed a request for reconsideration which the Department received on June 28, 1991. The Order on Reconsideration issued on August 6, 1991. Thus, we find that claimant's August 12, 1991 hearing request was timely filed within 180 days after the Determination Order issued (excluding the period of reconsideration). On the other hand, the insurer's November 5, 1991 cross-request for hearing was untimely filed 226 days after the Determination Order issued (excluding the period of reconsideration).

Because claimant's hearing request placed the Determination Order and Order on Reconsideration awards before the Referee, the Referee could have considered the insurer's request for reduction of those awards, notwithstanding the untimeliness of the insurer's cross-request for hearing. The above-quoted statutes and rule do not contain an express requirement that a cross-request for hearing be filed within the 180-day time limit. On the contrary, ORS 656.319(4) appears to allow a hearing on a Determination Order and Order on Reconsideration if a hearing request is timely filed. Because claimant filed a timely hearing request on the Determination Order and Order on Reconsideration in this case, those awards were properly before the Referee. Therefore, we conclude that the insurer was not barred from challenging those awards by its failure to timely cross-request a hearing. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983) (Employer may contest Determination Order award, though only the claimant requested a hearing on the award.)

Our conclusion is consistent with OAR 438-06-031, which allows referees to consider issues raised for the first time at hearing. The rule provides, in part:

> "Amendments [to issues] shall be freely allowed up to the date of the hearing. If, during the hearing, the evidence supports an issue or issues not previously raised, the referee may allow the issue(s) to be raised during the hearing. The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice."

This rule provides a remedy for the surprise and prejudice that may result from raising an issue for the time at hearing. In this case, however, there is no showing that claimant was surprised and prejudiced by the insurer's challenge to the Determination Order and Order on Reconsideration. Moreover, claimant did not request a continuance in response to the insurer's challenge.

In addition, claimant's withdrawal of issues at hearing did not prevent the insurer from challenging the Determination Order and Order on Reconsideration awards. While claimant withdrew the extent of permanent disability issues at hearing, she specifically reserved other issues, such as the rate of scheduled permanent disability. We find that, by reserving the rate issue, claimant maintained her challenge to the amount of compensation awarded by the Determination Order and Order on Reconsideration. See Charlene J. Erspamer, 44 Van Natta 1214 (1992) (Rate of scheduled disability issue raises an objection to the amount of compensation awarded by Determination Order or Notice of Closure.)

Our conclusion is supported by James S. Franklin, 43 Van Natta 2323 (1991), which was decided under the law in effect before the 1990 amendments. There, the claimant timely requested a hearing on a Determination Order, raising issues of premature claim closure and extent of scheduled and unscheduled disability. The insurer did not file a formal cross-request for hearing; however, at hearing the insurer requested a reduction of the unscheduled permanent disability award. The claimant sought to withdraw his hearing request on the issue of extent of unscheduled disability, arguing that the Referee was thereby deprived of authority to review that issue. The Referee disagreed and reversed the Determination Order award of unscheduled disability. We affirmed on that issue, holding that the claimant's withdrawal of a single issue, while still asserting other issues relating to the Determination Order, did not deprive the referee of authority to consider the insurer's challenge to the Determination Order award.

Likewise, in this case, claimant maintained her challenge to the amount of compensation awarded by the Determination Order and Order on Reconsideration. Therefore, claimant's withdrawal of issues at hearing did not preclude the Referee from considering the insurer's challenge to the award. However, we conclude that, by not requesting reconsideration of the Determination Order, the insurer is barred from challenging a portion of the award.

Subsequent to the Referee's order, we held in Raymond L. Mackey, 45 Van Natta 776 (1993), 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. Here, the insurer did not seek reconsideration of the Determination Order. Therefore, the insurer may not challenge the Determination Order awards of temporary disability or permanent disability for the first time at hearing or on Board review.

Although the insurer is barred from challenging the temporary disability and permanent disability benefits awarded by Determination Order, claimant raised the issue of entitlement to an increased scheduled award in her request for reconsideration, and by Order on Reconsideration, the Department awarded an additional 22 percent scheduled permanent disability for the right forearm. Under such circumstances, we conclude that the insurer may contest the increased scheduled permanent disability benefits awarded by the Order on Reconsideration. See Todd M. Brodigan, 45 Van Natta 438, 439 (1993).

In Brodigan, we held that an insurer which failed to contest a Determination Order 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 an insurer 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 applies here. Therefore, although barred from challenging the Determination Order awards, the insurer may challenge the 22 percent scheduled permanent disability for the right forearm awarded by Order on Reconsideration.

Scheduled Permanent Disability - Order on Reconsideration

We find that the record is sufficiently developed for our review of claimant's scheduled

The criteria for rating scheduled permanent disability is the permanent loss of use or function of the injured member "due to" the industrial injury. ORS 656.214(2). Because claimant's right forearm condition is alleged to have resulted directly from the industrial accident, she must prove by a preponderance of the evidence that the accident was a material contributing cause of the condition. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 422 (1992).

The record shows that, while working on November 3, 1989, claimant slipped and fell down a flight of stairs, landing on her right hand and striking her left arm and elbow. She sought treatment with Dr. Thomas for multiple contusions and left wrist and elbow pain. She did not report pain or numbness in the right arm. X-rays revealed a fracture of the left radial head. (Exs. 2, 3, 4). Claimant filed a claim for the left elbow and arm. (Ex. 1). The insurer accepted the claim for left knee and left hand contusion.

In April 1990, after four months without treatment, claimant returned to Dr. Thomas with complaints of pain and numbness in the left hand. (Ex. 6). She was referred to Dr. Gambee for nerve conduction tests, which revealed moderate to severe carpal tunnel syndrome on the left. Evidence of early carpal tunnel disease was also found on the right side, but it was reported to be asymptomatic. (Ex. 7). On May 15, 1990, claimant underwent left carpal tunnel release surgery. (Ex. 9).

On June 12, 1990, claimant reported bilateral wrist pain for the first time, stating that it resulted from the industrial accident. (Ex. 12). In July 1990, claimant saw Dr. Thomas with complaints of pain and numbness in the right hand. She reported to him that she injured the right hand in the industrial accident. (Ex. 15). He diagnosed right carpal tunnel syndrome and performed a carpal tunnel release on that side. (Exs. 15, 16).

Given the seven-month delay between the compensable injury and the onset of claimant's right carpal tunnel symptoms, we find that the causation issue in this case presents a complex medical question which must be resolved largely on the basis of 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). There is no medical opinion in the record that specifically relates claimant's right carpal tunnel syndrome to the compensable injury. Although Dr. Thomas rated the extent of permanent impairment in both forearms and apparently reported it to the insurer as permanent impairment due to the compensable injury, (see Exs. 21, 22, 23), he provided no explanation in support of a causal relationship between the right forearm condition and the compensable injury.

Based on the record, particularly the evidence that the right forearm symptoms began more than seven months after the compensable injury, we conclude that claimant has not sustained her burden of proof. Accordingly, we reverse the Order on Reconsideration award of 22 percent scheduled permanent disability for the right forearm. Given our conclusion above that the insurer is barred from challenging the Determination Order award, we do not disturb that award. See Raymond L. Mackey, supra.

Finally, at hearing the insurer requested authorization for an offset of overpaid permanent disability benefits against future awards of permanent disability. Inasmuch as we have reversed a portion of claimant's scheduled disability award, we now address the insurer's offset request and deny it.

In Debbie L. Stadtfeld, 44 Van Natta 1474 (1992), we held that compensation that was not stayed pending review of the award may not be offset against future compensation awards. We relied on ORS 656.313(2), which provides:

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

Here, the insurer apparently paid a portion of claimant's permanent disability award pending reconsideration and hearing. Inasmuch as those benefits were not stayed pending review of the award,

Temporary Disability Compensation

We affirm and adopt the Referee's opinion and conclusions with regard to this issue. See ORS 656.268(5); Raymond L. Mackey, supra; Mindi M. Miller, 44 Van Natta 2144 (1992); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Penalty and Attorney Fee

We affirm and adopt the Referee's opinion and conclusions with regard to this issue.

Rate of Disability Compensation

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 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 $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. Inasmuch as penalties are not "compensation," claimant is not entitled to an assessed fee for defending on that issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated November 21, 1991 is affirmed in part, modified in part and reversed in part. That portion of the order that dismissed the insurer's cross-request for hearing is reversed. The Referee's order is modified to reverse the Order on Reconsideration award of 22 percent (33 degrees) scheduled permanent disability for the loss of use or function of the right forearm (wrist). The Determination Order award is affirmed. That portion of the Referee's order that requires claimant's permanent disability award to be paid at the rate of $305 per degree is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
JOHN O. GILL, Claimant
Own Motion No. 92-0176M
OWN MOTION ORDER
Charles Duncan, Claimant Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable left foot injury. Claimant's aggravation rights have expired. The employer opposes reopening. We grant the request for own motion relief.

On March 16, 1992, Dr. Jones, treating orthopedist, requested authorization for amputation of claimant's left fifth toe. The insurer received this request on March 24, 1992. The record contains several reports from Dr. Jones relating the need for the left fifth toe amputation to the original injury. (See letter dated March 16, 1992, and two letters dated April 6, 1992).

On April 26, 1992, Dr. Woolpert, orthopedist, issued an IME report based on his April 17, 1992 examination of claimant. Dr. Woolpert opined that "the accepted condition probably has contributed to the need for surgery, but I would feel in terms of major contribution it would be the pre-existing situation." However, Dr. Woolpert also stated that, regardless of the causative factor, Dr. Jones was "absolutely correct that amputation of the 5th toe would be the treatment of choice." Thus, although the employer may have some colorable argument regarding causation, there is no medical evidence in this record to support any doubt about the reasonableness and necessity of the proposed treatment.

By letter dated May 6, 1992, the employer recommended that claimant's claim not be reopened for own motion relief on the ground that claimant's current condition and need for medical treatment were not related to the 1982 compensable injury. The Board informed the employer on May 14, 1992 that, if medical services were being denied, the employer was required to issue a formal denial under ORS 656.262.

By letter dated June 15, 1992, the employer notified Dr. Jones that it considered the proposed surgery not to be reasonable or necessary treatment for the compensable injury. By letter dated June 18, 1992, the Board reminded the employer that if medical services were being denied on the basis of causation, the employer was required to issue a formal denial under ORS 656.262. The Board also informed the employer that if it was denying the reasonableness and necessity of the proposed surgery, the Board was to be informed whether and when a Director's medical review would be requested as ORS 656.327 and OAR 436-10-045 require.

On June 30, 1992, the employer notified the Board that it would be requesting a Director's medical review. On July 6, 1992, the Board postponed action on the own motion request pending the outcome of the medical review. On June 10, 1993, the Board sent the employer a letter inquiring about the status of this claim because the employer had neither requested Director's review nor had it denied the medical services claim.. By letter dated June 11, 1993, the employer informed the Board that it had decided not to request a Director's medical review.

As noted above, the employer was aware of claimant's claim for medical services and own motion relief on March 24, 1992, the date it received Dr. Jones' request for authorization for surgery. The employer had an ongoing duty to process that claim, which included its duty to follow the Director's rules regarding medical treatment disputes. OAR 436-10-003(3) provides that the rules applying to medical services apply to "all compensable claims existing or arising on or after July 1, 1990. (WCB Admin. Order 13-1992, effective July 1, 1992). Thus, the rules regarding medical treatment disputes enacted by WCB Admin. Order 13-1992 apply to claimant's claim, since that claim was in existence after July 1, 1990. As noted above, the employer notified the Board on June 30, 1992 that it intended to request Director to review the medical dispute. Thus, any request for Director's review would be made pursuant to WCB Admin. Order 13-1992.

Instead, the employer did nothing with this claim. It was not until the Board inquired about the status of the claim, almost a year after postponing action in reliance on the employer's statement that it would be requesting Director's review, that the employer stated that it had decided not to request Director's review. However, OAR 436-10-046 does not allow the employer the option of inaction. If the employer questioned the proposed surgery, it was required to follow the procedures provided in OAR 436-10-046.

As stated previously, the medical evidence in this record tends strongly to support causation as well as the reasonableness and necessity of the surgical procedure. The employer has neither denied the claim nor requested medical review by the Director. Thus, any concerns the employer might have had have evidently been resolved to its satisfaction. Accordingly, the Board will proceed with its review of claimant's request for own motion relief.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he is hospitalized for the proposed surgery. When claimant is medically stationary, the employer 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 the employer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
GAY GRAY, Claimant
WCB Case No. 92-05258
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of that portion of Referee Hazelett's order which set aside its denial of claimant's low back claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction. Claimant testified that prior to seeing Dr. Berselli on February 10, 1992, she experienced a gradual onset of pain that happened over approximately a two week period of time. (Tr. 18).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had sustained a strain injury in January 1992, when she experienced a sudden onset of pain, which gradually worsened. The Referee further found that claimant's work activity was a material contributing cause of her disability and need for treatment. He concluded that claimant had established a compensable injury. We disagree.

The insurer argues that claimant's claim should be treated as an occupational disease claim rather than an injury claim. An occupational disease is distinguishable from an injury in that a disease does not arise unexpected and is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1981). In order to be considered "sudden," a condition must occur "during a short, discrete period, rather than over a long period of time." Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983) rev den 296 Or 350 (1984). The injurious event need not be an instantaneous happening with a traumatic, sudden cause. Morrow v. Pacific University, 100 Or App 198, 203 (1990).

Claimant testified that her pain developed gradually over a two week period. (Tr. 18). She related the onset of pain to performing her usual duties. (Tr. 20). Claimant worked as a "floater" which required her to perform a variety of duties in the employer's warehouse, including working "on the line," stocking, and picking. (Tr. 32-33). These jobs involve repetitive lifting, bending, and twisting. Claimant sought treatment from Dr. Berselli on February 10, 1992, who obtained a history of recurrent onset of low back pain but no history of any trauma. (Ex. 21). On February 14, 1992, Dr. Berselli took claimant off work. (Ex. 24). Based on claimant's testimony and history to Dr, Berselli, we conclude that claimant's symptoms were not "sudden in onset." See AMFAC, Inc. v. Ingram, 72 Or App 168, 170 (1985)(conditions arising after two weeks of repetitive activity treated as an occupational disease). Therefore, the claim is properly analyzed as an occupational disease.

The parties do not contest the Referee's finding that claimant's January 1990 compensable lumbar strain had resolved. Claimant also suffers from preexisting lumbar degenerative disc disease. Thus, in order to establish a compensable occupational disease, claimant must prove, by medical evidence supported by objective findings, that her work activity was the major contributing cause of a worsening of her underlying degenerative disease. ORS 656.802(2).

Two medical opinions address the causation issue. The independent medical examiners (IME) at Western Medical Consultants opined that claimant had not had any subsequent injury, but had occasional recurrences of back pain, and that her present symptoms were a waxing and waning of her preexisting degenerative disc disease.

Dr. Berselli, claimant's treating physician, initially opined that the major contributing cause of claimant's current condition was her underlying degenerative disc disease. He also concurred with the opinion of the IME doctors. Dr. Berselli subsequently changed his opinion to state that claimant had sought treatment in February 1992 for a lumbar strain and that claimant's work activities were the major contributing cause of her disability and need for treatment between February and March 1992.

Because Dr. Berselli's subsequent opinion is conclusory and because he offered no explanation for his changed opinion, we do not find his changed opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Rather, we rely on the report of the Western Medical Consultants, with Dr. Berselli's concurrence as well as his initial opinion, and conclude that claimant's preexisting degenerative disc disease is the major contributing cause of her current condition and need for treatment. Claimant has therefore failed to establish a compensable occupational disease.

ORDER

The Referee's order dated August 13, 1992 is reversed in part and affirmed in part. The insurer's March 13, 1992 denial and "de facto" denial of a low back injury are reinstated and upheld. The Referee's $2,000 assessed attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARK L. HADLEY, Claimant
WCB Case No. 91-18218
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael Johnson's order which held that an Order on Reconsideration, which had issued without appointment of a medical arbiter, was invalid and dismissed claimant's request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and extent. We remand.

FINDINGS OF FACT

On March 5, 1990, claimant sustained a compensable injury to his left arm. The claim was accepted by the self-insured employer as a disabling left arm injury. Claimant's treating physician was Dr. Buehler.

Claimant's claim was closed by a July 5, 1991 Determination Order. Claimant was found medically stationary as of March 4, 1991 and was awarded 13 percent scheduled permanent disability. The Determination Order was based on Dr. Buehler's March 4, 1991 chart note which indicated that claimant's condition was medically stationary with a loss of range of motion and strength.

On November 25, 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 did not check the box indicating that he disagreed with the impairment findings made by his attending physician at the time of claim closure. Claimant did check the box indicating that he disagreed with the rating of scheduled disability by Evaluation. (Ex. 40-A).

With his request for reconsideration, claimant submitted a supplemental report prepared by a hand therapist, in which she responded to questions from claimant's counsel with regard to the extent of claimant's permanent disability under the relevant Director's rules. (Ex. 40). The hand therapist examined claimant on August 8, 1991. (Ex. 40-17). Dr. Buehler concurred with the hand therapist's examination findings. (Ex. 40-17).

On December 16, 1991, an Order on Reconsideration issued which increased claimant's scheduled disability to 19 percent of the left arm, based on the March 4, 1991 closing examination and an April 18, 1991 letter in which Dr. Buehler clarified his earlier findings. The Appellate Unit did not consider the hand therapist's supplemental report. (Ex. 41-2).

At hearing, the employer objected to the receipt of Exhibit 40, the supplemental medical report, because it was based on an examination that occurred after claim closure. (Tr. 3 and 5). The Referee overruled the objection in order to provide a complete record. (Tr. 7).

Also at hearing, neither party challenged the validity of the Order on Reconsideration based on the lack of a medical arbiter examination or the jurisdiction of the Referee to address the order.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that, because impairment is the only factor establishing scheduled disability, an objection to a Determination Order awarding scheduled disability is automatically a disagreement with impairment unless the only issue is misapplication of the rules or a mathematical error. Because the Referee found that claimant's only disagreement was with impairment, not the application of the rules, he concluded that, because a medical arbiter examination was not performed, the Order on Reconsideration was invalid. Accordingly, he set aside the Order on Reconsideration and dismissed claimant's request for hearing. We disagree.

The Director is required to refer a claim to a medical arbiter if a party's objection on reconsideration to a determination order or notice of closure is based on a disagreement with the

impairment findings used to rate the worker's disability. ORS 656.268(7). An Order on Reconsideration is invalid under this statute if the basis for objection is 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). 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. See Dale A. Pritchett, 44 Van Natta 2134 (1992).

Here, claimant did not check "box 4" on the form provided by the Department of Insurance and Finance to indicate that he disagreed with his attending physician's impairment findings. At hearing, claimant did not challenge the validity of the Order on Reconsideration based on the lack of a medical arbiter examination. Inasmuch as claimant did not disagree with his attending physician's impairment findings, it was not necessary for the Appellate Unit to appoint a medical arbiter. Accordingly, we conclude that the Order on Reconsideration is valid. See Doris C. Carter, 44 Van Natta 769 (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 his ensuing dismissal of claimant's hearing request, the Referee closed the hearing without permitting the parties to present testimony. Under these circumstances, we find that the record is incompletely developed with regard to the issue of extent of permanent disability. See Charles R. Butler, 44 Van Natta 994 (1992).

We therefore remand this matter to the Referee for further proceedings consistent with this order. ORS 656.295(5). Such proceedings may be conducted in any manner that the Referee determines will achieve substantial justice.

ORDER

The Referee's order dated March 10, 1992 is vacated. The matter is remanded to Referee Michael Johnson for further proceedings consistent with this order.

In the Matter of the Compensation of
JERRY D. HEMENWAY, Claimant
WCB Case No. 92-06165
ORDER ON REVIEW
Kosta, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brown's order that: (1) upheld the SAIF Corporation's denial of his claim for a back injury; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, remand and penalties and attorney fees.

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

In his brief, claimant requests that we remand this matter to the Referee for further proceedings related to discovery violations. The record indicates that the Referee held the record open for seven days for exchange of any evidence that had been withheld for impeachment purposes. (Tr. 73). No such evidence was exchanged and the record does not establish that any "impeachment evidence" was withheld.

Under ORS 656.295(5), we may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding; a compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, we find that the evidence claimant seeks is not reasonably likely to affect the outcome. Consequently, we conclude that remand is not warranted. Moreover, even if the record established the occurrence of a discovery violation, the underlying claim is not compensable. Thus, there has been no unreasonable resistance to the payment of compensation. Under such circumstances, claimant would not be entitled to an attorney fee pursuant to ORS 656.382(1). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

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

In the Matter of the Compensation of
PATRICIA A. HINSEN, Claimant
WCB Case No. 91-08725
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's "back-up" denial of her claim for a back injury on the basis that claimant was not a subject worker. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

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

At the time SAIF accepted claimant's claim, it was aware that the injury had occurred while claimant was cleaning a private residence.

CONCLUSIONS OF LAW AND OPINION

It is undisputed that at the time of the alleged October 2, 1990 injury, claimant was cleaning a private residence while working as a maid for Kathy Beckers, dba Merry Maids (the noncomplying employer). Under ORS 656.027(1), claimant was a domestic servant and, thus, excluded from coverage when the injury occurred. See Kerns v. Guido-Lee, 107 Or App 721 (1991). Relying on Kerns v. Guido-Lee, supra, the Referee found that claimant was not a subject worker at the time of her injury, and therefore, upheld SAIF's "back-up" denial. We reverse.

ORS 656.262(6) allows a carrier to deny an accepted claim within two years of the acceptance if it accepts the claim in good faith but later obtains evidence that the claim is not compensable. Subsequent to the Referee's order, the Court of Appeals, in CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993), held that the phrase "later obtained evidence" means "requires new material, i.e., something other than the evidence that the insurer had at the time of its initial acceptance." Id. at 286. In addition, the court also noted that the reevaluation by the insurer of known evidence in light of a change in the case law, does not constitute "later obtained evidence" under the statute. Id.

Here, at the time of claim acceptance, SAIF already knew that claimant's injury occurred while she was engaged in cleaning a private home (Exs 1, 10). Nonetheless, SAIF accepted the claim. SAIF's subsequent reevaluation of known evidence in light of the court's pronouncements in Kerns v. Guido-Lee, supra, did not constitute "later obtained evidence" under ORS 656.262(6). For this reason alone, SAIF's "back-up" denial must be set aside to the extent it is based on the subjectivity argument.

We also note SAIF's argument that once a "back-up" denial under the provisions of ORS 656.262(6) issues, the full range of compensability defenses becomes available. (Respondent's brief at page 3). We assume that included in this argument is the contention that a carrier may deny the claim on the basis of a "back-up" denial, and then later at hearing deny the claim on another basis even though the alleged "later obtained evidence" does not pertain to the new denial. In this case, the denial rescinded a prior acceptance of claimant's injury claim on the basis that newly discovered evidence indicated the injury, as alleged, did not occur while claimant was employed at Merry Maids (Ex 28). At hearing, SAIF raised the subjectivity argument.

The purpose of the recent amendments to ORS 656.262 are twofold. First, to allow carriers 90 days to more fully evaluate claims for benefits. See Kenneth A. Foster, 44 Van Natta 148 (1992); Sharon I. True, 44 Van Natta 261 (1992). Second, under limited circumstances, the purpose was to allow carriers to issue "back-up" denials even in the absence of fraud, misrepresentation or other illegal activity by claimant. Thus, the statute was designed to encourage carriers to accept uncertain claims if they could subsequently "back-up" and deny the claim based on clear and convincing evidence that the claim was not compensable. The legislature gave no indication that it intended for this statute to be used as a "springboard" for carriers to issue denials that otherwise would not be allowed under the provisions of ORS 656.262(6). To permit carriers to do so would have the practical effect of eviscerating the statute.

In her reply brief, claimant agrees with SAIF that the "back-up" denial was permissible insofar as it was based on "later obtained evidence" concerning whether the injury occurred. (Claimant's reply brief at page 1). However, it is claimant's contention that SAIF failed to carry its burden of proof by clear and convincing evidence that the claim was not compensable. ORS 656.262(6).

Again, we agree with claimant's assertion. To the extent that SAIF's denial is based upon the testimony of witnesses concerning whether or not the accident occurred, we find that SAIF did not prove by clear and convincing evidence that claimant's injury was not compensable. The testimony of Ms. Smith (who did not witness the incident) as well as the testimony of Mr. Hoff (who investigated the scene approximately 6 months after the accident) is not persuasive evidence that claimant's injury did not occur. This is particularly true in light of claimant's testimony to the contrary. SAIF has not carried its burden of proving by clear and convincing evidence that claimant's injury is not compensable. Accordingly, the "back-up" denial must be set aside.

Finally, we note the parties' arguments regarding whether or not the November 26, 1990 Proposed and Final Order precludes the employer and SAIF from litigating the issue of subjectivity. However, inasmuch as the above discussion is dispositive of the "back up" denial issue, we find it unnecessary to reach this other issue. To conclude, this matter is decided based upon our analysis and understanding of ORS 656.262.

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 $5,000, to be paid by the SAIF Corporation, on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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 August 10, 1992 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $5,000, payable by the SAIF Corporation, on behalf of the noncomplying employer.

In the Matter of the Compensation of
LARRY W. HOLMES, Claimant
WCB Case No. 91-18279
ORDER ON REVIEW
Skalak & Alvey, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Spangler's order that set aside its denials of claimant's current low back condition. On review, the issues are evidence and aggravation. We affirm.

FINDINGS OF FACT

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

On December 2, 1981, Dr. Berkeley performed an L4-5 laminectomy and decompression.

In May 1986, claimant underwent a second low back surgery: an L4-5 decompression for canal stenosis and for residuals of the earlier surgery.

The May 1988 settlement between claimant and SAIF extinguished claimant's future rights to benefits under his LHWCA claim, with the exception of future medical care. (Ex. 41-DD-4).

On August 14, 1991, claimant sought treatment at a Kaiser clinic, not with Dr. Berkeley. (Ex. 49AA). Claimant was treated conservatively by Dr. Satyan. Time loss was not authorized. (Ex. 51).

On October 29, 1991, claimant was examined by Dr. Morris, neurosurgeon. (Ex. 52). Claimant did not work after November 1, 1991. Dr. Morris referred claimant to Dr. Waldram, orthopedic surgeon, to assess whether a fusion should be carried out in conjunction with a radical decompression and discectomy at L4-5. (Ex. 55A). On December 2, 1991, claimant was examined by Dr. Rosenbaum, neurosurgeon, at the request of the insurer. (Ex. 58).

On December 13, 1991, the insurer partially denied claimant's aggravation claim for his current low back condition. On February 3, 1992, the insurer denied responsibility for the same condition, citing as other possible responsible employers the FMS Corporation for the 1978 injury and Northwest Marine Company for the 1979 injury. (Ex. 62).

On February 19, 1992, the U.S. Department of Labor denied responsibility under the LHWCA on the basis that claimant's request for medical services is due to the new December 19, 1990 injury.

At hearing, the insurer withdrew its intent to disclaim against FMC. (Tr. 17).

Exhibit 63AA, a chart note from Dr. Morris dated February 14, 1992, was received by claimant on February 27, 1992. It was admitted by the Referee while the record remained open.

CONCLUSIONS OF LAW AND OPINION

Evidence

The insurer contends that the Referee should not have admitted Exhibit 63AA because claimant did not establish that the document could not have been produced at hearing, as required by OAR 438-07-025(2). We disagree for the following reasons.

First, the Referee had not yet closed the record and rendered an opinion. Accordingly, OAR 438-07-025, which permits a referee to reconsider his or her decision upon the request of a party upon discovery of new material evidence, does not apply.

Second, referees are not bound by common law or statutory rules of evidence and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

We conclude that the Referee did not abuse his discretion by admitting the chart note of Dr. Morris, which pertained to a telephone conversation between Dr. Morris and the insurer that took place on February 14, 1992. The evidence was not available at the time of hearing because claimant was not aware of the note or its contents until he received it on February 27, 1992, after the hearing but before the record closed. Furthermore, in order to cure any prejudice to the insurer, the Referee offered the insurer the opportunity to cross-examine Dr. Morris. The insurer declined. Moreover, the insurer has not offered any evidence to establish that it was materially prejudiced as a result of the timing of the disclosure.

We consequently conclude that it was not an abuse of discretion for the Referee to admit the chart note pertaining to the discussion between Dr. Morris and the insurer. In addition, we conclude that the manner in which the Referee conducted the hearing achieved substantial justice.

Compensability of Aggravation Claim

Assuming without deciding whether claimant has a preexisting condition so that ORS 656.005(7)(a)(B) would apply to the facts of this case, we affirm the Referee's opinion that claimant has proven that the injury is the major contributing cause of his current condition and need for treatment.

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 evidence and aggravation issues is $1,350, 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 statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 11, 1992 is affirmed. Claimant's attorney is awarded $1,350 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
JAMES L. JEFFERS, Deceased, Claimant
WCB Case No. C3-01319
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lombard, Gardner, et al., Claimant Attorneys
William Brickey (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On May 14, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. The CDA provided that a third party settlement had been approved in the amount of $403,336.35. Furthermore, the CDA provided that SAIF's costs totaled $63,336.35, with future reserves of $138,888.88. The May 1993 CDA provided for a total consideration of $138,888.88, the "lien waiver" amount asserted by SAIF.

On June 14, 1993, the Board received an unsolicited addendum to the agreement. The parties' addendum provided that a third party settlement had been approved in the amount of $402,090.13. The addendum provided that SAIF had paid costs in the amount of $62,724.39, with future reserves of $138,669.03. The parties agree that in consideration for claimant's beneficiary's release of rights under the CDA, SAIF would waive its lien of $138,669.03.

Inasmuch as the June 1993 addendum substantially altered the bargain underlying the exchange of consideration, the Board was without authority to approve the May 1993 CDA. See e.g. Karen Vearrier, 42 Van Natta 2071 (1990). Therefore, we considered the parties' addendum to constitute a request to withdraw our May 14, 1993 letter of acknowledgement. Accordingly, we considered the date of receipt of the parties' addendum as the date of resubmission of a revised CDA. Inasmuch as 30 days has expired from the submission of the revised CDA, we have proceeded with our review. See ORS 656.236(1)(c).

The amended agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, this amended claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1)

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARENCE A. MYERS, Claimant
WCB Case No. 92-05156
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Davis' order that upheld the insurer's partial denial of claimant's claim for right leg peroneal nerve damage. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On October 29, 1990, in the course and scope of his employment, claimant attempted to clear vines from a potato harvester by holding on to the machine above his head and swinging his legs at the vines tangled in the chains below him. The vines cleared, but claimant's legs were trapped in the chains. His right leg rotated externally, causing a wrenching injury. Claimant experienced immediate pain in his right knee and his whole right extremity felt hot, numb and painful soon thereafter.

Claimant's claim for a disabling right knee strain was accepted.

On December 11, 1990, Dr. Carpenter performed arthroscopic surgery, discovered a tear in the most medial portion of claimant's latter meniscus and excised a portion of the right posterior horn. After the surgery, claimant was on crutches for about a week and felt "woozy" from pain medication for about two weeks. Thereafter, he noted numbness in his right leg from the groin area to below the knee.

On February 11, 1991, claimant sought treatment for sharp pain in his right calf. Dr. Carpenter diagnosed deep vein thrombosis, for which claimant was hospitalized and treated.

In late March 1991, claimant fell at home when his right knee collapsed. He reported to Dr. Carpenter that his right thigh remained numb after the fall.

In May 1991 claimant sought treatment from Dr. Eisler, neurologist, for continuing right extremity numbness and pain. Eisler performed neuroelectrophysiological tests which revealed reduced nerve conduction velocity in claimant's right leg.

An August 2, 1991 Notice of Closure awarded temporary disability compensation and 15 percent scheduled permanent disability for loss of use of claimant's right leg. An August 29, 1991 Order on Reconsideration affirmed the Notice of Closure. By stipulation, the insurer agreed to pay claimant an additional 5 percent scheduled permanent partial disability.

In late summer 1991, claimant suffered gradually increasing low back pain. On October 21, 1991, he had a lumbar spine MRI.

Following his right knee injury, claimant fell numerous times when his knee gave way. As of September 21, 1991, claimant's right anterior thigh pain had increased and his right knee collapsed once or twice a day.

On November 27, 1991, the insurer denied claimant's aggravation claim for a worsened right leg condition. On July 1, 1992, it denied the compensability of claimant's claims for deep vein thrombosis, nerve damage to the right leg, and a low back strain. A hearing was held pursuant to claimant's appeal from the insurer's aggravation and compensability denials.

ULTIMATE FINDINGS OF FACT

Claimant's compensable injury was the major contributing cause of his deep vein thrombosis.

Claimant's compensable injury is a material contributing cause of his current right extremity pain, numbness, weakness and give-way symptoms, diagnosed as peroneal nerve damage.

Claimant's worsened right leg condition is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Standard of proof

Claimant challenges only that portion of the Referee's order which upheld the insurer's denial of claimant's claim for nerve damage to the right leg. The Referee found that claimant's current right leg problems are claimed as a direct result of the October 29, 1990 compensable right knee injury. The Referee upheld the insurer's denial of compensability, finding that claimant did not establish that the injury was a material contributing cause of his current condition, diagnosed as peroneal nerve damage. We reverse.

At the outset, we find that the claim is asserted as related to the compensable injury directly and/or indirectly. (See Tr. 6-7; 9-10). In other words, claimant offers alternative theories of compensability. First, he contends that his right leg problems, specifically pain, numbness, weakness and give-way, arose from his work accident. Alternatively, claimant argues that these problems arose indirectly from his compensable injury, via an off-work fall which occurred later, when his injured right knee buckled. Because we find the claim compensable under the first theory, we do not reach the alternative argument.

The insurer argues that, due to the passage of months between claimant's work injury and his reports of right leg numbness, claimant's current condition could only be an indirect result of the compensable injury. Thus, it contends, ORS 656.005(7)(a)A) requires claimant to prove that his injury is the major contributing cause of his current condition. We disagree.

First, the passage of time alone does not necessarily mean that a late-developing condition is an indirect consequence of a compensable injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Second, we do not find that claimant's peroneal nerve damage symptoms, particularly right leg numbness, were delayed for weeks or months as the insurer asserts. Instead, we find that claimant experienced some numbness almost immediately upon injury, more during his recovery from the December 1990 surgery, and still more as time passed. (See Tr. 13, Ex. 17-1). Under these circumstances, in the absence of intervening causes and on the basis of the medical evidence discussed below, we find that claimant's current condition is more likely a direct result of his compensable injury. Accordingly, claimant need only prove that his October 1990 injury is a material contributing cause of his current disability and/or need for treatment for his right lower extremity. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

Compensability

The issue of causation is a complex medical question which requires expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In a case such as this, where the medical evidence is divided, we rely on those opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, 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). Here, we find no such reasons.

The medical evidence supporting compensability is provided by claimant's treating physicians, Drs. Eisler and Donofrio. Dr. Eisler, neurologist, first examined and treated claimant for continuing right extremity problems in May 1991. Eisler performed neuroelectrophysiological tests which revealed reduced nerve conduction velocity in the peroneal nerve in claimant's right leg, specifically, "chronic denervation in the right extensor digitorum brevis and peroneus longus muscles." (Ex. 14-1). Although independent examiners question the significance of these test results, the fact that the results are abnormal is not questioned.

Dr. Eisler theorized that claimant has "a possible right L-5 radiculopathy or a peroneal nerve dysfunction or else this is a diffuse symptomatology [sic] from the soft tissue trauma to the right knee and periarticular soft tissue." (Ex. 14A-4). Considering the mechanism of claimant's right knee injury and in light of claimant's normal low back examination and x-rays, (see Ex. 14B), Eisler reasoned, "It is likely that the wrenching injury caused a possible traction of the anterior tibial or peroneal nerve in the thigh or at the popliteal fossa." (Ex. 14-1-2). Thus, Eisler concluded that claimant's "main problem" is "a traction injury to the peroneal more than the posterior tibial nerve, either at the knee or immediately above the knee. Secondary muscular strain and a deconditioned state have added to his symptoms." (Ex. 14B).

Claimant sought continuing treatment from Dr. Donofrio, internist, in June 1991. Noting claimant's symptoms of pain, weakness and give-way, Donofrio agreed with Eisler's diagnosis of chronic peroneal neuropathy and prescribed physical therapy. (Exs. 16, 16A, 16B, 16C; see Ex. 20-1). Following an August 27, 1991 examination, Donofrio noted claimant's decreased right leg sensation and absent right ankle reflexes and opined that claimant had suffered a "re-exacerbation" of his neuropathic condition. (Id).

In October 1991, Eisler reexamined claimant at Donofrio's request. Eisler noted, as he had previously, that claimant's symptoms are consistent with low back neuropathy and recommended an MRI to rule out that explanation. (Ex. 24). In that context, Eisler noted "no clear-cut evidence of a nerve damage." (Id). Considering Eisler's opinion as a whole, we believe that the latter comment refers only to the absence of evidence of low back nerve damage. In addition, we note that claimant's October 21, 1991 low back MRI failed to shed new light on claimant's right leg complaints. (See Ex. 27-3). Under these circumstances, we conclude that Eisler's opinion, which is supported by Donofrio's opinion, consistently supports a finding that claimant's current right leg condition remains causally related to his compensable injury via injury-related peroneal nerve damage.

The evidence challenging compensability is provided by Drs. Hazel, Tesar and Wilson, independent examiners, and, arguably, by Dr. Fry, medical arbiter.

Dr. Fry examined claimant on September 21, 1991 at the insurer's request. Fry opined that claimant's right leg numbness is related to possible back pathology, without mentioning claimant's prior unremarkable back x-rays. (Ex. 22-3). He concluded that claimant's subjective complaints are not substantiated by objective findings, without mentioning claimant's neurological test results. (Id). Because it is not clear that Fry was aware of claimant's x-rays and test results, his opinion is based on a doubtful history. Consequently, we do not find his conclusions to be persuasive. See Somers v. SAIF, supra.

On July 10, 1991, Dr. Hazel, orthopedist, examined claimant and reviewed his history, noting previous electrical evidence of abnormality in the muscles below the knee. (Ex. 17-3). Hazel opined that claimant's paresthesias is "probably real," as it is supported by electrical abnormalities. (Ex. 17-4). However, based on his understanding that claimant did not become aware of numbness until weeks after his surgery, Hazel concluded that this problem is probably not related to "a wrenching, turning, twisting injury, or it would have been evident sooner." (Id). On the other hand, Hazel opined, without explanation, that claimant's "modest weakness of the quadriceps and hamstrings on the right" is injury-related. (Ex. 17-5). Hazel did not "understand the genesis" of claimant's give-way problem and found insufficient objective clinical evidence supporting its existence. (Ex. 17-4). He examined claimant again on October 30, 1991 and noted claimant's complaints of greater loss of right leg sensation, more give-way and more frequent falls due to give-way. After reviewing claimant's October 21, 1991 MRI, Hazel described claimant's spinal canal and discs as "pristine." (Ex. 27-3). He concluded that claimant's paresthesias and leg weakness was "bizarre" and "inexplicable," apparently based on his understanding that claimant has no "clear-cut neuropathies or radiculopathy." (Ex. 27-3). Hazel also reported inconsistencies on examination and nonanatomic findings. (Ex. 27-4; see also Ex. 30-8).

On January 6, 1992, Drs. Tesar and Wilson examined claimant at the insurer's request. They opined that claimant's right lower extremity problems are unrelated to his compensable injury, based on their understanding that the symptoms began four months after claimant's knee surgery and six months after his work injury. (Ex. 30-7). In our view, the opinions of Drs. Tesar and Wilson are not particularly persuasive because their conclusions are based in part on their mistaken belief that claimant's right leg numbness was a long-delayed symptom. See Somers v. SAIF, supra.

Under these circumstances, we find no reason to discount the opinions of claimant's treating physicians. See Weiland v. SAIF, supra. Accordingly, based on the opinions of Drs. Eisler and Donofrio, we conclude that claimant has established the compensability of his claim for right leg nerve damage. In addition, even if claimant was subject to the higher standard of proof imposed by ORS 656.005(7)(a)(A), we would reach the same result on this record.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of his claim for right leg nerve damage. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of that claim is $5,000, 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 appellate briefs, statements 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 18, 1992 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for right leg peroneal nerve damage is reversed. That claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review concerning the claim for peroneal nerve damage, claimant's counsel is awarded an attorney fee of $5,000, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID R. SULLIVAN, Claimant
WCB Case No. 92-02342
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Hoguet's order that: (1) set aside an Order on Reconsideration which found claimant permanently and totally disabled; (2) awarded claimant 57 percent (85.5 degrees) scheduled permanent disability for loss of use or function of the left leg, whereas the Determination Order had not awarded any scheduled permanent disability; (3) awarded claimant 3 percent (9.6 degrees) unscheduled permanent disability whereas the Determination Order had not increased claimant's award beyond that previously awarded; and (4) declined to direct the insurer to pay claimant's award of scheduled permanent disability at a rate of $305 per degree. In addition, claimant requests that this matter be remanded in light of the Supreme Court's decision in Tee v. Albertsons Inc., 314 Or 633 1992). On review, the issues are remand, permanent total disability, extent of scheduled and unscheduled permanent disability and rate of scheduled permanent disability. We vacate.

In determining that claimant was not permanently and totally disabled, the Referee relied on the opinion of Mr. Stipe, vocational expert. Mr. Stipe opined that claimant is capable of regularly performing part-time work in several sedentary occupations, such as automobile brokering and sales, recreational vehicle sales, motel clerk, security guard and telephone solicitor. At hearing and on review, claimant contended that such work is 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., supra, 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).

Accordingly, we vacate the Referee's order and remand this case to Referee Hoguet 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.

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[1] The record on this issue consists of testimony from a vocational counselor, Stipe, that the aforementioned part-time jobs pay minimum wage, or minimum wage versus commission in the case of an automobile salesperson. (Tr. 44, 56-58, 67). The record also includes some limited testimony from vocational expert Nelson regarding minimum wage and the aforementioned jobs. (Tr. 81, 84). 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.).

In the Matter of the Compensation of
LYNNE M. TRUEBLOOD, Claimant
WCB Case No. 91-06945
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our June 18, 1993 Order on Review which affirmed that portion of the Referee's order that declined to award claimant temporary disability benefits from May 25, 1989 through November 1, 1989. Claimant argues that we erred in applying a higher standard of proof for entitlement to temporary disability than we did for medical benefits. Claimant also requests that this case be reconsidered by the entire Board sitting en banc. The self-insured employer has filed a response to claimant's motion.

Whether a case is reviewed en banc is a matter that the Board decides on its own motion. Such review may not be initiated by a party. After reviewing this case, we deny claimant's request for en banc review. See Ralph L. Witt, 45 Van Natta 449 (1993) (on recon); Kurt D. Cutlip, 45 Van Natta 79 (1993)(on recon); Brenda K. Allen, 45 Van Natta 2476 (1992)(on recon).

On the merits of claimant's motion, we disagree with claimant's characterization of the Board's prior order. The Board did not, as claimant alleges, make any pronouncement regarding the standard of proof for entitlement to medical benefits. Indeed, the compensability of medical benefits was not at issue. Rather, the sole issue was claimant's entitlement to temporary disability benefits. The Board found that claimant's temporary disability following the noncompensable motor vehicle accident was not due, in material part, to the compensable injury. See Botefur v. City of Creswell, 84 Or App 627 (1987).

Accordingly, the Board's June 18, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish the Board's June 18, 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
DANIEL B. MILLER, Claimant
WCB Case No. 92-08492
ORDER ON REVIEW
Davis & Bostwick, Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Viewpoint Restaurant and Lounge, a noncomplying employer, requests review of Referee Podnar's order which: (1) found that claimant was a subject worker for Viewpoint and not an independent contractor; and (2) declined Viewpoint's request to set aside the SAIF Corporation's acceptance of claimant's injury claim which SAIF had issued on behalf of Viewpoint. On review, the issue is whether claimant is a subject worker.

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

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).

The Referee concluded that claimant was paid an hourly wage rather than being paid for the completion of specific portions of the project. Accordingly, the Referee found that at least one of the provisions of ORS 670.600 had not been met, and claimant was not an "independent contractor" as defined by the statute. We agree.

Viewpoint argues that, even if claimant is not automatically exempted as a nonsubject worker under ORS 656.027, claimant is not a subject worker because Viewpoint did not exercise the requisite degree of direction and control. Viewpoint contends that the "right to control" test is applicable. In addition, despite claimant's failure to register as a contractor, rather than a journeyman electrician, with the Builders Board, Viewpoint argues that claimant should be precluded from asserting such an oversight by the doctrine of equitable estoppel. However, even if we overlooked claimant's failure to register with the Builders Board, we would still conclude that he was not an independent contractor.

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). The Court of Appeals has held that, in order for a party to be considered an independent contractor, all eight of the provisions of ORS 670.600 must be met. Liberty Northwest Ins. Corp. v. Potts, 119 Or App 252 (1993). Because "right to control" represents only one of eight provisions of ORS 670.600, that test alone is no longer determinative of the question of whether a worker is a subject worker. Liberty Northwest Ins. Corp. v. Potts, supra at 254.

ORDER

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

In the Matter of the Compensation of
JAMES F. PLUMMER, Claimant
WCB Case No. 92-02707
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of that portion of Referee Barber's order that upheld the self-insured employer's denial of his occupational disease claim for his bilateral hearing loss 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 concluded that, because claimant could not show ratable impairment under the "standards," he had not established compensability of his occupational disease claim for a bilateral hearing loss condition. We disagree.

In analyzing this case, the Referee relied upon two Board cases in which the claimants' hearing loss conditions were found to be not compensable. In Craig M. Pence, 38 Van Natta 879 (1986), we found that the claimant had no ratable hearing loss and his claim was not compensable. However, in Pence, the doctor who conducted the claimant's audiogram found that although the claimant had a high frequency hearing deficiency, his hearing was not abnormal, and his frequency deficiency was more likely attributable to off-work factors. Because we found the doctor's opinion persuasive, the occupational disease claim was not compensable.

Similarly, in Phillip D. Prince, 43 Van Natta 573 (1991), one doctor stated that the claimant did not have measurable hearing loss as defined under the "standards." Another doctor stated that, after comparing audiograms, he believed that the claimant had no hearing loss, and any difference between the claimant's right and left ears was not related to noise at work. In Prince, we concluded that the claimant had not proved that his hearing loss arose out of his employment and, therefore, it was not compensable.

Although the two cases cited by the Referee do contain references to measurable or ratable hearing loss under the "standards," the cases do not stand for the proposition that a ratable hearing loss under the administrative rules is a threshold requirement for compensability. Rather, whether a claimant does or does not have ratable impairment under the "standards" is one factor that may be considered in determining the persuasiveness of the proffered medical opinions. The critical determination to establish the compensability of an occupational disease claim remains whether claimant has proven that his work activities were the major contributing cause of his bilateral hearing loss condition. See Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991) on rem 44 Van Natta 117 (1992).

Here, claimant worked for the employer as a firefighter since 1974. In 1983, claimant indicated that he had experienced trouble hearing and understanding, and underwent a hearing test. In 1987, claimant's test results provided that his hearing was not within normal limits, and Dr. Mettler recommended hearing protection to be worn during noise exposure.

In November 1991, Peter Charuhas, audiologist, reported that claimant's evaluation demonstrated a "bilateral moderate high frequency sensorineural hearing loss." Without further explanation, Charuhas reported that claimant's loss is "not compensable."

In May 1992, Dr. McDonald, an ear specialist, reported that he had reviewed claimant's records and had examined claimant. Dr. McDonald reported that the "overall impression of the audiogram is a mild to severe, sloping, sensorineural hearing loss bilaterally." Dr. McDonald also reported that he had reviewed the employer's noise monitoring results from 1981, which showed a "significant exposure to sounds above 90 (decibels)." Dr. McDonald stated that he was convinced that claimant's hearing loss was of a noise induced nature and was contributed to primarily by job related noise exposure.

Claimant was also examined by Dr. Milligan, who reported in August 12, 1992 that claimant suffered from a hearing loss, and his work activities with the employer were the major contributing cause of his hearing loss condition.

The employer argues that the doctors' opinions should be discounted because claimant did not provide the physicians with an accurate history of his off-work noise exposure. We disagree. Claimant's unrebutted testimony establishes that he informed the physicians about his off-work noise exposure.

Under the circumstances, we rely upon the opinions of Drs. McDonald and Dr. Milligan, who examined claimant, reviewed his records and his noise exposure, and opined that work was the major cause of his hearing loss condition. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980). We do not rely upon the conclusory opinion of the audiologist who found that claimant had a hearing loss condition, but provided only a "legal" opinion that the claim was "not compensable."

Finally, the employer contends that claimant's hearing loss condition is not compensable because it has not resulted in disability or required medical services. We recently addressed this issue in another hearing loss case, in which we found that the claimant had received medical services as he had sought treatment for his increased hearing loss, undergone a physical examination and audio tests for his condition, and was referred for future yearly hearing examinations. See David M. Crymes, 45 Van Natta 267 (1993); Finch v. Stayton Canning Co., 93 Or App 168 (1988). Similarly, in the present case, claimant underwent audio tests and physical exams for his hearing loss condition and was directed by Dr. Mettler to wear hearing protection. We, therefore, conclude that claimant has shown that his occupational disease required medical services.

Consequently, we conclude that claimant has established the compensability of his occupational disease claim for his bilateral hearing loss condition. The Referee's order is, therefore, reversed.

Claimant is entitled to an assessed attorney fee for services at hearing and on review for prevailing over the employer'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 fee for services at hearing and on review is $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 7, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant is awarded an assessed fee of $3,500, to be paid by the employer.

In the Matter of the Compensation of
LELA M. KENFIELD, Claimant
WCB Case No. 91-08331
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

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

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

In October 1990, claimant began receiving medical treatments relating to her compensable injury. The underlying dispute involves the question of whether those medical treatments are palliative or curative. In Gladys M. Theodore, 44 Van Natta 905, 908 (1992), we concluded that such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue. Therefore, original jurisdiction over that dispute lies exclusively with the Director. Mary S. Leon, 45 Van Natta 1023 (1993); Rexi L. Nicholson, 44 Van Natta 1546, 1548 (1992). Nevertheless, claimant argues that the Hearings Division has jurisdiction to consider her contention that the 1990 amendments to ORS 656.245 are unconstitutional. We disagree.

The Board, and thus our Hearings Division, has jurisdiction over matters concerning a claim. ORS 656.704(3). A matter concerns a claim if the claimant's right to receive compensation, or the amount thereof, is directly at issue. See Stiehl v. Timber Products, 115 Or App 651, 654 (1992). A worker's right to receive compensation, or the amount thereof, is directly at issue if resolution of the contested matter will necessarily determine the claimant's right to receive compensation, or the amount thereof. See Spencer House Moving Company, 44 Van Natta 2522, 2523 (1992).

If we agreed with claimant's contention, that the 1990 amendments to ORS 656.245 are unconstitutional, the compensability of claimant's medical treatments would still be at issue. Consequently, resolution of her constitutional argument will not necessarily determine her right to receive compensation, and the Referee properly dismissed claimant's request for hearing. Moreover, we have previously held that where we lack jurisdiction over a palliative care dispute, we do not have the authority to address a claimant's arguments concerning the constitutionality of ORS 656.245. Mary S. Leon, supra.

ORDER

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

In the Matter of the Compensation of
DONNA J. ENGLAND, Claimant
WCB Case No. 90-02863
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Charles J. Cheek (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. England v. Thunderbird, 315 Or 633 (1993). The Court has mandated that we reconsider claimant's unscheduled permanent disability award. In accordance with the Court's instructions, we proceed with our reconsideration.

FINDINGS OF FACT

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

Claimant has not received a high school diploma or GED. Claimant's highest specific vocational pursuit (SVP) level in the last ten years was as a cocktail waitress (DOT # 311.477-018).

CONCLUSIONS OF LAW AND OPINION

The Supreme Court has reversed the Court of Appeals' opinion, 112 Or App 324 (1992), which affirmed our order, Donna J. England, 43 Van Natta 1617 (1991), that affirmed a Determination Order's award of 9 percent (28.8 degrees) unscheduled permanent disability for a neck injury. Claimant contended that the Director's disability standards were invalid in that they did not consider claimant's age, education, and adaptability because she had returned to her regular work following the compensable injury. In our decision, we relied on former ORS 656.726(3)(f)(A), which authorizes the Director to adopt "standards for the evaluation of disabilities," and former ORS 656.295(5), which directs the Board to apply the Director's "standards." Consequently, we declined to declare the Director's rules invalid. We also found that claimant had not established that she suffered greater disability than indicated by the "standards." ORS 656.295(5).

In rendering its opinion, the Supreme Court held that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a) (which held that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work) were inconsistent with former ORS 656.214 (which provided that "[e]arning 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 given job.")

Noting that "earning capacity" under the former statute was an inexact term, the Court declared that its role was to determine whether the agency "erroneously interpreted a provision of law" (ORS 183.482(8)(a)) and that the ultimate interpretative responsibility rested with the Court in its role as the arbiter of questions of law. See Springfield Education Assn. v. School Dist., 290 Or 217, 234 (1980). Turning to the statute, the Court determined that the legislature had chosen to list four factors (age, education, impairment and adaptability) which must be considered in rating a worker's permanent loss of earning capacity.

Reasoning that post-injury employment may establish earnings but not necessarily establish earning capacity, the Court concluded that the Director's former rules (which gave no value for age, education, and adaptability based on a worker's post-injury earnings) were contrary to the legislative intent. Since we did not consider those factors in rating claimant's permanent disability, the Court has remanded for further proceedings. We now proceed with our reconsideration.

The Referee affirmed the 9 percent unscheduled permanent disability awarded by the Determination Order. We modify.

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

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

The Referee found that claimant was entitled to a 9 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 (1) and education (4) for a total of (5). Therefore, we adopt this value when we calculate claimant's permanent disability and discuss only the value for adaptability.

Here, since claimant returned to regular work, her adaptability value under the standards is zero. Former OAR 436-35-310(2)(a). Since claimant's adaptability value is used as a multiplier pursuant to former OAR 436-35-280(6), claimant would also receive no value for age and education. However, in light of the Court's mandate, we must consider claimant's age, education, and adaptability in determining the extent of claimant's unscheduled permanent disability.

Former OAR 436-35-280(4) provides that the values for age and education are added together. Former OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. Former OAR 436-35-280(7). As noted above, when a claimant's adaptability value is zero, the values for age and education are essentially not considered because zero is the multiplier.

Consistent with the England court's mandate, we conclude that where a claimant's adaptability value is zero, former OAR 436-35-280(6) cannot be used in determining the extent of unscheduled permanent disability. Rather, we find that pursuant to former OAR 436-35-280(7), the value for age and education should be added to the value for impairment to arrive at the percentage of unscheduled permanent disability to be awarded. Such an analysis would essentially be the same as assigning an adaptability value of 1. Inasmuch as claimant's age, education and training would be considered for purposes of rating extent of unscheduled permanent disability under this analysis, we consider this formula to be consistent with the Director's standards, as altered by the Supreme Court's holding.[1]

In reaching this conclusion, we also note that in her appellant brief before the Board, claimant contended that inasmuch as her at-injury job had an SVP value of 3 and she had returned to the same job, she was entitled to an adaptability value of 1. (Claimant's Appellant Brief at p. 7). Moreover, SAIF concurs with claimant's contention. (SAIF's Supplemental Brief at p. 2). Finally, claimant has reiterated her contention in her supplemental brief. In that brief, she agrees that she is entitled to an award of 14 percent using an adaptability value of 1. (Claimant's Supplemental Brief at p. 1).

Applying this analysis to the instant case, when the total value for claimant's age and education (5) is multiplied by the adaptability value (1), the total is 5. When this value is added to the value for impairment (9), the result is 14. Therefore, claimant's unscheduled permanent disability is 14 percent.

ORDER

The Referee's order dated November 30, 1990 is modified. In addition to the Determination Order's award of 9 percent (28.8 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for a total unscheduled award of 14 percent (44.8 degrees). Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800.

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[1] The Director has recently promulgated temporary rules in response to the Court's decision in England, supra. (WCD Admin. Order 93-052). Inasmuch as claimant was medically stationary prior to July 1, 1990, the temporary rules are not applicable to this case. OAR 436-35-003(1). However, we note that application of the temporary rules would also result in claimant receiving an adaptability value of 1. OAR 436-35-310.

In the Matter of the Compensation of
DOLORES J. GILPIN, Claimant
WCB Case Nos. 92-01115 & 92-02237
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Pamela A. Schultz, Defense Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corporation, on behalf of Chris' Coffee Shop (Liberty/Chris'), requests review of Referee Hazelett's order that: (1) set aside its denials of claimant's aggravation claim for a current low back condition; (2) upheld its denial, on behalf of Al's Corner (Liberty/Al's), of claimant's new injury claim for the same condition; and (3) assessed a penalty for its allegedly unreasonable denial of compensability. In its Reply Brief, Liberty/Chris' requests remand for admission of additional evidence concerning claimant's alleged new injury at Liberty/Al's. On review, the issues are remand, compensability, responsibility, aggravation and penalties. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

In its Reply Brief, Liberty/Chris' requests remand for admission of additional evidence concerning claimant's alleged mopping injury during her employment at Liberty/Al's. In this regard, Liberty/Chris' argues that remand is appropriate because some physicians lacked complete histories, i.e., were unaware that the claimed incident occurred. Assuming, without deciding, that Liberty/Al's motion is timely, we deny the motion, based on the following reasoning.

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

Here, the apparent reason that some physicians were unaware of the alleged mopping incident is that claimant did not report it to them. Under these circumstances, we do not find that medical evidence concerning that event was unobtainable with due diligence at the time of hearing. Accordingly, we do not consider the present record, without additional medical evidence regarding the "new injury" claim, to be improperly, incompletely or otherwise insufficiently developed. Consequently, Liberty/Chris' motion to remand is denied.

Compensability

We adopt the Referee's "Conclusion of Law and Opinion" on this issue, with the following comment.

We need not decide whether Liberty/Chris' 1988 stipulated acceptance of claimant's aggravation claim necessarily included claimant's then-current right leg pain, because we agree with the Referee that claimant's present low back problems, including the condition causing her right leg pain, remain directly related to the accepted 1987 injury.

Responsibility/Aggravation/Penalties

We adopt the Referee's "Conclusion of Law and Opinion" on these issues, with the following modification.

In place of the second two paragraphs on page 6, we apply the following law regarding responsibility.

Under ORS 656.308(1), when an accepted injury is followed by an increase in disability during employment with a later employer/insurer, responsibility rests with the original employer/insurer 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, Liberty/Chris', as the last employer/insurer with whom claimant had a compensable low back injury, remains presumptively responsible. In order to avoid responsibility, Liberty/Chris' has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for Liberty/Al's. Gerald K. Mael, 44 Van Natta 1481, 1482 (1992).

In order to prove a "new compensable injury," Liberty/Chris' must show that the claimed 1991 mopping 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).

Here, because we agree with the Referee that Liberty/Chris' has not proven, by medical evidence supported with objective findings, that claimant suffered a new injury during her employment at Liberty/Al's, we conclude that responsibility remains with Liberty/Chris'.

Claimant is entitled to an assessed attorney fee for prevailing over the Liberty/Chris' 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, responsibility and aggravation issues is $1,200, to be paid by Liberty/Chris'. 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 October 7, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,200, payable by Liberty Northwest Insurance Corporation on behalf of Chris' Coffee Shop.

In the Matter of the Compensation of
EILENE E. HARDING, Claimant
WCB Case No. 92-04801
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Neal's order that decreased claimant's scheduled permanent disability award for the loss of use or function of the left leg (knee) from 15 percent (22.5 degrees), as awarded by an Order on Reconsideration, to 5 percent (7.5 degrees). In her brief, claimant also objects to the admission of Exhibits 28, 29, 30 and 31. On review, the issues are evidence and extent of scheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

Claimant, 42 at hearing, worked for the employer as a lead central supply technician for 14 years. On May 3, 1991, she compensably injured her left knee when she turned a corner in the supply room and felt a pop in her knee. (Ex. 1). She was first seen by Dr. Bradley, M.D., who diagnosed a possible anterior cruciate ligament tear. Bradley put claimant in a knee immobilizer, gave her crutches, took her off work and referred her to Dr. Tennant, orthopedic surgeon. (Ex. 2). Dr. Tennant diagnosed Grade 1 sprain of the left patellar ligament and continued conservative treatment, which included physical therapy beginning June 4, 1991. (Ex. 7). On June 17, 1991, Dr. Tennant concluded that he had exhausted treatment for patellar tendonitis and referred claimant to a work hardening program. (Ex. 8).

Claimant returned to light duty work in June 1991, but her condition did not improve. (Exs. 8 and 9). She was referred to Dr. Vigeland, orthopedic surgeon, for a second opinion. (Ex. 9). He first saw her on June 24, 1991. He thought her complaints were patellofemoral but could not rule out a torn medial meniscus. By September 5, 1991, he had resumed her physical therapy. On September 19, 1991, he referred claimant for a radioactive bone scan, which he concluded was normal.

Claimant was next evaluated by Dr. Butler, orthopedic surgeon, on October 21, 1991. He was unable to establish a clear diagnosis and recommended psychological counseling. (Exs. 14 and 15).

Claimant was evaluated at Worker's Rehabilitation Services at St. Vincent Hospital on November 14, 1991. (Ex. 16). She had a psychological evaluation by Dr. Davis. Dr. Davis did not think claimant was a good candidate for a pain center program, although he thought she might be a candidate for a trial of work hardening. (Ex. 16-3).

Claimant was enrolled in a work hardening program from November 14, 1991 to December 4, 1991. (Ex. 18). At its conclusion, claimant's job was modified to avoid pushing anesthesia machines. (Ex. 18-1 and 18-3).

On December 16, 1991, Dr. Tennant declared claimant medically stationary and released her to "regular" work as of November 22, 1991. (Ex. 19).

Claimant's claim was closed by a January 3, 1992 Determination Order that awarded no permanent disability.

On January 22, 1992, claimant requested reconsideration, objecting to the impairment findings used in rating her disability at the time of claim closure.

On February 11, 1992, Dr. Gritzka, orthopedist, performed a medical arbiter's examination. He found that claimant had a chronic and permanent condition which limits the repetitive use of her left knee, i.e., chronic infrapatellar tendinitis and mild retropatellar bursitis. He also found knee flexion on the left to be 120 degrees, as compared to 155 degrees on the right.

A March 5, 1992 Order on Reconsideration awarded claimant a scheduled award of 15 percent (22.5 degrees) for the loss of use and function of her left leg (knee).

The insurer requested a hearing. At hearing, claimant objected to Exhibits 28, 29, 30 and 31 on the basis that they were generated after the Order on Reconsideration.

FINDINGS OF ULTIMATE FACT

Claimant has sustained an 11 percent loss of use or function of the left leg (knee) due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee admitted four post-Reconsideration Order medical reports over claimant's objection at hearing: Exhibits 28, 29, 30 and 31. Exhibits 28, 29 and 30 are "check-the-box" responses to the insurer's questions about range of motion from Dr. Butler, dated March 9, 1992; Dr. Vigeland, dated March 11, 1992; and Dr. Tennant, claimant's treating physician, dated March 24, 1992. Exhibit 31 is an April 29, 1992 letter from the insurer to Dr. Tennant, to which Tennant concurred.

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 1799 (1991). Here, Drs. Butler and Vigeland are neither the attending physician nor the medical arbiter, nor are their reports concurred in by Dr. Tennant. Therefore, they may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability. See Agnes C. Rusinovich, 44 Van Natta 1544, corrected 44 Van Natta 1567 (1992).

ORS 656.268(5) allows the submission of corrective reports and any medical evidence that should have been but was not submitted by the attending physician at the time of claim closure. See Agnes C. Rusinovich, supra. However, medical evidence from the attending physician, offered pursuant to ORS 656.268(5), must be submitted "at the reconsideration proceeding." ORS 656.268(5); Gary C. Fischer, 44 Van Natta 1597 on recon 44 Van Natta 1655 (1992). Finally, with the exception of a medical arbiter's report pursuant to ORS 656.268(6)(a), any medical evidence generated after an Order on Reconsideration is not admissible. ORS 656.268(7); ORS 656.283(7); 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); Gary C. Fischer, supra.

Here, although Exhibits 30 and 31 are from claimant's attending physician, the exhibits were generated after the March 5, 1992 Order on Reconsideration. Thus, they cannot be considered. Nancy A. Worth, supra; Teresa L. Erp, supra; Tor J. East, supra; Gary C. Fischer, supra. Accordingly, we conclude that the Referee erred in considering the disputed evidence. Consequently, we do not consider this evidence on review.

Extent of Scheduled Permanent Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the "standards" for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the issuance of the Determination Order control the evaluation of scheduled permanent partial disability at hearing and on review of the reconsideration order. OAR 436-35-003(2); OAR 438-10-010. The Determination Order issued on January 13, 1992. Accordingly, we apply the "standards" in effect on that date: WCD Admin. Order 2-1991 and 7-1991 (temp.).

Here, Dr. Gritzka performed a medical arbiter examination on February 11, 1992. He diagnosed claimant with a chronic and permanent condition, chronic infrapatellar tendinitis and mild retropatellar bursitis. He also found knee flexion on the left to be 120 degrees, as compared to 155 degrees on the right. However, he stated:

> "The quantitative extent to which left knee function is limited by the examinee's condition cannot be determined *** from a physical examination. To do so would require testing with a device such as a Cybex machine and/or formal physical capacities evaluation. However, in general terms, it can be stated that [claimant] does have a chronic and permanent condition limiting repetitive use of the left knee.

> "[Claimant] is presently working at a job that requires that a walker stand for greater than two hours in an eight-hour work period. Based on the evaluation today, no reason is seen that [claimant] cannot continue to work at her present job. She does state, however, that to stand or walk for two hours or more during a work day causes knee pain." (Emphasis added).

We find Dr. Gritzka's diagnosis of claimant's chronic condition and range of motion measurements to be more persuasive than the reports by Dr. Tennant. Dr. Gritzka diagnosed claimant with chronic infrapatellar tendinitis and retropatellar bursitis. He measured and compared claimant's range of motion in both legs. In contrast, there is no evidence in the record that Dr. Tennant actually examined claimant between June 17, 1991 and December 16, 1991, when he declared her medically stationary and released her to regular work. In June, Tennant had found that claimant had a "full range of motion" in the left leg, but her condition at that time was still in a state of flux. There is no evidence in the record that Dr. Tennant performed a closing examination or concurred in the findings of the other physicians who treated claimant between June and December. Furthermore, claimant's "regular work" had actually been modified during this period.

Accordingly, based on the preponderance of the evidence, we are more persuaded by the opinion of Dr. Gritzka, the medical arbiter, and conclude that claimant has 11 percent impairment due to loss of flexion in the knee. See OAR 436-35-220(1).

However, the arbiter's opinion is not sufficient to prove that claimant's condition renders her unable to repetitively use her knee. Even though the arbiter stated that claimant has a chronic condition that limits her ability to repetitively use her right knee, his opinion is conclusory and does not establish that claimant is prevented from repetitively using the knee. See Donald E. Lowry, 45 Van Natta 1452 (1993). Furthermore, even though he reports claimant's complaints of pain after standing or walking for two hours or more during a work day, he finds no need to restrict her from performing her present job, which requires standing for more than two hours in a work day, and does not restrict claimant from using the knee. We accordingly conclude that this evidence is not sufficient to carry claimant's burden to prove her entitlement to an award for a chronic condition. See ORS 656.266.

Thus, based on the arbiter's opinion, we conclude that claimant has 11 percent loss of use or function of the left leg (knee) due to her compensable injury.

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 (a 6 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).

ORDER

The Referee's order dated July 10, 1992 is modified. In addition to the 5 percent (7.5 degrees) scheduled permanent disability awarded by the Referee, claimant is awarded 6 percent (9 degrees) scheduled permanent disability, giving her a total award of 11 percent (16.5 degrees) scheduled permanent disability for her right leg (knee) injury. Claimant's attorney is awarded a fee of 25 percent of the increased compensation created by this order, not to exceed a total of $3,800 in fees approved by the Referee and the Board. 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
ROBERT L. HARDT, Claimant
WCB Case No. TP-92015
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Claimant has petitioned the Board to resolve a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, claimant contends that the SAIF Corporation is not entitled to that portion of its lien ($40,000) which is attributable to claim costs for a Claim Disposition Agreement (CDA). We hold that SAIF is entitled to reimbursement for these incurred costs.

FINDINGS OF FACT

In September 1988 claimant suffered a compensable injury while performing his work activities as a log truck driver. Specifically, while unloading a load of logs, claimant was struck by a cable. SAIF accepted the claim for a right shoulder fracture and provided benefits.

Claimant also retained legal counsel to pursue a third party action arising from his compensable injury. The action pertained to the conduct of the plywood company where claimant had been delivering logs at the time of his injury.

An August 17, 1989 Determination Order (DO) closed the claim. Claimant was awarded 61 percent unscheduled permanent disability for a right shoulder injury and 20 percent scheduled permanent disability for loss of use of function of the right arm. Claimant requested a hearing, seeking additional unscheduled and scheduled permanent disability awards, as well as permanent total disability (PTD). That hearing was postponed awaiting resolution of pending litigation regarding claimant's third party lawsuit.

On July 22, 1992, Ms. Blair, SAIF's third party adjuster, provided claimant's counsel with a copy of its actual and projected lien. The lien, which totalled $84,410.36, was composed of the following actual costs: (1) $10,483.95 (temporary disability); (2) $8,504.41 (medical benefits); (3) $552 (vocational services); and (4) $23,870 (permanent disability). SAIF also projected $41,000 in future costs, which included $40,000 from a proposed Claim Disposition Agreement and $1,000 in "future medical aid."

The proposed CDA provided as follows. In return for $40,000 (less a $5,875 attorney fee), claimant released his rights to "all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278 for any and all past, prior and future conditions resulting directly or indirectly from this claim for occupational injury or disease, but does not include compensable medical services."

An addendum to the proposed CDA (executed by both claimant's counsel and SAIF's counsel) provided that SAIF retained its third party lien rights. The addendum was signed by SAIF's counsel on July 22, 1992 and by claimant's counsel on July 24, 1992. On July 24, 1992, the Board approved the amended CDA.

SAIF's counsel's intention in recommending the CDA was to avoid the potential of a PTD claim arising from claimant's pending hearing request. SAIF's counsel's approval of the CDA was not provided "solely on the basis that there might be future aggravation and the Board's 'own motion' benefits."

On August 11, 1992, a Referee dismissed claimant's pending hearing request regarding the DO. The Referee noted that the issues raised by claimant's hearing request had been resolved pursuant to the recently approved CDA. The Referee dismissal order carried an inaccurate WCB Case Number.

On August 14, 1992, claimant sought dismissal of his pending hearing request under the correct WCB Case Number. On August 25, 1992, a Referee issued an Amended Order of Dismissal. Repeating that the CDA had resolved the pending issues, the Referee dismissed claimant's hearing request.

On August 22, 1992, claimant's counsel forwarded a letter to Ms. Blair at SAIF confirming their telephone conversation. Claimant's counsel acknowledged SAIF's approval of the third party's $325,000 settlement offer. In addition, claimant's counsel stated that "[w]e will reimburse SAIF's lien in the sum of $84,410.36."

On September 22, 1992, claimant and the third party entered into the settlement. Shortly thereafter, another attorney from claimant's counsel's firm notified SAIF that claimant was questioning SAIF's entitlement to recover the $40,000 for CDA proceeds. Contending that the majority of such payments would be for future aggravation or own motion claims, claimant argued that such compensation was not recoverable under ORS 656.593(3)(c).

On October 19, 1992, Ms. Blair responded to claimant's current counsel. Noting that a hearing request regarding claimant's entitlement to PTD had been pending at the time of the CDA, Ms. Blair asserted that the basis for the $40,000 payment was "PTD exposure, not aggravation and Board's Own Motion benefits." Furthermore, Blair declared that SAIF was unwilling to amend an agreement which had been previously made regarding "the amount of the gross settlement, its distribution, and on the amount of SAIF's lien."

On November 12, 1992, claimant's former counsel forwarded a letter to claimant's current counsel. Enclosing a copy of Ms. Blair's July 22, 1992 letter (which had itemized SAIF's lien including the $40,000 in CDA proceeds), claimant's former counsel confirmed that SAIF approved the $325,000 settlement, less its lien. Claimant's former counsel left the question of whether the $40,000 in CDA proceeds were specifically exempted from recovery to claimant's current counsel.

Notwithstanding their disputes, the parties agreed that the third party settlement could proceed. The parties further stipulated that claimant's current counsel would retain $40,000 of the settlement proceeds in trust pending resolution of the dispute. Unable to resolve this matter, claimant has petitioned the Board for relief.

CONCLUSIONS OF THE 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 556.794. See 656.593(1)(c). Finally, any remaining balance from the third party recovery shall be paid to the worker. ORS 656.593(1)(d).

Here, the dispute concerns whether SAIF is entitled to receive reimbursement for $40,000 of its asserted lien, which pertains to its CDA payment. Noting that its approval of the $325,000 third party settlement was expressly granted in return for claimant's former counsel's recognition of SAIF's entire lien (including the $40,000 in CDA costs), SAIF asserts that claimant must honor its entire lien. In essence, SAIF is charging that claimant is attempting to revise the previously approved settlement and proposed distribution of third party proceeds.

Our review of relevant court and Board decisions supports SAIF's contention that claimant is obligated to satisfy SAIF's lien in its entirety. When either a worker or a paying 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. Williams, supra, at p. 620. In Williams, the paying agency provided a statement regarding its lien that did not include its anticipated future claim costs. Relying upon the statement, the claimant settled the third party action. Thereafter, the paying agency asserted its lien, which included an additional amount

for anticipated future claim costs. Reasoning that the claimant was entitled to rely on the paying agency's prior representation concerning its lien, the court held that the paying agency's "just and proper" share of the third party settlement would be limited to the amount of the originally asserted lien.

We applied the Williams reasoning in Timothy J. Gheen, 43 Van Natta 1484 (1991). In Gheen, the claimant agreed to honor a paying agency's $18,000 lien in return for the agency's approval of a third party settlement. Following the settlement, the claimant objected to a portion of the agency's lien which apparently pertained to a projected pain center program. Reasoning that the paying agency was entitled to rely on claimant's representation that its lien would be honored, we declined to alter the parties' mutually agreed "just and proper" distribution.

Here, as in Gheen, claimant expressly agreed to reimburse SAIF for its entire lien. In exchange for that promise, SAIF granted its approval of the third party settlement. We hold that the parties should abide by their prior proposed distribution. The time for claimant to challenge SAIF's lien was when claimant's former counsel received SAIF's statement concerning its actual and projected lien. Yet, rather than questioning the lien or any of its components, claimant's former counsel notified SAIF that its lien would be reimbursed in an amount which included the CDA expenses.

In light of such circumstances, we are not prepared to modify the parties' previous agreement. To permit either party to challenge or alter any portion of a previously approved lien at a date subsequent to a third party settlement would create further instability in the negotiation process. We decline to take such an action, particularly when claimant agreed to fully reimburse SAIF for its claim costs he was fully aware that SAIF was including CDA proceeds in its lien.

Even if we overlooked claimant's obligation to honor his agreement with SAIF, we would continue to conclude that SAIF is entitled to reimbursement for its CDA payments. In reaching such a conclusion, we disagree with claimant's assertion that CDA payments do not constitute "compensation."

We recently addressed this issue in Scott Turo, 45 Van Natta 995 (1993). In Turo, while the claimant's third party (TP) action was pending, he and his workers' compensation carrier entered into a CDA. The CDA did not refer to the TP action. Once the TP settlement was approved, the carrier sought reimbursement for the CDA proceeds. Relying on ORS 656.005(8), 656.593(1)(c) and (3), we concluded that since the CDA proceeds were benefits provided for a compensable injury, they were "compensation" which were recoverable as an actual claim cost from the claimant's TP settlement.

In reaching our conclusion in Turo, we recognized that future claim costs for aggravation claims and own motion claims are not lienable under ORS 656.593(1)(c). Nevertheless, since actual CDA payments were expended in existence at the time of the TP settlement, we reasoned that they did not retain any specific identity with any or all of the future rights extinguished in the CDA. Id. Thus, because CDA proceeds represented actual claim costs for compensation paid to a worker, we held that the CDA payments were fully reimbursable. Id.

Here, the relevant facts are similar to those present in Turo.[1] 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.[2] In return, claimant received $40,000. SAIF did not waive or

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[1] Although signatory to this order, Board Member Gunn directs the parties to his dissent in Scott Turo, supra.

[2] Consistent with our reasoning in Turo, we have concluded that once expended, CDA payments do not retain any specific identity with any or all of the future rights extinguished in the CDA. However, even if we were to examine whether the $40,000 in consideration pertained to future aggravation or own motion claims, the record would not support such a conclusion. At the time of the CDA, claimant's hearing request remained pending. Pursuant to that request, claimant was seeking additional unscheduled and scheduled permanent disability awards, we well as a PTD award. Since there had not been a final order determining the extent of disability arising out of claimant's claim closure order, any additional disability resulting from claimant's pending hearing request would be likewise lienable. See Julio Mejia, 44 Van Natta 2140, on recon 44 Van Natta 2288 (1992); John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985).

Inasmuch as claimant's hearing request was expressly dismissed in direct response to the approved CDA, we are persuaded that the CDA payments were devoted to possible awards resulting from the pending litigation. This possibility is further confirmed by SAIF's counsel's affidavit, which attests that the CDA was not solely based on future aggravation and "Own Motion" claims. Instead, SAIF's counsel states that the CDA was proposed due to the potential that claimant would receive PTD.

reduce its third party lien as consideration for the CDA. To the contrary, an addendum to the CDA expressly provided that SAIF retained its third party lien rights. In accordance with the Turo rationale, we hold that SAIF's CDA payment is reimbursable from the third party settlement.

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 $40,000 payment, claimant requests that SAIF's recoverable lien be limited to claim costs incurred prior to that payment. Such an alteration would be inconsistent with the parties' approved addendum to the CDA, which expressly provided that SAIF retained its third party lien rights. Moreover, 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).

Accordingly, we hold that SAIF is entitled to recover its entire lien (including the $40,000 CDA payment) as its "just and proper" share of the third party settlement. See ORS 656.593(3). Therefore, claimant's attorney is directed to forward to SAIF the aforementioned $40,000 from counsel's trust account.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY E. O'NEAL, Claimant
WCB Case No. 91-12978
ORDER ON REMAND
Gatti, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. O'Neal v. Tewell, 119 Or App 329 (1993). The court has reversed that portion of our prior order which declined to award an "out-of-compensation" attorney fee when the SAIF Corporation increased the rate of claimant's temporary total disability (TTD) without a hearing. Relying on OAR 438-15-030, we had found that claimant's counsel had not been "instrumental in obtaining compensation" for claimant without a hearing. Reasoning that the aforementioned phrase was applicable only to "insurer-paid" attorney fees under ORS 656.386(1), the court held that there was no such limitation for "out-of-compensation" attorney fees under ORS 656.386(2). Consequently, the court has remanded for reconsideration of the attorney fee issue.

It is undisputed that the rate of claimant's TTD was increased prior to hearing. In light of such circumstances, claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-15-030; O'Neal v. Tewell, supra. In accordance with claimant's attorney retainer agreement, this fee shall equal 25 percent of the increased TTD, not to exceed $1,050. Accordingly, SAIF is directed to pay claimant's counsel an attorney fee consistent with the aforementioned formula.

In the event that the increased TTD has already been paid to claimant, this order will have created an overpayment of compensation equal to the attorney fee granted herein. Should such circumstances exist, SAIF is authorized to recover the overpayment created by this order against claimant's future permanent disability awards under this claim. See Kenneth V. Hambrick, 43 Van Natta 1287, 1288 (1991).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTO S. SANCHEZ, Claimant
WCB Case No. 90-16219
ORDER ON RECONSIDERATION
Kelley & Kelley, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

The SAIF Corporation requests reconsideration and abatement of our June 25, 1993 Order on Review which awarded claimant scheduled permanent disability and increased his award of unscheduled permanent disability. In particular, SAIF points out that, in the body of the order, we awarded 16 percent scheduled permanent disability, yet the order portion of the order awarded 18 percent scheduled permanent disability.

We correct the order portion of the Order on Review to award 16 percent (24 degrees) scheduled permanent disability. Therefore, we withdraw our prior order. On reconsideration, as modified herein, we adhere to and republish the June 25, 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
DONNA M. WOLFE, Claimant
WCB Case No. 91-15244
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee McCullough's order that: (1) declined to direct the SAIF Corporation to "reimburse" claimant for medical bills that had been previously paid by claimant's private insurer which in turn had already been reimbursed by a "third party" insurer as a result of a settlement achieved before SAIF assumed responsibility for claimant's workers' compensation claim; and (2) declined to assess a penalty against SAIF for allegedly unreasonable claim processing. On review, the issues are claim processing and penalties. We dismiss claimant's hearing request for lack of jurisdiction.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW

The Referee denied claimant's request for "reimbursement" from SAIF for medical bills which had already been paid by claimant's private insurer while the compensability of the claim had been pending. Noting that the private insurer had been reimbursed by the "third party" insurer from a settlement (which had been achieved prior to the inception of SAIF's responsibility for the claim), the Referee reasoned that no unpaid medical bills existed for SAIF to provide reimbursement.

Claimant seeks review, contending that SAIF is obligated to pay for medical services resulting from her compensable injury. See ORS 56.245. Yet, the record does not reveal a claim from a medical service provider asserting an unpaid bill. In fact, claimant acknowledges that her medical bills have been paid by her private insurer.

Claimant asserts that she should be personally "reimbursed" for that portion of her settlement with the "third party" insurer which was used to reimburse her private insurer for payments made to her medical services provider. In essence, she is seeking to assume the private insurer's position; i.e.,

demand reimbursement from the workers' compensation insurer for expenditures made prior to the inception of the workers' compensation insurer's responsibility for the processing of the claim. Such insurer disputes do not constitute "matters concerning a claim." ORS 656.704(3); Lloyd v. Employee Benefits Insurance Company, 96 Or App 591 (1989). Consequently, neither the Hearings Division nor the Board have jurisdiction to resolve this dispute.

ORDER

The Referee's order dated November 12, 1992 is reversed. Claimant's hearing request is dismissed.

In the Matter of the Compensation of
MARK E. LANDON, Claimant
WCB Case No. 92-10468
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Spangler's order that upheld the SAIF Corporation's denial of claimant's medical services for drug treatment programs. On review, the issues are jurisdiction and medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable knee injury. In 1991 and 1992, claimant participated in two drug treatment programs. SAIF denied the compensability of such medical services based on its contention that they had not been approved by an attending physician and were not related to his compensable injury. The Referee upheld the denial, finding that claimant had not proved that the treatment was causally related to his injury and, alternatively, an attending physician had not approved the treatment.

We lack original jurisdiction of disputes concerning the compensability of medical services where the contention is that the treatment was not approved by an attending physician. See Julie M. Harper, 44 Van Natta 820 (1992). Therefore, we vacate that portion of the Referee's order determining that the drug treatment programs were not compensable because they were not approved by an attending physician.

We have also held, however, that we have original jurisdiction to consider the causal relationship between medical services and the compensable injury. See Michael A. Jaquay, 44 Van Natta 173 (1992). With regard to this issue, we affirm and adopt the relevant portion of the Referee's order.

ORDER

The Referee's order dated November 23, 1992 is affirmed in part and vacated in part. That portion of the Referee's order that purported to uphold the SAIF Corporation's denial on the lack of attending physician approval is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DONALD RHUMAN, Claimant
WCB Case No. C301690
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Royce, Swanson, et al., Claimant Attorneys
Kathryn Olney (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On June 24, 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). 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.

Here, the CDA has failed to provide whether claimant has been able to return to the workforce. Therefore, the CDA does not contain all of the information required by the Director's rules.

Furthermore, the proposed disposition agreement provides, in part, that a dispute exists between claimant and the insurer concerning claim processing penalties. Pg. 2, Ln. 21. It further provides that a certain amount of the total CDA settlement is intended to compromise claimant's claim for such penalties. Pg. 2, Ln. 22.

The function of a claim disposition is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. See ORS 656.236(1). It is not the function of a CDA to dispense with disputes arising from allegedly unreasonable claims processing. 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). Consequently, because such language exceeds the bounds of OAR 438-09-020(1)(b), we find that the CDA is "unreasonable as a matter of law." ORS 656.236(1)(a).

Because the offensive 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 (1991). Consequently, we decline to approve the agreement and return it to the parties. See ORA 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. 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
SHAUN M. DONOVAN, Claimant
WCB Case No. C3-01646
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Schneider, et al., Claimant Attorneys
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On June 18, 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 approve the proposed disposition.

The originally submitted CDA proposed to award an attorney fee out of the settlement proceeds, which consisted of an annuity having a present value of $44,787. Pg. 2, ln. 5, 24. Accordingly, the $6,375 attorney fee exceeded the amount provided in the Board's rules. OAR 438-15-052(2). See Thomas M. Green, 43 Van Natta 1517 (1991). The parties' addendum clarifies that the $6,375 attorney fee is in addition to the present value of the annuity, making the total consideration of the agreement equal to $51,162.

On June 28, 1993, we requested an addendum to correct an excessive attorney fee of $6,375 or to provide extraordinary circumstances to justify the excessive fee. On July 15, 1993, we received the parties' addendum to the claim disposition.

Therefore, upon review of the document as a whole, we find that it is the intent of the parties to settle this matter for a total consideration of $51,162, with an attorney fee of $6,375 to claimant's attorney and $44,787 to claimant. Moreover, because the parties' addendum has not changed the amount of the present value of the annuity, we do not find that the revision represents an alteration of the amount of consideration underlying the bargain. See Mary A. Smith, 45 Van Natta 1014, 45 Van Natta 1072 (1993).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARVIN L. THRASHER, SR., Claimant
WCB Case No. 92-07640
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Montgomery Cobb, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Galton's order that set aside its partial denial of claimant's chondromalacia condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, who was employed as a utility maintenance worker with the employer for 16 years, sustained a disabling injury to his left knee on September 4, 1990, when he was tearing down a brick flue and some bricks fell and struck his left knee. (Exs. 1 and 11). After the pain and swelling persisted, he sought treatment from Dr. Lockwood, his family doctor, who referred him to Dr. Utterback, orthopedist. Utterback initially diagnosed a knee strain. However, claimant's symptoms continued and on February 5, 1991, Dr. Utterback performed an arthroscopy of claimant's left knee. (Ex. 7).

At arthroscopy, Dr. Utterback found extensive chondromalacia, a large osteophyte and floating cartilaginous debris in the joint. His post-operative diagnosis was degenerative joint disease of the left knee. (Ex. 7).

Dr. Farris, orthopedist, performed an independent medical examination (IME) on July 8, 1991. He diagnosed extensive chondromalacia and found a reduced range of knee motion. Dr. Utterback concurred with the IME report.

On September 18, 1991, a Determination Order issued awarding claimant 9 percent scheduled permanent disability based on reduced range of motion. (Ex. 14).

On November 25, 1991, claimant requested reconsideration, contending that he should receive an additional impairment value due to chondromalacia. His request was supplemented by a letter in which Dr. Utterback rated his chondromalacia. (Ex. 16).

On April 9, 1992, the Standards Review Committee of DIF declined to promulgate a temporary rule for chondromalacia. (Ex. 17).

An April 14, 1992 Order on Reconsideration reduced claimant's scheduled permanent disability to 6 percent, based on reduced range of motion. (Ex. 18). Claimant requested a hearing, seeking additional scheduled permanent disability based on chondromalacia. The insurer defended the Order on Reconsideration award.

By Opinion and Order dated May 29, 1992, Referee Lipton affirmed the Order on Reconsideration award. Referee Lipton noted that he did not have the authority to go outside the rules promulgated by the Director in order to evaluate claimant's chondromalacia. (Ex. 22).

On May 29, 1992, the insurer issued a partial denial, stating:

> "We have reviewed available information and must advise you that we are denying your chondromalacia as your compensable injury is not the major contributing cause of the chondromalacia." (Ex. 23).

Claimant requested Board review of Referee Lipton's order. By Order on Review dated March 30, 1993, we affirmed Referee Lipton's order. Marvin L. Thrasher, 45 Van Natta 565 (1993). Although noting that the Director had adopted OAR 436-35-230(13)(a)-(b) subsequent to the Order on Reconsideration to evaluate impairment due to chondromalacia, we found that claimant had not sustained his burden of proving entitlement to an impairment value under the rule.

ULTIMATE FINDINGS OF FACT

Claimant's compensable knee injury is the major contributing cause of his current disability or need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer is barred by res judicata from raising the issue of the compensability of claimant's current chondromalacia condition, based on the insurer's failure to raise the compensability issue at the "extent" hearing before Referee Lipton. The insurer contends that the denial must be upheld as a "back-up" denial and that claim preclusion does not apply. We affirm the Referee's order.

Even were we to agree with the insurer that it is not barred by the prior "extent" litigation from denying the current chondromalacia condition, we would still find that claimant has established the compensability of the chondromalacia. If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (June 2, 1993).

Dr. Utterback, claimant's treating orthopedist, initially opined that, while claimant has degenerative joint disease of the left knee, the initiating factor and major contributing cause of his current disability is the injury sustained on September 4, 1990. (Ex. 10). Dr. Farris, orthopedist, independently examined claimant regarding solely the results of the September 1990 injury. He diagnosed generalized chondromalacia of the left knee. (Ex. 11). Dr. Utterback concurred with Dr. Farris's findings and recommendations. (Ex. 12). Neither doctor indicated that claimant's current disability was in any way unrelated to the injury.

We are not persuaded by Dr. Utterback's response to the insurer's May 8, 1992 letter, which was conclusory and contradictory. In it, Dr. Utterback indicated in a "check-the-box" fashion that the major contributing cause of claimant's chondromalacia condition is probably genetic, with overuse as the other contributing cause. However, he also stated that his answers may well be reversed. (Ex. 19).

Furthermore, whether the chondromalacia may have been caused by genetic factors or by overuse, the proper inquiry is whether the compensable left knee injury combined with the preexisting condition to cause or prolong disability or a need for treatment. Based on the record, we find that claimant has carried his burden of proving that the compensable September 1990 injury is and remains the major contributing cause of his current disability and need for treatment.

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 $1,500, 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 September 4, 1992 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ROSEMARY A. WEISENBACH, Claimant
WCB Case No. 91-13397
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Thye's order which: (1) found that the Hearings Division had jurisdiction to consider the issue of extent of permanent disability; and (2) set aside a Determination Order, which terminated claimant's permanent total disability (PTD) award, and reinstated the PTD award. On review, the insurer objects to a pre-hearing interim order which denied its request to compel claimant to appear for a vocational evaluation. Claimant has also filed a motion to remand for additional evidence. On review, the issues are remand, jurisdiction, the pre-hearing ruling, permanent total disability, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

A June 19, 1991 Determination Order terminated claimant's PTD benefits. On August 20, 1991, claimant filed a request for reconsideration with the Appellate Review Unit, objecting to the June 19, 1991 Determination Order and raising the issue of permanent total disability. (Ex. 202A). Then, on September 18, 1991, claimant filed a request for hearing from the June 19, 1991 Determination Order, raising the issues of permanent partial and permanent total disability. The Appellate Review Unit issued its Order on Reconsideration on September 5, 1991, which affirmed the Determination Order. (Ex. 204). On December 10, 1991, claimant filed a supplemental request for hearing, objecting to the September 5, 1991 Order on Reconsideration and raising the issues of permanent partial and permanent total disability. The hearing proceeded on both hearing requests.

The insurer contends that, based on claimant's August 1991 request for reconsideration, the Referee lacked jurisdiction before the Evaluation Section issued its reconsideration order. See former ORS 656.268(4). We disagree.

The Referee found that the amendments to ORS 656.268(5), which require reconsideration of a Determination Order by the Appellate Unit before a request for hearing may be filed, did not apply to the Determination Order issued upon review of a permanent total disability award because claimant became medically stationary on or before July 1, 1990. OAR 436-30-065(7). Therefore, the Referee concluded that the Hearings Division had jurisdiction. We agree.

OAR 436-30-065(7)(a) provides that any party to the claim who disagrees with the Determination Order which reviewed a permanent total disability award, may request reconsideration by the Evaluation Section or request a hearing, if the worker became medically stationary on or before July 1, 1990. See also former ORS 656.268(4)(request for reconsideration of a Determination Order must be made prior to the time a request for hearing is made).

Under former ORS 656.268(4), claimant's September 18, 1991 request for hearing was premature because jurisdiction remained with the Evaluation Section. However, even assuming that claimant was invoking the reconsideration process under former ORS 656.268(4) rather than amended ORS 656.268(5), claimant's December 10, 1991 request for hearing from the Order on Reconsideration conferred jurisdiction on the Hearings Division.

Remand

Claimant has filed a motion to remand to the Referee for receipt of "post-hearing" medical evidence consisting of a February 22, 1993 operative report and a March 2, 1993 discharge summary, both authored by claimant's treating physician, Dr. Nash.

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. 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.

Although the proferred evidence concerns claimant's disability, we conclude that claimant has failed to show a compelling reason to warrant remand. Claimant contends that the evidence is material because it rebuts the insurer's contention that claimant's L4-5 fusion is now solid and that the complete fusion is the primary medical reason claimant's condition has improved. The insurer contends that claimant is attempting to bolster Dr. Nash's opinion and that such evidence was available at the time of hearing. Thus, the issue of whether or not claimant's fusion is solid goes to the weight to be given the opinion of Dr. Rutledge (who opined that the fusion was solid) and that of Dr. Nash (who opined that claimant had lumbar vertebral instability at L4-5).

Even if we were to find that the post-hearing surgery reports show that claimant's spinal fusion was not solid, we do not find that remanding to the Referee is reasonably likely to affect the outcome of this case. Since the Referee was persuaded by Dr. Nash's "non-solid fusion" opinion prior to surgery, it is reasonable to assume that Dr. Nash's "post-surgery" opinion confirming that prior opinion would have no effect on the Referee's prior decision.

Because we find that even if such evidence were admitted, it is not reasonably likely to affect the outcome of the case, we deny claimant's motion to remand.

Evidentiary Matters

By means of a pre-hearing ruling, the Assistant Presiding Referee denied the insurer's motion to compel claimant to appear for a vocational evaluation. The referee reasoned that the insurer failed to demonstrate the exercise of due diligence justifying its failure to obtain a vocational report prior to hearing. We agree.

ORS 656.283(7) provides that "the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." We review the Referee's discovery ruling for abuse of discretion. See James D. Brusseau, II, 43 Van Natta 541 (1991)(review for abuse of discretion where the referee excluded evidence as untimely pursuant OAR 438-07-018); Renia Broyles, 42 Van Natta 1203(1990)(referee did not abuse his discretion in declining to reopen record for admission of further evidence under OAR 438-07-025). Based on the following reasoning, we do not find that the Referee abused his discretion by denying the insurer's motion to compel.

Prior to submitting the claim for redetermination pursuant to ORS 656.206(5), the insurer referred claimant to Dr. Rutledge, who is located in Florida, where claimant resides. Pursuant to a June 19, 1991 Determination Order, claimant's permanent total disability award was terminated. This action was based on Dr. Rutledge's March 19, 1991 examination and opinion that claimant's spinal fusion was solid and that she was capable of gainful employment. However, no vocational evaluation was obtained prior to the permanent total disability termination nor before claimant's arrival in Oregon (a few days before the scheduled December 27, 1991 hearing). When the insurer was unable to arrange a time with claimant for a vocational evaluation, the insurer requested, on December 19, 1991, an order compelling claimant to appear for an evaluation and to postpone the hearing.

The Referee denied the motion, reasoning that the insurer had failed to establish due diligence as required to justify granting the motion. See OAR 438-06-081. Given the lapse of time between the June 19, 1991 Determination Order and the December 27, 1991 hearing, we conclude that it was not an abuse of discretion for the Referee to hold that the insurer failed to exercise due diligence in obtaining a vocational evaluation prior to hearing.

In the event that the insurer's contention constitutes a motion for remand, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). We note that the insurer's vocational expert attended the hearing, heard claimant's testimony, and testified at hearing. In addition, to merit remand for consideration of additional evidence, it must clearly be shown that the material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., supra. As found above, the evidence the insurer seeks to submit was obtainable at the time of hearing with the exercise of due diligence. Accordingly, remand is denied.

Permanent Total Disability

We affirm and adopt the Referee's findings and conclusions on the issue of permanent total disability.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved. Claimant's counsel's unsuccessful efforts regarding the remand motion have not been considered.

ORDER

The Referee's order dated July 17, 1992 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,500, payable by the insurer.

In the Matter of the Compensation of
LARRY D. FOWLER, Claimant
WCB Case No. 92-02706
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Barber's order that set aside the self-insured employer's denial of his occupational disease claim for his bilateral hearing loss 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 first concluded that claimant had failed to establish compensability of his bilateral hearing loss condition, as he had not shown that he had ratable impairment under the "standards."

We recently held that whether claimant has shown ratable impairment under the standards is not dispositive on the issue of compensability. See James F. Plummer, 45 Van Natta 1477 (1993). Although we acknowledged that a showing of ratable impairment (or a lack of such impairment) under the standards might affect the weight of the evidence in a particular case, we concluded that such a showing was not a threshold requirement in an occupational disease claim for a hearing loss condition. Rather, we concluded that the issue remained whether the claimant had proven that work exposure was the major contributing cause of his hearing loss condition. Plummer, supra. Consequently, we reject the employer's contention that claimant is precluded from establishing compensability because he has not shown ratable impairment under the standards.

As a result of our above conclusion, we next determine whether claimant has proven that work is the major contributing cause of his hearing loss condition.

Claimant worked for the employer as a firefighter since 1974. Following his promotion to captain in 1987, claimant continued to go on fire and emergency response runs. A May 1983 hearing test reported that claimant had high frequency hearing loss. A hearing test in September 1988 provided that claimant's hearing was not within normal limits and Dr. Mettler recommended hearing protection to be worn during exposure to noise. A November 2, 1990 audiogram review report found that claimant had significant hearing loss.

In November 1991, Peter Charuhas, audiologist, reported that claimant had a bilateral moderate hearing loss. Charuhas reported that claimant's hearing was within normal limits in the low to mid-frequency range and had remained normal over the years. He further stated that claimant's "loss has been rated as noncompensable, however this individual should be considered a candidate for amplification."

On June 4, 1992, audiologist Lavina Fowler reported that claimant was seen for an audiologic evaluation. Claimant informed her that he had noticed significant changes in his hearing prior to the initiation of baseline hearing tests several years ago. Claimant stated that he had not been exposed to any significant noise outside of his employment, and he reported that he had been experiencing tinnitus approximately once a month. Claimant informed Ms. Fowler that in his position as an officer situated in the fire engine his right ear would have been exposed to more noise than his left. Finally, claimant reported that he first noticed significant hearing loss in his right ear, and had experienced difficulty understanding speech, primarily in the presence of background noise.

Ms. Fowler stated that claimant's test results were essentially within normal limits, with a mild to severe high frequency sensorineural loss bilaterally. She found that claimant's hearing through the primary speech frequency range was technically within the range of normal, however, claimant had a severe dropoff in the high pitches, which was most commonly associated with excessive noise exposure. Ms. Fowler believed that claimant might be a candidate for high frequency amplification.

On August 12, 1992, Dr. Dowsett acknowledged that he had performed a physical examination of claimant, who had provided a history of his on and off-work noise exposure. Dr. Dowsett agreed with a letter from claimant's attorney which stated that claimant had a neurosensory hearing loss and his work activities with the employer were the major contributing cause of his condition.

Under the circumstances, we find no reason not to defer to the opinion of Dr. Dowsett, who is the only doctor to have examined claimant, taken his history, and to have provided an opinion on causation. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980). We are not persuaded by the opinion of audiologist Charuhas, who reported that claimant had a hearing loss condition, but who subsequently offered only a "legal" opinion that the claim was not compensable.

Finally, the employer contends that claimant's hearing loss condition is not compensable because it has not resulted in disability or required medical services. We recently addressed this issue in another hearing loss case, in which we found that the claimant had received medical services, as he had sought treatment for his increased hearing loss, undergone a physical examination and audio tests for his condition, and was referred for future yearly hearing examinations. See David M. Crymes, 45 Van Natta 267 (1993); Finch v. Stayton Canning Co., 93 Or App 168 (1988). Similarly, in the present case, claimant underwent audio tests and physical exams for his hearing loss condition. Further, claimant was directed by Dr. Mettler to wear hearing protection and audiologist Charuhas noted that claimant was a candidate for amplification. Under the circumstances, we find that claimant has shown that his occupational disease required medical services.

Accordingly, we conclude that claimant has established that his work activities with the employer were the major contributing cause of his hearing loss condition. We, therefore, reverse the Referee's order on the issue of compensability.

Claimant is entitled to an assessed attorney fee for services at hearing and on review for prevailing over the employer's denial. ORS 656.386(1). After considering the factors set forth in

OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services at hearing and on review is $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 5, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant is awarded an assessed attorney fee of $3,500, to be paid by the employer.

In the Matter of the Compensation of
JACK E. LAYTON, SR., Claimant
WCB Case No. 92-02708
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of that portion of Referee Barber's order that set aside the self-insured employer's denial of his occupational disease claim for his bilateral hearing loss 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 first concluded that claimant had failed to establish compensability of his bilateral hearing loss condition, as he had not shown that he had ratable impairment under the "standards."

We recently held that whether claimant has shown ratable impairment under the standards is not dispositive on the issue of compensability. See James F. Plummer, 45 Van Natta 1477 (1993). Although we acknowledged that a showing of ratable impairment (or a lack of such impairment) under the standards might affect the weight of the evidence in a particular case, we concluded that such a showing was not a threshold requirement in an occupational disease claim for a hearing loss condition. Rather, we concluded that the critical determination to establish the compensability of an occupational disease claim remained whether the claimant had proven that work exposure was the major contributing cause of his hearing loss condition. Plummer, supra. Consequently, we reject the employer's contention that claimant is precluded from establishing compensability because he has not shown ratable impairment under the standards.

As a result of our above conclusion, we next determine whether claimant has proven that work is the major contributing cause of his hearing loss condition.

Claimant worked for the employer as a firefighter since 1974. In November 1991, Peter Charuhas, audiologist, reported that an audiometric evaluation performed by Dr. Milligan demonstrated a bilateral mild to moderate high frequency sensorineural hearing loss. Charuhas reported that claimant had a gradual deterioration of hearing sensitivity in the left ear since 1983. He further stated that claimant's "loss is not compensable, but (he) is a good candidate for amplification."

On August 12, 1992, Dr. Milligan acknowledged that he had performed a physical examination of claimant, who had provided a history of his on and off-work noise exposure. Dr. Milligan agreed with the letter from claimant's attorney that stated that claimant had a neurosensory hearing loss and his work activities with the employer were the major contributing cause of his condition.

Under the circumstances, we find no reason not to defer to the opinion of Dr. Milligan, who is the only doctor to have examined claimant, taken his history, and to have provided an opinion on causation. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980). We are not persuaded by the opinion of the audiologist, who reported that claimant had a hearing loss condition, but who subsequently offered only a "legal" opinion that the claim was not compensable.

Finally, the employer contends that claimant's hearing loss condition is not compensable because it has not resulted in disability or required medical services. We recently addressed this issue in another hearing loss case, in which we found that the claimant had received medical services, as he had sought treatment for his increased hearing loss, undergone a physical examination and audio tests for his condition, and was referred for future yearly hearing examinations. See David M. Crymes, 45 Van Natta 267 (1993); Finch v. Stayton Canning Co., 93 Or App 168 (1988). Similarly, in the present case, claimant underwent audio tests and physical exams for his hearing loss condition and was found to be a good candidate for amplification. Under the circumstances, we find that claimant has shown that his occupational disease required medical services.

Accordingly, we conclude that claimant has established that his work activities with the employer were the major contributing cause of his hearing loss condition. We, therefore, reverse the Referee's order on the issue of compensability.

Claimant is entitled to an assessed attorney fee for services at hearing and on review for prevailing over the employer'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 fee for services at hearing and on review is $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 5, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant is awarded an assessed attorney fee of $3,500, to be paid by the employer.

In the Matter of the Compensation of
WILLIAM D. MARSH, Claimant
WCB Case No. 92-05416
ORDER ON REVIEW
Douglas S. Hess, Claimant Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The self-insured employer requests review of Referee Mills' order which: (1) set aside its denial of claimant's right knee injury claim; and (2) assessed a penalty for allegedly unreasonable claim processing and discovery violations. On review, the issues are compensability and penalties.

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

Compensability

In order to prove compensability of an industrial injury, claimant must prove that the injury arose out of and in the course of employment and 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). If the injury combines with a preexisting condition to cause or prolong disability or the 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), mod 120 Or App 590 (1993).

Here, claimant had been treating with Dr. Hazel, orthopedic surgeon, for symptoms of the medial compartment of his right knee before the November 5, 1991 incident. Noting physical and radiographic abnormalities in the lateral compartment of the right knee after the November 5, 1991 work incident, Dr. Hazel opined that a new injury had occurred. (Ex. 1-9). Subsequent surgery also revealed fresh tears in the lateral compartment. (Ex. 47). In any event, Dr. Hazel also concluded that the November 5, 1991 work injury was the major contributing cause of claimant's current need for treatment. (Ex. 1-9).

In light of Dr. Hazel's persuasive opinion that the November 5, 1991 injury was to the lateral compartment of the knee, whereas pre-injury symptoms were limited to the medial compartment, we conclude that claimant suffered a new injury on November 5, 1991, which did not combine with a preexisting condition to result in the current disability or need for treatment. Thus, claimant is required only to prove that the injury was a material contributing cause of his disability and need for treatment. Tektronix, Inc. v. Nazari, supra, 120 Or App at 594. Because claimant's treating physician stated, and we find, that the work injury was the major contributing cause, we agree with the Referee that claimant has met his burden of proving that he suffered a compensable right knee injury.

Interim Compensation

With the consent of the worker, an employer may deduct from any sick leave payments amounts equal to workers' compensation benefits received by the worker with respect to the same injury that gave rise to the sick leave. ORS 656.240. However, the deduction of sick leave shall not exceed the difference between the worker's daily wage and his/her daily time loss benefits. Id.

Here, claimant did not request to be paid sick leave, rather than time loss benefits, for his injury. Moreover, his absence from work was totally allotted to his accrued sick leave. Thus, the employer's conduct was contrary to ORS 656.240. Therefore, we agree with and adopt the Referee's conclusion that the employer's failure to pay interim time loss benefits was unreasonable.

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 $850, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated September 17, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $850, payable by the self-insured employer.

In the Matter of the Compensation of
FRANCISCO VILLAGRANA, Claimant
Own Motion No. 90-0077M
OWN MOTION ORDER DENYING RECONSIDERATION

Claimant has requested reconsideration of the Board's May 10, 1993 Own Motion Order Reviewing Carrier Closure. The request is denied.

OAR 438-12-065(2) provides that a motion for reconsideration of an Own Motion order shall be filed within 30 days of the date of mailing of the final order, or within 60 days of that mailing date if the party requesting reconsideration establishes good cause for failure to file the request within 30 days of that mailing date. If these requirements are not met, the request for reconsideration is untimely.

Here, the Board's order issued on May 10, 1993. The 30 day time period for filing a request for reconsideration ended on June 9, 1993. Claimant mailed his request for reconsideration on June 29, 1993 and it was received by the Board on July 2, 1993. Thus, claimant's request for reconsideration was filed more than 30 days but less than 60 days after the mailing date of our May 10, 1993 order. Therefore, claimant's request for reconsideration is untimely unless he establishes good cause for his failure to file his request within 30 days. Claimant makes no good cause argument. Therefore, we conclude that claimant has failed to establish good cause for the failure to file his request for reconsideration within 30 days of the Board's order. His request for reconsideration is denied as untimely.

In any event, even if we reconsidered our May 10, 1993 order, we would not alter it. Dr. Ford is a foot surgeon who recommended further surgery for claimant's foot condition, performed that surgery, followed claimant's recovery, and rendered an unrebutted opinion that claimant was medically stationary as of January 1, 1993. Making a general reference to the 1990 statutory amendments to the Workers' Compensation Law, claimant argues that Dr. Ford is not qualified to render an opinion as to his medically stationary status because Dr. Ford was not claimant's attending physician.

Without deciding whether Dr. Ford was claimant's attending physician, we would find that claimant's argument fails. Nothing in the 1990 amendments restricts consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. See Timothy H. Krushwitz, 45 Van Natta 158 (1993) (treating chiropractor was qualified to render an opinion regarding the medically stationary status of a worker he was treating even though he was, by statute, not qualified to serve as the worker's attending physician at the time he rendered the opinion).

Accordingly, as discussed above, claimant's request for reconsideration is denied as untimely. The parties' rights of reconsideration and appeal shall run from the date of our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA K. TUCKER, Claimant
Own Motion No. 91-0280M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Dennis O'Malley, Claimant Attorney

Claimant requests review of the insurer's March 22, 1993 Notice of Closure which closed her claim with an award of temporary disability compensation from August 12, 1992 through February 24, 1993. The insurer declared claimant medically stationary as of February 24, 1993. Claimant contends that she is entitled to additional benefits as she 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). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 22, 1993 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). Claimant bears the burden of proving that she was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). 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).

Here, at claim closure, Dr. Su, claimant's treating podiatrist, recommended further surgery in the form of the removal of the plantar medial nerve branch in claimant's right foot. Dr. Su opined that claimant would not be medically stationary until that nerve branch was removed. (Letter dated November 9, 1992). In a letter dated March 31, 1993, Dr. Ireland, consulting neurologist, confirmed claimant's need for a neurectomy for the persistent pain caused by her Morton's neuroma.

Subsequently, the insurer sent Dr. Ireland some unidentified information to review. As a result of his review of this information, Dr. Ireland stated that he was unwilling to recommend further treatment for claimant. (Letter dated June 1, 1993). Dr. Ireland defended the previously proposed foot surgery against assertions by various independent medical examiners that this surgery would ultimately be detrimental to claimant. However, he stated that his recommendation for further surgery was based on claimant's subjective complaints, the veracity of which had been called into question by the information provided by the insurer. As a result, he was unwilling to recommend further treatment for claimant. We note that, although Dr. Ireland's June 1993 opinion was rendered after claim closure, it did not relate to a change in claimant's condition. Rather, it related to a change in the basis of his own opinion regarding the need for further treatment. Compare, Sullivan v. Argonaut Ins. Co., supra; Alvarez v. GAB Business Services, supra.

Medical opinions based on inaccurate information are not persuasive. Dr. Ireland's comments raise a question as to whether Dr. Su's opinion is based on accurate information about the level of claimant's symptoms. The record contains no further report (following his November 9, 1992 letter) from Dr. Su regarding the issue of claimant's medically stationary status.

In addition, Dr. Su's opinion regarding claimant's medically stationary status is not unrebutted. Prior to claim closure, Dr. Watson, examining neurologist, and Dr. Rothstein, a podiatrist who performed a record review, both indicated that claimant was medically stationary and recommended against further surgery. (February 24, 1993 report from CorCare [Dr. Watson], March 17, 1993 report from Western Medical Consultants [Dr. Rothstein]). In addition, prior to claim closure, although not giving an explicit opinion regarding claimant's medically stationary status, three other independent medical examiners/reviewers also recommended against further surgery. (February 24, 1993 report from CorCare [Dr. Lamy, podiatrist]; March 11, 1993 report from Orthopaedic Consultants [Dr. McKillop, orthopedic surgeon, and Dr. Rich, neurologist]).

Under such circumstances, we conclude that the most expedient manner in which to resolve this matter is to refer it to the Hearings Division for an evidentiary hearing. OAR 438-12-040. At the hearing, the assigned Referee shall take evidence on the question of whether claimant was medically stationary at the time her claim was closed. This hearing may be conducted in any manner that the Referee

determines will achieve substantial justice. Following the hearing, the Referee shall issue a recommendation to the Board within 30 days. In that recommendation, the Referee shall make findings of fact on the question of claimant's medically stationary status. Based on those findings of fact, the Referee shall recommend to the Board whether it should set aside the insurer's March 22, 1993 Notice of Closure.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA R. FARROW, Claimant
WCB Case No. 92-09607
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of that portion of Referee Schultz' order that awarded temporary total disability benefits from January 21, 1992 through September 17, 1992. In her brief, claimant contests that portion of the order that declined to assess a penalty or related attorney fees for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

The employer accepted claimant's claim for a bilateral arm and wrist condition. This claim was closed by an October 3, 1991 Notice of Closure. (Ex. 26).

Following the injury, claimant returned to regular work on July 15, 1991. Claimant worked until November 5, 1991 at which time she was laid off from her job. Following her layoff, claimant did not return to work.

On December 4, 1991, claimant sought treatment from Dr. Layman for worsened hand and wrist symptoms. Claimant had experienced these same symptoms prior to being laid-off. Dr. Layman noted that claimant's symptoms had not lessened since her lay-off. Following nerve conduction studies, Dr. Layman requested authorization to perform right carpal tunnel release surgery. On January 21, 1992, Dr. Layman filled out a prescription form which indicated that claimant was restricted from performing any rapid repetitive wrist and hand motion.

Claimant filed an aggravation claim that was denied by the employer on February 5, 1992 and April 22, 1992. (Exs. 30 and 36). Claimant requested a hearing, and in a May 29, 1992 Opinion and Order, Referee Davis set aside the employer's aggravation denials and directed the employer to accept claimant's aggravation claim. The employer requested review of Referee Davis' order.

On July 21, 1992, claimant submitted a Request for Hearing. In her hearing request, she indicated that the issue was the employer's "failure to pay temporary total disability from 5/29/92 to present; penalties and attorney fees."

On September 17, 1992, Dr. Layman released claimant to "full duty."

On December 7, 1992, we affirmed Referee Davis' May 29, 1992 order. Sandra R. Farrow, 44 Van Natta 2412 (1992). On December 30, 1992, the employer requested judicial review of our order.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Temporary Disability Benefits

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders and docketed appeals. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as our prior decision and the employer's request for judicial review meet the aforementioned standard, we take administrative notice of them.

Here, Referee Schultz concluded that temporary total disability was payable from January 21, 1992 through September 17, 1992, on the basis that claimant had established her substantive right to temporary total disability during that period. We note, however, that claimant had not requested a hearing on her substantive entitlement to temporary disability. Instead, she sought enforcement of the employer's payment of temporary total disability following the date of the May 29, 1992 Opinion and Order pursuant to ORS 656.313(1)(a).

As a preliminary matter, the employer is not obligated to pay temporary disability benefits accruing prior to Referee Davis' May 29, 1992 order. Although Referee Davis set aside the employer's aggravation denial and directed it to process claimant's aggravation claim, his order was timely appealed first to the Board and then to the Court of Appeals. Therefore, pursuant to ORS 656.313(1)(a), the employer was not obligated to pay temporary disability accruing prior to May 29, 1992, the date of Referee Davis' order. See Christine Sutton, 45 Van Natta 192 (1993); Walden J. Beebe, 43 Van Natta 2430 (1991).

Referee Schultz directed the employer to pay temporary disability benefits from May 29, 1992 through September 17, 1992. Inasmuch as these benefits accrued following Referee Davis' May 29, 1992 order, the benefits are not stayed pending the employer's appeal. See ORS 656.313(1)(a)(A). However, the employer contends that it is not obligated to pay the temporary disability benefits on grounds other than ORS 656.313. We disagree.

The employer first argues that claimant failed to establish that she experienced diminished earning capacity, thus defeating her aggravation claim. However, Referee Davis' May 29, 1992 order found claimant's aggravation claim to be compensable. We affirmed his order on December 7, 1992. Sandra R. Farrow, supra. Even though the employer subsequently timely requested judicial review of this order, it is presently the law of the case that claimant's aggravation claim is compensable.

The employer next contends that claimant is not entitled to temporary disability benefits because she was not in the work force. We disagree.

To receive temporary disability upon the aggravation of a work-related injury, a claimant must be in the work force at the time of the aggravation. Cutright v. Weyerhaeuser, 299 Or 290 (1985). A claimant is deemed in the work force if: (1) she was engaged in regular gainful employment at the time of the worsening; (2) although not employed, she was making reasonable efforts to obtain employment at the time of the worsening; or (3) although willing to work, she was not looking for employment for reasons related to the compensable injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The critical time for determining whether a claimant has "withdrawn" from the work force is at the time of her disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990).

Following her compensable injury, claimant, then 35 years of age, returned to regular work on July 15, 1991. She worked from that date until November 5, 1991, at which time she was laid off from her job. Claimant did not work following her November 5, 1991 lay-off. Thus, claimant was not engaged in regular gainful employment when she first sought treatment with Dr. Layman for her worsened condition on December 4, 1991. However, prior to being laid off, claimant was experiencing recurrent hand and wrist symptoms. Furthermore, Dr. Layman noted that claimant's symptoms had not decreased since leaving work. Following nerve conduction studies, Dr. Layman sought authorization for right carpal tunnel release surgery. Finally, on January 21, 1992, Dr. Layman restricted claimant from performing any rapid repetitive wrist or hand motion. Claimant's work duties for the employer involved data entry and typing which were not within the restrictions provided by Dr. Layman. Dr. Layman did not alter these limitations until September 21, 1992, when claimant was released to full time regular duties.

We conclude that claimant was in the work force at the time of her worsened condition. Prior to being laid off, claimant was experiencing the same symptoms that she had when she sought treatment from Dr. Layman in December 1991. Dr. Layman noted that claimant had experienced no decrease in symptoms since her lay-off. In addition, Dr. Layman indicated that, as a result of these symptoms, claimant was restricted from performing her regular work duties. While Dr. Layman's release to modified work was not dated until January 21, 1992, he later indicated that claimant was still experiencing the same symptoms that she had in December 1991 which caused him to recommend surgery. Finally, claimant sought treatment approximately one month after lay-off from an employer she had worked for since 1974.

Under these circumstances, we find that at the time of her worsening, claimant was not working or looking for work because her work-related worsening and impending surgery rendered such efforts futile. Therefore, we find that claimant was in the work force at the time of her worsening. Accordingly, claimant is entitled to payment of temporary disability benefits from May 29, 1992 through September 17, 1992.

Penalty and Attorney Fees

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

ORDER

The Referee's order dated October 23, 1992 is modified in part and affirmed in part. In lieu of the Referee's temporary disability award, the employer is directed to pay claimant temporary disability benefits from May 29, 1992 through September 17, 1992. The Referee's out-of-compensation attorney fee award shall be modified accordingly. The remainder of the order is affirmed.

July 27, 1993 Cite as 45 Van Natta 1508 (1993)

In the Matter of the Compensation of
DANIEL P. ROAM, Claimant
Own Motion No. 93-0675M
OWN MOTION ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 18, 1992 Own Motion Order, as reconsidered on July 1, 1993. In that order, we determined that claimant's condition worsened requiring surgery in February 1992. We based this determination on the fact that the record contained no evidence of any request for surgery until the February 12, 1992 request by Dr. Butters, claimant's treating orthopedic surgeon. We also concluded that, although claimant had proved a worsening of his compensable condition requiring surgery, he had not established that he was in the work force at the time of his disability.

In his request for reconsideration, claimant contends that: (1) his compensable condition worsened requiring surgery in 1988; and (2) he was in the work force at the time of that worsening. In support of these contentions, claimant submits a copy of a November 2, 1988 letter from Dr. Butters in which he discusses the possibility of surgery for the compensable injury, if claimant can get his psychiatric problems in order. Claimant also submits a copy of Referee Gruber's June 27, 1989 Opinion and Order in which he determined that, although compensability of the psychological condition was foreclosed by a 1987 disputed claim settlement, claimant was entitled to a sufficient level of treatment for his psychiatric problems to allow Dr. Butters to proceed with the surgery and allow claimant to recover from that surgery. Claimant notes that Referee Gruber's order was affirmed by the Board and the Court of Appeals. Finally, claimant submits a copy of the transcript of the hearing before Referee Gruber in which claimant testified that he worked from September 1987 to June 1988.

In order to consider claimant's motion, we withdraw our December 18, 1992 order, as reconsidered on July 1, 1993. 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
JEFFREY D. SKOCHENKO, Claimant
WCB Case No. 90-13603
ORDER ON REMAND
Karen M. Werner, Claimant Attorney
John Pitcher, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Skochenko v. Weyerhaeuser Company, 118 Or App 241 (1993). The court has reversed our prior order which held that claimant's herniated disc and resulting surgery were not compensable. Reasoning that we misinterpreted some of the medical evidence in reaching our conclusion on the compensability issue, the court has remanded for reconsideraton of compensability of the herniated disc.

Subsequent to the court's decision, we granted the self-insured employer's request to file supplemental briefs on remand. Having received the parties' supplemental briefs, we proceed with our reconsideration.

In our prior order, we adopted the Referee's finding that Dr. Gripekoven and Dr. Parsons agreed that claimant's work activities were not the major contributing cause of his herniated disc. The court has held that this is an incorrect statement. Rather, the court reasoned that the doctors agreed that the herniated disc was caused by physical stress, but that they could not determine whether claimant's work activities were the major contributing cause of his condition. 118 Or App at 244. Therefore, on reconsideration, the issue is whether claimant has established that his work activities (physical stress), when compared to off-work physical stresses, were the major contributing cause of his herniated disc. ORS 656.802.

Only Dr. Ruckman affirmatively attributes claimant's herniated disc to his work activities. He ruled out the spondylolisthesis as a contributing factor, stating that slippage secondary to the spondylolisthesis was not unstable. Thus, the spondylolisthesis should not be able to cause a disc herniation. Dr. Ruckman, therefore, concluded that claimant's work activities were the major contributing cause of his herniated disc.

We are not persuaded by Dr. Ruckman's opinion because it is refuted by both Dr. Gripekoven and Dr. Parson. Dr. Gripekoven found instability as indicated on motion films. Dr. Parsons explained that claimant's congenital instability increased the risks that physical stresses may cause herniation of the disk.

In addition to Dr. Gripekoven's statement related by the court, Dr. Gripekoven opined that claimant's herniated disc and need for surgery were due to a combination of factors involving both the congenital deformity and all of claimant's physical activities, including his work activities. He stated that heavy physical labor would have contributed, but the degree of contribution would have to be weighed with claimant's other physical activities. He concluded that it would be extremely difficult to apportion the degree of involvement of each contributing factor.

Dr. Parsons similarly opined that claimant's herniated disc could have been the result of the congenital deformity, a culmination of physical stresses, or a combination of the two. Because it was probably a culmination of physical stresses, both at work and off-work, over a period of years, Dr. Parsons stated that there was no medical way to determine the major contributing cause. He could only state that it was possible that work activities were the major contributing cause.

Given the multiple contributors to and the gradual nature of claimant's condition, we find that the causation issue presents a complex medical question, which must be resolved largely on the basis of competent medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985) rev den 300 Or 546 (1986). We also find that this case involves expert analysis rather than expert external observations, and therefore, we do not defer to the opinion of long-time treating physician, Dr. Ruckman, as opposed to Drs. Parsons and Gripekoven. Allie v. SAIF, 79 Or App 284 (1986). In addition, we agree with the Referee that the treating surgeons are better qualified to explain the cause of claimant's back condition and need for surgery. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988).

We find that, based on the opinions of Drs. Gripekoven and Parsons, the major contributing cause of claimant's herniated disc cannot be determined to the degree of reasonable medical probability. Claimant's burden of proof is not met unless he presents medical evidence affirmatively attributing the elements of his condition to work activities, on the basis of medical probability, rather than possibility. See Miller v. SAIF, 60 Or App 557 (1982); Gormley v. SAIF, 52 Or App 1055 (1981). Claimant has failed to sustain his burden of proof. Therefore, his claim for herniated disc is not compensable.

Accordingly, on reconsideration, the Referee's order dated December 26, 1990 is affirmed.

IT IS SO ORDERED.

July 27, 1993 Cite as 45 Van Natta 1510 (1993)

In the Matter of the Compensation of
BUDDY W. VAUGHN, Claimant
WCB Case Nos. 92-01764 & 91-14595
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lester R. Huntsinger (Saif), Defense Attorney
Cummins, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our June 28, 1993 Order on Review that affirmed the Referee's order declining to award him an assessed attorney fee for his counsel's services at hearing. Claimant contends that he is entitled to an assessed fee under ORS 656.386(1) for overturning the SAIF Corporation/Hage Brother Farm's denial of responsibility for medical services. We disagree.

A claimant is not entitled to an assessed fee under ORS 656.386(1) if an insurer denies responsibility, but not compensability, and a hearing is held. Multnomah County School Dist. v. Tigner, 113 Or App 405, 408 (1992); Mercer Industries v. Rose, 103 Or App 96, 98, rev den 311 Or 150 (1991); Thomas W. Wiles, 45 Van Natta 1167 (1993) (on reconsideration); John L. Law, 44 Van Natta 1619 (1992) (on reconsideration).

Here, SAIF/Hage Brothers Farm disclaimed responsibility for claimant's current condition on the basis that his more recent work activities with another employer were the major contributing cause of his condition. (Exs. 54, 55). SAIF/Hage Brothers Farm did not deny the compensability of claimant's current condition or need for treatment. Although it denied claimant's aggravation claim on the basis that his compensable condition had not worsened, claimant did not prevail against that denial and would, therefore, not be entitled to an assessed fee under ORS 656.386(1).

Accordingly, we withdraw our June 28, 1993 order. On reconsideration, as supplemented herein, we adhere to and republish our June 28, 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
EDNA A. GARMAN, Claimant
WCB Case No. C3-01691
ORDER WITHDRAWING ACKNOWLEDGEMENT LETTER
Emmons, Kropp, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig, Westerband, and Gunn.

On June 24, 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.

In this case, the insurer's attorney signed the proposed CDA on January 11, 1993, and claimant signed on January 13, 1993. Claimant's attorney signed the proposed agreement on June 23, 1993 and submitted it to the Board. On June 24, 1993, we acknowledged receipt of the CDA.

It is undisputed that, by letter dated March 16, 1993, the insurer notified claimant that it had withdrawn the offer to enter into the CDA, and accordingly, the settlement papers should not be submitted to the Board. Despite having received the letter, claimant's attorney, as previously discussed, signed the proposed agreement on June 23, 1993 and submitted it to the Board for approval. The insurer now argues that the Board should not acknowledge or approve the CDA, since the insurer withdrew its offer before the CDA was submitted to the Board.

A CDA is 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). To be binding, the CDA must be approved by the Board. ORS 656.236(1) states in relevant part:

> "(1)***Any such disposition shall be filed for approval with the board. ***Submission of a disposition shall stay all other proceedings and payment obligations, except for medical services, on that claim. The disposition shall be approved in a final order unless:
>
> "(a) The board finds the proposed disposition is unreasonable as a matter of law;
>
> "(b) The board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or
>
> "(c) Within 30 days of submitting the disposition for approval, the worker requests the board to disapprove the disposition." (Emphasis added).

Submission of the CDA to the Board is an important event. After submission, the worker, and only the worker, is given 30 days to request disapproval by the Board. ORS 656.236(1)(c). Furthermore, the Board must approve the CDA unless the worker requests disapproval or the Board finds that the CDA is the product or fraud, or that its terms are "unreasonable as a matter of law."

The question here is whether a party to the CDA may withdraw its offer after the CDA has been signed by all parties, but before the CDA is submitted to the Board. The answer depends on whether a CDA is a contract enforceable by either party prior to Board approval. We think not.

A CDA is not an ordinary contract. Before the enactment of ORS 656.236 in 1990, injured workers had no authority to agree to release their rights in an accepted claim. They may now "contract" to do so, if the Board approves the proposed agreement. Thus, until the Board approves, the "agreement" for the release represents no more than a proposed mutual offer to settle, which is not binding on either party. As such, either party may withdraw its offer before submission of the CDA to the Board.

The Board has processed thousands of CDA's since the law was passed in 1990. Yet, this is the first case of this kind to come before the Board, and it is doubtful that there will be many others. The only case precedents available are court decisions from other states interpreting similar provisions of similar laws, to the same effect.

Although not binding, we find such case law to be informative. See Justice v. Davidson Kennedy Co., 391 SE 2d 414, 195 Ga App 585 (1990) (Any settlement between employer and employee represents no more than a proposed mutual offer to settle which must be accepted and approved by the Board before binding settlement is reached.); Levey v. North Dakota Workers' Compensation Bureau, 425 NW 2d 376 (ND 1988)(Proposed stipulation for settlement of workers' compensation claim did not establish a contract, absent approval of Board).

Here, on January 11, 1993, the insurer executed a proposed CDA. Nevertheless, by March 1993, the insurer had notified claimant (through her counsel) that it had withdrawn its offer. Such notice was given prior to submission of the agreement to the Board. Accordingly, there was no proposed disposition for the Board to acknowledge, approve, or disapprove.

Accordingly, we withdraw our June 24, 1993 letter of acknowledgment. Inasmuch as the letter acknowledging the CDA has been withdrawn, the insurer shall recommence payment of any temporary or permanent disability that it may have discontinued upon submission of the proposed CDA.

IT IS SO ORDERED.

Board Member Westerband, specially concurring.

I write separately to express that substantial part of me that agrees with the dissent. In fact, I signed the majority opinion in this unusual case, primarily because a decision had to be made by the Board and the majority opinion may allow for appellate court review whereas Board approval of the CDA, as urged by the dissent, probably would not. ORS 656.236(a) states that a Board order "approving disposition of a claim pursuant to this section is not subject to review." The statute contains no similar language regarding Board orders disapproving CDA's or concluding, as we conclude here, that a proposed CDA was not "submitted."

Board Member Gunn dissenting.

Although I am aware that the majority has not "technically" approved or disapproved this proposed claim disposition agreement, I conclude that an order withdrawing the Board's acknowledgment letter has the same effect as an order of disapproval. Consequently, for the following reasons, I disagree with the majority's opinion.

The majority has found that, because the insurer "withdrew" its offer before the CDA was submitted to the Board, there is no contract before us. However, in this case, the insurer and claimant both signed the agreement within two days in January 1993. As our rules only require that the agreement provide a signature from each of the parties, the proposed CDA was in compliance with our rules and could have been immediately submitted for acknowledgment. OAR 438-09-001(1).

Here, a March 16, 1993 letter from the insurer to claimant's counsel requested that the CDA not be submitted as there was some confusion between claimant and the employer over claimant's willingness to accept a job. The insurer's letter provided that it wished to withdraw its monetary offer "pending a determination of (claimant's) employment status."

We have previously held that a claimant's right to reemployment under ORS Chapter 659, and an attempt to release such rights, concern matters outside of ORS Chapter 656, and are not proper matters for disposition under ORS 656.236 and the rules promulgated thereunder. Evelyn Christenson, 43 Van Natta 819 (1991). Under the circumstances, I fail to see how a dispute regarding a reemployment issue can constitute a ground for the majority's withdrawal of the letter acknowledging this proposed CDA which properly involves only the settlement of workers' compensation benefits pursuant to Chapter 656. The majority's action is inconsistent with our past practice of disapproving CDA's that purport to release matters outside of ORS Chapter 656.

Moreover, it is not clear why the CDA was not signed by claimant's counsel until June 1993, but our rules do not require a signature from claimant's counsel where claimant has already signed the agreement. Therefore, I conclude that the agreement between the parties in this matter was reached in January 1993, after both the insurer and claimant had signed the CDA. I find no reason to permit an insurer to back out of an agreement which it has presumably had the opportunity to evaluate from the time it first accepted the claim. Considering the resources available to the insurer, I conclude that it is

most likely that the agreement was not signed by its representative until after it had carefully considered the terms of the agreement and the amount of consideration. For that reason, I cannot find that there was an absence of agreement between the parties.

Finally, it is clear that the legislature intended for only a claimant to have a "cooling off" period where a CDA is involved. ORS 656.236(1). As the majority has noted, only claimant may request disapproval within the 30-day period, if the CDA complies in all other respects with the statute and rules. Consequently, I would point out that we have not found this agreement to be unreasonable as a matter of law, there has been no intentional misrepresentation of material fact, and claimant has not requested disapproval. I therefore conclude that the statute requires us to approve the proposed CDA, and I dissent from the majority's decision which effectively disapproves this agreement.

July 28, 1993 Cite as 45 Van Natta 1513 (1993)

In the Matter of the Compensation of
JEFFREY D. WARD, Claimant
WCB Case No. 92-08126
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of that portion of Referee Galton's order that assessed a penalty-related attorney fee for its allegedly unreasonable delay in authorizing claimant's left elbow surgery. In his respondent's brief, claimant seeks an assessed attorney fee under ORS 656.386(1) for SAIF's alleged rescission of its "compensability" denial. On review, the issues are attorney fees. We vacate in part, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact as found in his September 18, 1992 order, with the following supplementations.

At the September 15, 1992 hearing, claimant raised the issues of: (1) the Director's June 10, 1992 order which found that the proposed left elbow surgery was not reasonable and necessary; and (2) penalties and attorney fees for SAIF's allegedly untimely processing of the surgery claim. The Referee issued his order on September 18, 1992 affirming the Director's order and denying claimant's request for penalties and attorney fees. On October 12, 1992, claimant requested reconsideration of that portion of the Referee's order that failed to award an attorney fee under ORS 656.382(1) for SAIF's failure to properly process the surgery claim pursuant to OAR 436-10-070(2). SAIF responded to claimant's motion on October 27, 1992. The Referee issued an order on reconsideration on November 5, 1992, awarding a $2,500 assessed attorney fee, but otherwise adhering to the remainder of his September 18, 1992 order. On November 12, 1992, SAIF filed a motion requesting the Referee to reconsider his November 5, 1992 order. The Referee denied SAIF's motion on November 24, 1992.

CONCLUSIONS OF LAW AND OPINION

The focal issue is claimant's entitlement to an attorney fee under ORS 656.382(1) for SAIF's failure to timely comply with the requirements of OAR 436-10-070(2)[1]. In its October 27, 1992 response to claimant's request for reconsideration seeking an attorney fee, SAIF stated that the left elbow surgery was not compensable, and therefore, claimant was not entitled to a fee.

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[1] OAR 436-10-070 outlines the processing procedures for requests for elective surgery to treat a compensable injury or illness.

Upon learning that SAIF had authorized the left elbow surgery prior to hearing, and based on SAIF's October 27, 1992 response, the Referee found that SAIF had altered the scope of review by raising the issue of compensability, "at least as it relate[d] to whether assessed attorney's fees should be allowed." The Referee then found that the surgery was compensable, for purposes of applying ORS 656.382(1), and assessed a $2,500 attorney fee for SAIF's unreasonable delay and resistance to the payment of compensation; i.e., failure to comply with OAR 436-10-070.

SAIF contends that the Referee erred in concluding that the compensability issue had been raised. We agree.

The Referee's scope of review is limited to issues raised by the parties. Alden D. Muller, 43 Van Natta 1246 (1991)(Board vacated the portion of the referee's order that addressed an issue not raised by the parties); see also Rene L. Pence, 37 Van Natta 235 (1985)(Board will not decide issues raised post-hearing).

We do not regard SAIF's October 27, 1992 response as raising the issue of "compensability." Rather, SAIF made a valid argument against the assessment of attorney fees. See Joseph N. Thomas, 37 Van Natta 501, 502(1985)(employer's alternative argument asserted on Board review was not a "new issue"); Michelle C. Mendoza, 37 Van Natta 641 (1985)(Board distinguished between a "new issue" and a legal theory advanced for the first time on review). Specifically, there was no attempt by SAIF to deny a causal relationship between the compensable injury and the left elbow surgery. Rather, SAIF was defending against a penalty-related attorney fee on the well-established basis that there could be no resistance to compensation so long as the surgery is determined to be not reasonable and necessary, and that decision by the Director is not overturned.[2]

Because no "new issue" of compensability was raised by SAIF, the Referee exceeded his scope of review. Therefore, we vacate that portion of the Referee's order purporting to address and set aside SAIF's "compensability" denial of surgery.

Based on the Director's order finding the surgery inappropriate, SAIF had a legitimate doubt as to its liability for the surgery. Thus, its refusal to pay for or accept the surgery was reasonable. In addition, SAIF's decision to pay for the surgery, despite the Director's order, was gratuitous and not an admission that its earlier refusal to pay was unreasonable. See ORS 656.262(9)(mere payment does not constitute acceptance of the claim nor an admission of liability). Finally, and most importantly, because the claim for the left elbow surgery has been found not reasonable and necessary, no compensation has been awarded. SAIF has not unreasonably resisted payment of compensation. Therefore, claimant is not entitled to attorney fees under ORS 656.382(1). Ellis v. McCall Insulation, 308 Or 74 (1989); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

Given the above, the remaining issues raised by SAIF in its brief are moot.

For the first time on Board review, claimant seeks a separate attorney fee under ORS 656.386(1) for obtaining compensation based on SAIF's alleged rescission of its "compensability" denial. The Board generally will not decide issues raised for the first time on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Brian J. Shaw, 39 Van Natta 438 (1987). In any event, given our holding vacating the Referee's compensability findings, there was no compensability denial over which claimant prevailed. Claimant therefore would not be entitled to a fee under ORS 656.386(1). See Greenslitt v. City of Lake Oswego, 305 Or 530, 533-534 (1988); Simpson v. Skyline Corp., 108 Or App 721 (1991).

ORDER

The Referee's order dated September 18, 1992, as modified on November 5, 1992, is vacated in part, reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's alleged "compensability" denial is vacated. The Referee's award of an assessed attorney fee is reversed. The remainder of the Referee's order is affirmed.

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[2] Furthermore, to the extent "compensability" was broadly defined to include the reasonableness and necessity of the treatment, claimant raised the issue at hearing, and lost.

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case No. 91-18171
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of our March 29, 1993 Order on Review that found claimant's claim compensable on the basis that SAIF failed to sustain its burden to prove by clear and convincing evidence that the claim, which it had previously accepted, is not compensable. On reconsideration, SAIF argues that the portion of amended ORS 656.262(6) which shifts the burden of proof from claimant to the insurer does not apply when an insurer accepts and then denies a claim within the 90 day period permitted under the statute for notifying claimant of acceptance or denial.

In order to fully consider the matter, we abated our prior order and granted claimant an opportunity to respond. After receiving claimant's response, we proceed with our reconsideration.

FINDINGS OF FACT

Claimant sprained his left ankle on August 24, 1991, during a company picnic. (Exs. 1 and 4).

SAIF accepted the claim as a compensable nondisabling injury on November 19, 1991. (Ex. 7). On November 20, 1991, SAIF issued a denial, on the basis that claimant's injury did not arise from his employment. (Ex. 8).

In deciding whether the picnic was primarily for the benefit of the workers rather than the employer, the Referee, pursuant to the parties' agreement, applied amended ORS 656.262(6), which shifts the burden of proof from claimant to the insurer and requires the insurer to prove by clear and convincing evidence that the previously accepted claim is not compensable.

CONCLUSIONS OF LAW AND OPINION

In our initial order, we applied amended ORS 656.262(6) and shifted the burden of proof to SAIF. On reconsideration, SAIF contends that the legislature did not intend to shift the burden of proof when an insurer revokes its acceptance within the statutory 90 day period. SAIF relies on Bauman v. SAIF, 295 Or 788 (1983), and Rogers v. Weyerhaeuser Co., 82 Or App 46 (1986), for the proposition that an insurer may withdraw its acceptance and issue a denial, without a showing of fraud, misrepresentation or illegal activity, if the revocation of the acceptance occurs within the statutory time limitation for accepting or denying a claim. SAIF contends that, even though these cases interpreted the statute prior to its amendment in 1990, when there was no provision for a "back-up" denial, they should continue to apply to amended ORS 656.262(6). We disagree.

Former ORS 656.262(6) provided, in pertinent part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim."

In Bauman v. SAIF, supra, the Court interpreted former ORS 656.262(6) to prohibit an insurer from denying a claim, once it had been accepted, after the statutory 60 day time limit had elapsed, absent fraud, misrepresentation or other illegal activity. In Rogers v. Weyerhaeuser Co., supra, the court held that an insurer may withdraw its acceptance and issue a denial, without a showing of fraud, misrepresentation or illegal activity, if the revocation of the acceptance occurred within the statutory time limitation for accepting or denying a claim.

Amended ORS 656.262(6) provides, in pertinent part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. However, if the

worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible for the claim."

In construing a legislative enactment, our first task is to discern the legislature's intent. See ORS 174.020. If the language is unambiguous, we ordinarily apply it according to its plain meaning, without resort to legislative history. Satterfield v. Satterfield, 292 Or 780, 782 (1982). Only if the legislative purpose is unclear from the language of the enactment do we consider legislative history as an aid in determining legislative intent. State v. Leathers, 271 Or 236 (1975).

We conclude that the amended statute is not ambiguous. Under the statute, an insurer or employer has an initial 90-day period that stops running from the point of acceptance. From acceptance forward for two years, the "back-up" denial provisions apply by the plain language of the statute. Consequently, SAIF bears the burden of proving by clear and convincing evidence that the claim is not compensable.

Furthermore, SAIF conceded the burden of proof at hearing. To permit SAIF to challenge the burden of proof on reconsideration, when claimant is no longer able to present evidence to remove the case from equipoise, would be improper and inappropriate. See Mavis v. SAIF, 45 Or App 1059, 1062 (1980).

By raising the burden of proof on reconsideration, compensability was at issue. Consequently, claimant's compensation remained at risk. Therefore, claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration concerning the burden of proof issue is $500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the motion to reconsider), the complexity of the issue, and the value of the interest involved.

Accordingly, as amended herein, we adhere to and republish our March 29, 1993 Order on Review in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

Board Member Neidig, specially concurring.

I agree with the majority that the clear and unambiguous language of amended ORS 656.262(6) requires SAIF to prove by clear and convincing evidence that the claim is not compensable. I write separately to express my lingering concern that the legislature did not intend this result.

This decision marks a departure from years of case precedent. In Rogers v. Weyerhaeuser Co., 82 Or App 46 (1986), the court held that an insurer may revoke its acceptance within the statutory claim processing period, without having to satisfy the Bauman requirement of showing that its acceptance was induced by fraud, misrepresentation or illegal activity. At the time Rogers was decided, the statutory claim processing period was 60 days.

In 1990 the legislature extended the claim processing period to 90 days and allowed insurers two years from the date of claim acceptance in which to revoke an acceptance under limited circumstances. The legislative history of that session provides ample evidence of intent to accomplish those changes. What is absent from that history, however, is evidence that the legislature also intended to repeal Rogers. In fact, there is evidence that the legislature did not intend to do so. In explaining amended ORS 656.262(6) before the House, Representative Mannix stated:

"There is a provision that extends from 60 to 90 days the time in which a claim can be accepted or denied. * * * * Now we'll say you [insurers] now have up to 90 days. Beyond that, 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. So there's a shift of burden against the employer if it wants to do a denial after these 90 days if it previously accepted the claim." (Special Session, House Floor Debates, May 7, 1990, tape 2, side A, at 184.) (Emphasis added.)

Representative Mannix clearly assumed that the new "clear and convincing evidence" burden of proof would only apply to "back-up" denials issued after the 90 day processing period. His assumption was reasonable, given the lack of legislative history to the contrary, and is also supported by sound policy reasons.

One policy reason is the recognition that mistakes are sometimes made. If an insurer accepts a claim in error, the Rogers rule would allow that insurer the rest of the 90 day processing period to correct that error. Under the language of amended ORS 656.262(6), however, that error will force the insurer to prove by clear and convincing evidence that the claim is not compensable. Often, an insurer will not be able to satisfy that burden of proof and will be forced to pay on a mistakenly accepted claim. The immediate consequence will be higher claim costs for employers. Ultimately, insurers will be deterred from promptly accepting a claim, leading to delays in the processing of claims and, potentially, the receipt of benefits to the worker.

Another policy reason was noted by the court in Rogers, supra. The court stated that the policy of Bauman, in prohibiting back-up denials, would not be served by extending the prohibition to a case where an acceptance is revoked within the claim processing period. 82 Or App at 45. The court noted that in Bauman the employer had accepted the claim and paid benefits for three years before issuing its back-up denial. 82 Or App at 45 n 1. It was the extended period of time that elapsed between the acceptance and back-up denial that motivated the Supreme Court to prohibit such denials. As the Court stated:

> "The insurer * * * is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability." 295 Or 788, 793.

The Bauman Court also noted the practical, evidentiary problems of litigating a claim after an extended period of time had passed.

As the Rogers court implied, the concerns of the Bauman Court are not as compelling when an acceptance is revoked within the relatively short period of time allowed for claims processing. Similarly, I believe that the policy underlying the statutory limitations on back-up denials is not served by extending those limitations to this case.

Notwithstanding my reservations, I am compelled to apply the unambiguous terms of the statute. The statute can only be changed by the legislature, not by this forum. Because I am bound by the statute, I specially concur.

In the Matter of the Compensation of
STEVEN K. BAILEY, Claimant
WCB Case Nos. 92-05890, 92-04226 & 92-05367
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Michael V. Johnson'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 "new injury" claim for the same condition; and (3) upheld the Farmers Insurance Group (Farmers) denial of the same condition. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to award an assessed attorney fee payable by Liberty; and (2) declined to award a penalty against SAIF for its allegedly unreasonable denial of compensability. Farmers moves to strike Liberty's appellant's brief, alleging that it was not timely filed. On review, the issues are responsibility, penalties, attorney fees and the motion to strike. We deny the motion to strike, reverse in part and affirm in part.

FINDINGS OF FACT

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

SAIF's April 9, 1992 denial of compensability was unreasonable claim processing. Issuance of the denial precluded an order designating a paying agent pursuant to ORS 656.307 thereby delaying the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Liberty's appellant's brief was due on November 30, 1992. The postmark on that brief indicates that it was not mailed until December 1, 1992. Farmers has moved to strike Liberty's appellant's brief, arguing that it was not timely filed. We disagree.

OAR 438-05-046(1)(c) provides that, for documents that can be sent to the Board by first class mail, such as an appellant's brief, "[a]n attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." See Joseph W. Ramsay, 44 Van Natta 144, 145 (1992). Liberty's counsel certified that he filed Liberty's appellant's brief by "mailing on November 30, 1992" that brief to the Board. That certificate does not specifically state that the brief was "deposited" in the mail on November 30. Nevertheless, in light of the fact that the brief was postmarked only one day after November 30, we construe Liberty's counsel's assertion that he mailed the brief to mean that he deposited the brief in the mail. Consequently, we conclude that its appellant's brief was timely filed on November 30, 1992, and deny the motion to strike.

Responsibility

The Referee concluded that Liberty is responsible for claimant's low back condition. We disagree.

Inasmuch as Farmers has previously accepted a claim for claimant's low back condition, ORS 656.308(1) governs the assignment of responsibility. Under that statute, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury or occupational disease during the subsequent work exposure. SAIF v. Drews, 117 Or App 596, rev allowed __ Or __ (1993); Donald C. Moon, 43 Van Natta 2595 (1991); Ricardo Vasquez, 43 Van Natta 1678 (1991). Farmers, therefore, as the last insurer with whom claimant had a compensable low back claim, remains presumptively responsible.

To establish a new compensable injury, Farmers has the burden of proving that a work incident at claimant's subsequent employment was a material contributing cause of disability or need for treatment. See ORS 656.005(7); SAIF v. Drews, supra; Mark N. Wiedle, 43 Van Natta 855 (1991). In order to establish a new occupational disease, Farmers has the burden of establishing that subsequent work activities were the major contributing cause of a pathological worsening of the underlying compensable condition. See ORS 656.802(2); Randy L. Dare, 44 Van Natta 1868 (1992); Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991); Donald C. Moon, supra. Because of the various possible causes of claimant's low back condition, including the prior compensable injury and his continued work activities, we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The record contains two opinions concerning the cause of claimant's current low back condition. An independent medical examination (IME) conducted by the Orthopaedic Consultants concluded that claimant had suffered no new discrete injuries at work or at home. The IME doctors further concluded that the cause of claimant's low back condition "is a combination of his initial injury in 1982 as well as his ongoing work activity as a truck driver * * * We would assign the major contributing 'cause' at 50% to each." (Ex 102). Claimant's treating orthopedist, Dr. Rosenbaum, concluded:

> "If [claimant's] work activities requires [sic] heavy lifting and moving of drums and if this has occurred over the span of the past four years it would be my opinion that the major contributing factor of the current need for surgery would be his recent work activity although this is certainly argumentative [sic] and without the 1982 injury his current work activity would not likely have caused a disk herniation." (Ex 104). (Emphasis supplied).

Dr. Rosenbaum also concluded that claimant's low back condition was not the result of a discrete injury. (Ex 101).

Based on the medical reports, the Referee found, and we adopt his finding, that claimant did not suffer a discrete injury involving his low back subsequent to the time that Farmers was on the risk. (Ex 101, 102). Consequently, Farmers cannot shift responsibility to a subsequent insurer on that basis. See Lloyd G. Currie, 45 Van Natta 492, 494 (1993). Nevertheless, all of the medical opinions agree that claimant's compensable low back condition pathologically worsened. The Referee shifted responsibility to Liberty, because he concluded that work activities while Liberty was on the risk were the major contributing cause of that worsening. We disagree.

The IME doctors concluded that all of claimant's work activities subsequent to his initial 1982 injury constituted 50% of the cause of claimant's low back condition. Even if we were to conclude on the basis of their opinion that claimant's work activities were the major contributing cause of claimant's pathological worsening, Liberty was on the risk for only a small part of the causal period. Consequently, claimant's work activities while Liberty was on the risk, by themselves, could not be the major contributing cause of claimant's condition were we to adopt the opinion of the IME physicians.

Likewise, a liberal reading of Dr. Rosenbaum's opinion reflects that, at best, claimant's work activities over the last four years were the major cause of claimant's low back condition. Liberty was not on the risk during all of those four years. Moreover, no medical opinion asserts that claimant's work activities during the discrete period that Liberty was on the risk were the major contributing cause of claimant's condition. Consequently, we conclude that Farmers failed to prove that claimant suffered a new occupational disease while Liberty was on the risk. For those same reasons, Farmers failed to prove that work conditions while SAIF was on the risk were the major contributing cause of the pathological worsening. Farmers, therefore, remains responsible for claimant's low back condition.

Penalty

Claimant asserts that SAIF should be penalized for unreasonably denying compensability of his low back condition. A penalty may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent. This penalty may be based on the "amounts then due" from the responsible carrier. Michael P. Yauger, 45 Van Natta 419 (1993); Steven R. Holmes, 45 Van Natta 330 (1993).

The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of the denial. The evidence establishes that claimant's current low back condition was compensable. Although there may have been a question as to the responsible carrier, SAIF had no legitimate basis to doubt compensability as to some employer at the time of its denial of compensability. Thus, SAIF's denial of compensability was unreasonable.

SAIF's unreasonable denial of compensability precluded the possibility of the designation of a paying agent pursuant to ORS 656.307 and constituted an unreasonable delay in the payment of compensation. Yauger, supra; Holmes, supra. Accordingly, for SAIF's unreasonable compensability denial, a penalty will be assessed equal to 25 percent of all compensation due as of the hearing, including medical services. Yauger, supra; Ben Santos, 44 Van Natta 2228, on recon 44 Van Natta 2385 (1992); Kim S. Jeffries, 44 Van Natta 419 (1992), rev'd on other grounds Conagra, Inc. v. Jeffries, 118 Or App 373 (1993).

Assessed attorney fee

Claimant contends that he is entitled to an assessed attorney fee, payable by Liberty, for prevailing over its denial. We have reversed the Referee and reinstated Liberty's denial. Accordingly, claimant has not finally prevailed on Liberty's denial and is not entitled to an assessed attorney fee. See ORS 656.386(1).

ORDER

The Referee's order dated September 25, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the Liberty Northwest Insurance Corporation's denial for claimant's low back condition is reversed. That denial is reinstated and upheld. The Farmers Insurance Group's denial of that condition is set aside and the claim is remanded to Farmers for processing pursuant to Oregon's Workers' Compensation Law. Claimant is awarded a penalty equal to 25 percent of all compensation, including medical services, owing at the time of the hearing, payable by SAIF Corporation. Claimant's attorney shall receive one-half of the penalty in lieu of an attorney fee. ORS 656.262(10)(a). The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DAVID M. BRUCE, Claimant
WCB Case No. 93-01574
ORDER ON REVIEW
Tooze, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant, pro se, requests review of Referee Schultz' order that dismissed claimant's request for hearing from an Order on Reconsideration as untimely filed. On review, the issue is whether claimant requested a hearing within the 180-day period required by ORS 656.268(6)(b).

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

Claimant has moved to strike the self-insured employer's respondent's brief. Contending that the employer's brief was not filed within 21 days of his appellant's brief, claimant asserts that the employer's response was untimely filed. We deny the motion to strike and shall consider the employer's brief.

Claimant's request for review contained his written argument opposing the Referee's order. The Board mailed its notice establishing a briefing schedule on April 15, 1993. Pursuant to that schedule, claimant's appellant's brief was due within 21 days (May 6, 1993) and employer's respondent's brief was due within 21 days from the date of mailing claimant's appellant's brief. When the employer did not receive claimant's appellant's brief by May 6, 1993, it contacted the Board's Appellate Section and was advised that no additional argument had been received from claimant. On May 17, 1993, the employer filed its respondent's brief.

Notwithstanding the inclusion of claimant's written argument with his request for review, he was still entitled to submit an appellant's brief pursuant to the Board's April 15, 1993 briefing schedule. Thus, the employer was not aware that claimant would not be filing an appellant's brief until the 21 day period from the April 15, 1993 briefing schedule expired (May 6, 1993). Inasmuch as the employer filed its respondent's brief on May 17, 1993 (within 21 days from the expiration of the allotted time for claimant to file an appellant's brief), we shall accept the employer's brief. OAR 438-11-030; 438-11-020(2). Since claimant has also filed a reply brief, we have proceeded with our review.

Asserting that the employer failed to move for dismissal of his hearing request within the 180-day time period required by ORS 656.268(6)(b) or within 10 days of his hearing request (ORCP 15(A)), claimant argues that the employer is precluded from contesting the "timeliness" issue. We disagree.

To begin, it would be impossible for a party to move for dismissal of a hearing request based on timeliness grounds under ORS 656.268(6)(b) before expiration of the 180-day time period. Secondly, ORCP 15(A) is a rule of civil procedure which has no application to the rules of procedure before this forum. The relevant rule is OAR 438-06-045, which requires that pre-hearing motions be filed in writing with copies simultaneously served on all parties or their attorneys. Finally, and most importantly, jurisdictional issues such as this are not dependent on whether a party has raised the issue. See Southwest Forest Industries v. Anders, 299 Or 205 (1985). In other words, the issue is always raisable.

We turn to the issue of whether claimant timely filed his hearing request. A Determination Order (DO) issued May 18, 1992. The DO represents that the order was mailed to claimant and the employer on May 18, 1992. ORS 656.268(6)(b) provides that the 180-day period to seek a hearing begins to run from the date copies of the DO are mailed to, not received by, the parties. Therefore, the 180-day period began May 18, 1992.

Claimant's request for reconsideration of the DO was received by the Department on October 27, 1992. Since the date of the DO and the date of Department receipt of the request for reconsideration are not considered in calculating the 180-day period, 161 days had expired by the time the reconsideration process began. Robert E. Payne, Sr., 44 Van Natta 895 (1992).

The Order on Reconsideration issued January 14, 1993. The order was mailed to claimant and the employer on that date.[1] The date of mailing the reconsideration order is not considered in the 180-day calculation. ORS 656.268(6)(b); OAR 436-30-050(3). However, since ORS 656.268(6)(b) provides for the tolling of the 180-day period only during the reconsideration process, the 180-day period does not remain tolled until a party's receipt of the reconsideration order. Thus, claimant had until February 2, 1993 to file his hearing request.

Claimant's hearing request was dated February 3, 1993, mailed to the Board (by regular uncertified mail) on February 5, 1993, and received by the Board on February 8, 1993. Pursuant to OAR 438-05-046(1)(b), the request was "filed" the date the Board received the hearing request. However, even if we considered the date of "filing" to have been the date on claimant's hearing request (February 3, 1993), the request would still have been filed on the 181st day after mailing of the DO. Consequently, the hearing request must be dismissed as untimely. See ORS 656.268(6)(b).

ORDER

The Referee's order dated March 18, 1993 is affirmed.

[1] Relying on OAR 438-05-065, claimant argues that the Department was required to mail its order via registered or certified mail. We disagree. The rule expressly pertains to the issuances of denials from employers and insurers; it has no application to the Department or the mailing of its decisions.

In the Matter of the Compensation of
WILLIAM J. EMERY, Claimant
WCB Case Nos. 92-10927 & 92-06427
ORDER ON REVIEW
Susan Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Kemper Insurance Company (Kemper) requests review of Referee Lipton's order which: (1) found that claimant had established good cause for failure to file a timely request for hearing from its denial; (2) set aside its denial of claimant's "new injury" claim for a low back condition; and (3) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's aggravation claim for the same condition. On review, the issues are timeliness of request for hearing and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Responsibility

In finding that Liberty had established a "new compensable injury" to shift responsibility to Kemper, the Referee reasoned that the responsibility question, as defined in ORS 656.308, was not a complicated medical issue, but rather a purely legal issue. We disagree.

In enacting ORS 656.308, the legislature intended to tighten the standard for shifting responsibility by eliminating the various tests developed by the courts. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 4, Side A at 184; May 4, 1990, Tape 18, Side A at 320. In Ricardo Vasquez, 43 Van Natta 1678 (1991), we interpreted ORS 656.308(1) to require that a claimant sustain a "new compensable injury," as defined by amended ORS 656.005(7)(a), in order to shift responsibility. We held that:

> "[I]n cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Thus, under [ORS 656.308(1), the insurer] as the last carrier against whom claimant had an accepted [*] injury, remains presumptively responsible." Id. at 1680.

We concluded that in order for that carrier to shift responsibility, it must establish, by medical evidence supported by objective findings, that claimant's subsequent work exposure was a material contributing cause of his disability or need for treatment. Id. at 1681; see SAIF v. Drews, 117 Or App 596 (1993). The question of whether the work activity was a material contributing cause of the disability and need for treatment is a question of medical causation. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976).

Kemper contends that, under prior case law, responsibility shifted if the work activities with the subsequent employer "independently contribute[d] to the causation of the disabling condition, i.e., to a worsening of the underlying condition." See Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). Under that standard, a worsening of symptoms alone was insufficient to shift responsibility. Id. at 294. It therefore contends that a mere worsening of symptoms without an additional pathological injury is insufficient to establish a "new compensable injury" under ORS 656.308(1).

In Peggy Holmes, 45 Van Natta 272 (1993), the Board considered but decided against adopting the Hensel Phelps Const. v. Mirich test for cases under ORS 656.308. Here, however, we need not accept Kemper's invitation to revisit ORS 656.308(1) to determine whether or not a pathological worsening is required to establish a "new injury." Under the facts of this case, we find that Liberty failed to establish a "new injury" at Kemper's insured.

Liberty accepted claimant's July 19, 1990 injury claim for a low back strain. A November 21, 1990 Determination Order closed the claim without an award of permanent partial disability. Following claim closure, claimant continued to seek treatment on a regular basis until he moved out of state in October 1990. Claimant worked at various jobs while out-of-state. Claimant returned to Oregon in October 1991 and began working for Kemper's insured sometime in December 1991 or January 1992.

The Orthopedic Consultants examined claimant on December 5, 1991. At that time, claimant complained of intermittent back spasms, and mid to low back pain and stiffness. The doctors felt that claimant had chronic back pain with no objective evidence of abnormality.

On January 9, 1992, while lifting overhead, claimant experienced a sudden onset of low back pain. He sought treatment from Dr. Atchenson, who diagnosed low back muscle strain. Dr. Atchenson prescribed medication and released claimant from work through January 13, 1992. Claimant's condition returned to pre-injury status by that time. A comparison of claimant's examination findings on December 5, 1991; January 9, 1992; and January 13, 1992 were essentially the same except for mild tenderness found on the January 1992 examinations.

Dr. Atchenson reported that the January 9, 1992 incident was a material contributing factor to claimant's need for medical treatment and time loss. We reject Dr. Atchenson's "check-the-box" response as conclusory and not based on complete information because it does not appear that the doctor had the benefit of claimant's prior records or Dr. Rabie's subsequent examination findings. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Rabie, who examined claimant on January 13, 1992, opined that claimant had a worsening of symptoms on January 9, 1992 which had returned to his previous intermittent chronic long-standing pain that he has had since the July 1990 injury. Dr. Rabie reasoned that claimant's July 1990 low back injury condition had not resolved and that the January 1992 incident represented only a minor temporary symptomatic increase of his chronic condition. He felt there had been no separate injurious event nor a pathological worsening of claimant's underlying condition. Although Dr. Rabie had opined

that the January 1992 incident was a material contributing cause of claimant's disability and need for treatment, he felt that claimant would have required medical treatment even if the January 9, 1992 incident had not occurred, because of claimant's chronic condition due to the July 1990 injury.

Based on Dr. Rabie's opinion, we conclude that the January 1992 incident was merely another symptomatic exacerbation of his 1990 injury and not an actual, independent injury. See Ricardo Vasquez, 43 Van Natta at 1680. Accordingly, we find that the January 1992 incident at Kemper's insured was not a material contributing cause of claimant's current low back condition. Liberty has not established that claimant sustained a "new compensable injury" on January 9, 1992. Therefore, responsibility does not shift to Kemper.

Given our conclusion that Kemper is not responsible for claimant's condition, we need not address the issue of whether claimant has established good cause for failure to timely file a hearing request from Kemper's denial.

Attorney Fees

The parties conceded at hearing that compensability was not at issue. Nevertheless, because no order designating a paying agent pursuant to ORS 656.307 issued and because of the "untimely" hearing request issue, we conclude that claimant's compensation was at risk at the Board level. Consequently, claimant's attorney is entitled to a fee for services on review, payable by Liberty, the insurer responsible for claimant's condition.

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 considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue presented and the value of the interest involved.

ORDER

The Referee's order dated December 11, 1992 is reversed. Kemper's denial is reinstated and upheld. Liberty's denial is set aside and the claim is remanded to Liberty for processing according to law. The Referee's assessed attorney fee award shall be paid by Liberty, rather than Kemper. For services on Board review, claimant's counsel is awarded a $500 fee, payable by Liberty.

July 29, 1993 Cite as 45 Van Natta 1523 (1993)

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

Reviewed by Board Members Gunn and Neidig.

Albany Retirement Center, Inc. (Albany), a noncomplying employer, requests review of Referee Lipton's order which dismissed its request for hearing. In its appellant's brief, Albany moves for remand. On review, the issues are propriety of the dismissal order and remand. We remand.

FINDINGS OF FACT

By letter dated April 15, 1992, Albany (through its president, Mr. Sleutel) requested a hearing challenging the SAIF Corporation's acceptance, on its behalf, of claimant's injury claim. The hearing was scheduled for July 30, 1992.

On July 6, 1992, claimant moved for dismissal, contending that Albany, as a corporation, was required pursuant to ORS 9.320 to be represented by an Oregon attorney. The transcript of the hearing indicates that claimant, his attorney, and SAIF's counsel were present at the July 30, 1992 hearing. The transcript does not indicate that anyone representing Albany was present. The Referee stated Mr. Sleutel, the representative of Albany who requested the hearing on Albany's behalf, had not appeared. (Tr. 1).

On July 31, 1992, the Referee dismissed Albany's hearing request. By letter dated August 10, 1992, Mr. Sleutel objected to the dismissal of his hearing request and asserted that another representative of Albany was present at the hearing. This letter was received by the Board and treated as a request for Board review of the Referee's order.

On September 29, 1992, we remanded this matter to the Referee to determine whether Albany failed to appear at the hearing, and if Albany failed to appear, whether that failure was justified. Donald L. Grant, 44 Van Natta 1855, on recon 44 Van Natta 2117 (1992). In response to our order, the Referee sent a letter to the parties on November 25, 1992, which stated, in part:

> "The only issue I must decide is whether Albany appeared through an Oregon attorney on July 30 since that is the only manner in which a corporation can make an appearance. ORS 9.320. Since [claimant's attorney's] July 6, 1992 Motion, which the Board forwarded to John Sleutel at Albany on July 21, identified the requirement of ORS 9.320 if Albany was not represented by an attorney at the July 30, 1992 hearing and thus did not appear, the failure to appear was per se unjustified.
>
> "If you wish to reconvene to pursue this issue, please choose some available dates between yourselves and advise us of those dates. We will provide you with a new Notice of Hearing."

On December 2, 1992, claimant responded to the Referee's letter and indicated he did not desire a hearing. The Referee received no response to his letter from Albany.

On December 28, 1992, the Referee issued an order dismissing Albany's hearing request with prejudice. Noting that only claimant had responded to his letter seeking the parties' respective positions regarding a rescheduling of the hearing, the Referee found that an Oregon attorney did not appear on behalf of Albany at the hearing. Reasoning that there was an unjustified failure to appear at the prior hearing, the Referee again dismissed the hearing request.

Claimant requested reconsideration seeking an attorney fee. On February 5, 1993, the Referee awarded a $1,000 attorney fee. On March 5, 1993, Albany moved for reconsideration, asserting that it had never received the Referee's November 25, 1992 letter. The Referee denied the motion by an order dated March 8, 1993.

CONCLUSIONS OF LAW AND OPINION

On September 29, 1992, we remanded this matter to the Referee to determine whether Albany failed to appear at a scheduled hearing, and, if so, whether such a failure was justified. Donald L. Grant, supra. In response to our order, the Referee sent a November 25, 1992 letter to the parties which, among other things, asked the parties if they wished to convene a hearing. On December 28, 1992, after receiving no response from Albany to his November 25, 1992 letter, the Referee dismissed Albany's hearing request without convening a hearing. The Referee concluded that Albany was not represented by an attorney at the July 30, 1992 hearing and, therefore, Albany did not appear. The Referee further found that Albany's failure to appear was per se unjustified.

Asserting that it never received the Referee's November 25, 1992 letter, Albany moves to remand this case for further proceedings. Specifically, Albany contends that it has been deprived of the opportunity to either establish its appearance at the prior hearing or to provide justification for its failure to appear. Claimant opposes Albany's motion, contending that Albany failed to follow the statutory and regulatory scheme by not appearing at the original hearing through an attorney.

Unjustified failure of a party or a party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-06-071(2). If the party that waives appearance is the party that requests the hearing, the referee shall dismiss a request for hearing unless extraordinary circumstances justify postponement or continuance of the hearing. Id. A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081.

Here, we remanded this matter to the Referee to determine whether Albany failed to appear at a scheduled hearing, and, if so, whether such a failure was justified. In response to that order, the Referee sought the parties' respective positions regarding whether an additional hearing needed to be convened. When Albany failed to respond, the Referee issued a supplemented dismissal order. Albany has subsequently replied, asserting that it did not receive the Referee's letter and wishes to present evidence at a hearing concerning the events which transpired at the initial hearing.

In light of these circumstances, we conclude that the record as presently developed is insufficient for us to resolve the issue of whether Albany failed to appear at the initial hearing and whether its failure was unjustified. OAR 438-06-071(2); Kathy A. Schalk, 45 Van Natta 1262 (1993). Consequently, we consider it appropriate to remand this matter to the Referee. See ORS 656.295(5). The Referee may very well find on remand that Albany did not appear through an attorney at the initial hearing. Moreover, the Referee may conclude that such action constitutes a failure to appear and that this failure was "unjustified." Nevertheless, under these circumstances, we hold that such determinations should be rendered after the parties have an opportunity to present their respective positions.

Accordingly, the Referee's order dated December 28, 1992, as reconsidered on February 5, 1993 and March 8, 1993, is vacated. This matter is remanded to Referee Lipton for further proceedings consistent with this order; i.e., to take further evidence, make findings and render conclusions regarding whether Albany failed to appear at hearing, and if so, whether such a failure was justified. See OAR 438-06-071(2). In conducting these further proceedings, the Referee may proceed in any manner that will achieve substantial justice.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANCISCO OCHOA, Claimant
WCB Case No. 92-01836
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Crumme's order that upheld the SAIF Corporation's denial of claimant's injury claim for a right arm contusion and low back strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, who is a Mexican native, first worked for the employers, Joe and Bill O'Meara, father and son, in December 1990. Claimant's primary language is Spanish.

In 1991, claimant, his wife, and one son lived in a house belonging to the O'Mearas, which was leased to the Deckers, a neighboring family. The Deckers used the house as a "labor camp." Claimant believed that Joe O'Meara allowed him to live in the house.

Claimant took a leave of absence in December 1991, traveled to Mexico and returned on January 8, 1992, bringing a second son and a brother-in-law with him. As of his return, five family members including claimant lived in the upstairs of the house.

On January 9, 1992, claimant worked at the employer's Wildwood golf course. In the morning, Bill O'Meara operated a Ditch Witch and claimant cleaned out the ditch to ready it for laying drain pipe. O'Meara told claimant to help him, pointing to a shovel and some mud and rocks. When claimant responded to O'Meara's directions, he slipped on wet grass, fell backward --uphill, extending his arms and landing in a sitting position on mud and rocks thrown out by the Ditch Witch. After awhile, claimant got up, using the shovel for support. He felt some pain, but continued working the rest of the day.

Art Huber, another employee, was not present when claimant fell, but worked with him later that day.

Claimant sought medical treatment the next day, complaining of right arm and low back pain. Dr. Kenney, treating physician, diagnosed a right arm contusion and low back strain. Claimant's arm pain lessened thereafter, but his back pain increased over the next several days. He treated with Ibuprofen, bed rest and physical therapy.

Claimant was off-work for two days, then unsuccessfully attempted to return to work.

On January 20, 1992, Dr. Kenney released claimant for modified work. The employer had no such work for claimant and claimant feared that he would lose his job. Kenney reinstated claimant's time loss authorization.

On February 19, 1992, a man claimant did not know came to his house, entered without permission, and screamed things claimant did not understand. Claimant was startled out of bed. Once up, he was unable to move and felt excruciating pain in his low back. He called the police. Days later, several people, including Joe O'Meara, Dave Horesky (who investigated the claim for the employer), the Decker family of three and a man named Ruben Martinez came to claimant's house. At this time, claimant understood that he was being told to move out. Claimant called the police again.

Claimant's right arm problem resolved sometime before March 6, 1992; his low back strain resolved by July 16, 1992.

FINDINGS OF ULTIMATE FACT

Claimant's January 9, 1992 fall at work was a material contributing cause of his subsequent disability and need for medical treatment for his right arm and low back. Claimant's right arm and low back injury is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee dismissed claimant's hearing request, although no party requested dismissal. Because the Referee reached and decided the merits and we are aware of no authority for dismissal absent such a request, we conclude that the Referee should not have dismissed claimant's hearing request in this case. Therefore, we give no effect to the purported dismissal.

The Referee found that claimant did not injure himself at work, based on his belief that claimant's testimony was not trustworthy. The Referee's adverse credibility finding is expressly based on claimant's demeanor at hearing and on two arguable inconsistencies between claimant's testimony and the testimony of the employers' witnesses. Thus, the outcome of this case at the hearings level apparently turned on claimant's demeanor, which the Referee described as follows:

> "[E]ven allowing for the difficulties of testifying through an interpreter and [claimant's] unfamiliarity with the hearing process, claimant's demeanor while testifying was not trustworthy. He often appeared nervous and uncertain and not infrequently took an undue amount of time to answer questions about the events in issue." (O&O p. 2).

As a matter of practice, we generally give "deference to findings made below, especially when they relate to witness credibility." See Erck v. Brown Oldsmobile, 311 Or 519, 525 (1991); see id. at 526 ("[O]n de novo review, it is good practice for an agency or court to give weight to the factfinder's credibility assessment."). However, we are not statutorily required to explain our departure from a referee's credibility determination. 311 Or at 526. Instead, pursuant to our de novo review authority, we may "affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as [we determine] to be appropriate." ORS 656.295(6); see ORS 656.295(5); 311 Or at 523.

In this case, we defer to the Referee's description of claimant's appearance at hearing. In other words, we acknowledge that claimant was nervous and hesitant and took time to answer questions. However, under the circumstances of this case, we conclude that there are explanations for claimant's physical manifestations at hearing which do not call for the conclusion that claimant is not trustworthy. Accordingly, we reevaluate claimant's credibility on de novo review. See Erck v. Brown Oldsmobile, supra.

To begin, we do not find that claimant's nervousness, hesitancy and apparent uncertainty indicate that he was lying about the occurrence or mechanism of his injury. Instead, considering the events threatening claimant's home, family and livelihood, particularly his post-injury eviction and inability to work, we find nervousness and hesitancy to be understandable and reasonable responses. Thus, in our view, the demeanor observed by the Referee is as likely related to claimant's undisputed misfortune as to discomfort from lying. Given the former explanation for claimant's appearance at hearing, we do not find that claimant's testimony was necessarily untrustworthy, based on his demeanor.

As we have stated, the Referee also found claimant's testimony unbelievable, upon comparing it with that of other witnesses. In this regard, we make an independent credibility finding, based on our review of the record. See Davies v. Hanel Lumber Co., 67 Or App 35 (1984). First, we note that claimant and his wife testified that claimant's clothing was muddy after he fell, while Bill O'Meara testified that it was surprisingly clean all day, considering the dirty nature of his work. On this evidence alone, we cannot say which description of claimant's clothing is more persuasive. Consequently, the state of claimant's clothing does not weigh one way or another in our analysis.

Second, SAIF argues that claimant's testimony at hearing that he did not have any back problems before January 9, 1992 is inconsistent with an "out-of-court" admission he allegedly made that he needed help, due to back pain before the claimed injury. On this issue, O'Meara, Decker and Horesky testified that claimant stated that he brought his brother and second son back from Mexico in 1991 because he needed help, due to preexisting back problems. According to the employer's witnesses, claimant made this admission when the O'Mearas and Deckers notified claimant that he was evicted in February. We find the occurrence of such an admission to be unlikely.

The employers' and Decker's reason for evicting claimant's family was that too many people lived in the house, i.e., five instead of three. This was not the case until after claimant brought his second son and brother-in-law back from Mexico. Because the employer and several other people went to the house, on or about February 19, 1992, for the purpose of evicting claimant and this purpose was communicated to claimant at that time, we think it is likely that claimant was explaining that he needed his brother-in-law and second son to help him then, in February, after he became disabled due to his January injury. In other words, despite what the employer believes claimant admitted, we doubt that claimant stated that he needed help due to back problems before he was injured. (See Tr. 13-15; Tr. 97). In this regard, we note that there is no evidence arguably suggesting that claimant had prior back problems, other than the above mentioned "admission" evidence. The witnesses who testified to the admission speak little or no Spanish themselves and base their opinion regarding the content of claimant's statement on claimant's twelve-year-old son's attempted translation of his father's explanation for the presence of five people in the house. Considering the emotional nature of the February 1992 confrontation and the language barrier, we conclude that the employers' witnesses probably misunderstood the boy's translation or the boy misspoke himself during the heat of the moment.

In summary, considering the circumstances of this case, we do not find that claimant's demeanor at hearing casts doubt on his credibility. Nor do we find that claimant admitted that he had pre-January 1992 back problems or that his clothing was suspiciously clean on the day of the claimed injury. Consequently, on this evidence, we find no persuasive to reason to conclude that claimant is not credible. Furthermore, we find that the medical evidence, including that contemporaneous with the injury, is entirely consistent with claimant's reporting. (See Exs. A, 1-A, 3-B-D, 4-B, 5, 7, 8, 9). Thus, in our view, the record establishes that claimant injured his right arm and low back at work on January 9, 1992. Accordingly, we conclude that claimant has carried his burden of proof and the claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on this claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning this claim is $4,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The Referee's order dated September 28, 1992 reversed. The SAIF Corporation's denial is set aside. The claim is remanded to SAIF for further processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $4,000, payable by SAIF.

In the Matter of the Compensation of
RAYMOND L. OWEN, Claimant
WCB Case No. 92-11258
ORDER ON REVIEW
Gloria Schmidt, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Daughtry's order which: (1) affirmed an Order on Reconsideration awarding claimant 8 percent unscheduled permanent disability for a low back injury; and (2) awarded claimant an assessed attorney fee of $1,500 for his counsel's services at hearing concerning the employer's unsuccessful challenge to the reconsideration order award. On review, the issues are extent of unscheduled permanent disability and attorney fees.

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

In determining where the preponderance of evidence lies with respect to claimant's impairment findings, the Referee considered only the reports of the medical arbiter, Dr. Burr, and the attending physician at the time of claim closure, Dr. Peterson. The employer contends that the Referee erred in not also considering the reports of Drs. Daskalos and Woolpert in determining the preponderance of evidence. Neither Dr. Daskalos nor Dr. Woolpert was an attending physician at the time of claim closure, nor did the attending physician concur in their findings.

The employer relies on our order in Timothy W. Reintzell, 44 Van Natta 1534 (1992), wherein we stated that the "level of impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings." Id. at 1535 (emphasis added). See also Joaquin M. Betancourt, 44 Van Natta 1762 (1992); Glen L. Burtis, 44 Van Natta 2116 (1992). Based on the above-quoted language, the employer contends that when there is a medical arbiter's opinion, any prior impairment findings should be considered in weighing the preponderance of the evidence. We disagree.

In each of the cases cited by the employer, we evaluated only the opinions of the attending physician and the medical arbiter. This is consistent with the statutory mandate that provides: "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." ORS 656.245(3)(b)(B); see also Dennis E. Connor, 43 Van Natta 2799 (1991). The exception refers to impairment findings made by a medical arbiter appointed pursuant to ORS 656.268(7). See Easter M. Roach, 44 Van Natta 1740 (1992). The impairment findings of an independent medical examiner may be used for rating claimant's impairment only when the attending physician has ratified those findings. See Raymond D. Lindley, 44 Van Natta 1217 (1992). Nothing in our prior orders was intended to supercede this statutory scheme.

ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." In Timothy W. Reintzell, supra, we held that a Director's rule which required use of a medical arbiter's impairment findings, whenever an arbiter was appointed, conflicted with this statute. See former OAR 436-35-007(9). Subsequently, the Director's rule was amended to provide that impairment is determined by the attending physician, or by the medical arbiter when one is used, "except where a preponderance of medical opinion establishes a different level of impairment." OAR 436-35-007(9).

Nothing in our orders or in the Director's rule authorizes impairment to be determined by anyone other than a medical arbiter appointed under ORS 656.268(7) or the attending physician at the time of claim closure, unless the attending physician concurs with another medical opinion. Accordingly, we clarify our prior orders to specify that impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior relevant impairment findings. See, e.g., Timothy W. Reintzell, supra; Joaquin M. Betancourt, supra. Relevant impairment findings include the findings of the attending physician at the time of claim closure or any findings with which he or she concurred, as well as the findings of the medical arbiter when one is appointed. See ORS 656.245(3)(b)(B); 656.268(7); OAR 436-35-007(9).

We find that the Referee did not err in considering only the impairment findings of the attending physician and the medical arbiter, when the attending physician did not concur with the independent examiners' findings. After our review of the record, we affirm and adopt the Referee's order which affirmed the Order on Reconsideration.

The employer also contends that the amount of the attorney fee awarded to claimant for his counsel's services at hearing is unreasonable because it is greater than the fee his counsel would have received out of increased compensation. The Referee awarded claimant $1,500 in assessed attorney fees under ORS 656.382(2), since the employer requested the hearing challenging the Order on Reconsideration. The employer contends that this attorney fee is excessive, since an out-of-compensation fee based on obtaining 8 percent permanent disability would only be $640.

Since the employer requested a hearing challenging the Order on Reconsideration award, and since the Referee found that the compensation awarded to claimant should not be disallowed or reduced, claimant is entitled to an assessed attorney fee under ORS 656.382(2) for his counsel's services at hearing. The factors to be considered in determining a reasonable fee are set forth in OAR 438-15-010(4). The amount of attorney fee claimant's counsel would have received out of increased compensation, as provided in ORS 656.386(2), is not one of the factors to be considered.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee's determination that a reasonable fee for claimant's attorney's services at hearing concerning the extent of unscheduled disability issue is $1,500. In reaching this conclusion, we have particularly considered the attorney's skill and experience, the complexity of the case, and the value of the interest interest involved, as well as the risk that claimant's attorney's efforts might go uncompensated. We conclude that the attorney fee awarded by the Referee is reasonable.

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 extent of unscheduled permanent disability issue is $500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In addition, we note that claimant's counsel is not entitled to attorney fees on Board review for her services regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated December 17, 1992 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the self-insured employer.

July 29, 1993 Cite as 45 Van Natta 1529 (1993)

In the Matter of the Compensation of
E. C. PARK, Claimant
WCB Case Nos. 92-09256, 92-05662, 92-07840, 92-08068 & 92-12929
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Janice Pilkenton, Defense Attorney
Meyers & Radler, Defense Attorneys
Beers, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Mission Insurance/Scott Wetzel Services (Mission) requests review of those portions of Referee Baker's order that: (1) set aside its denial of claimant's current cervical/thoracic condition; (2) upheld the denials of EBI, Safeco and Reliance of the same condition; and (3) awarded claimant's attorney an assessed fee of $3,500 for services at hearing. Claimant cross-requests review of those portions of the Referee's order that: (1) awarded a $3,500 assessed attorney fee; and (2) declined to assess penalties and attorney fees against Mission for an allegedly unreasonable denial. On review, the issues are compensability, responsibility, penalties and attorney fees.

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

Compensability

The Referee found that claimant's current cervical/thoracic condition is the same condition which resulted from the June 1985 compensable injury. The Referee further found that the cervical/thoracic condition continued to be compensable and continued to be the responsibility of Mission/Scott Wetzel. We agree.

Due to the passage of time since the June 1985 compensable injury, causation of claimant's cervical/thoracic condition presents a complex medical question. Therefore, expert medical evidence is required in order to resolve the compensability issue. Uris v. Compensation Department, 247 Or 420 (1967). The medical evidence concerning causation of the cervical/thoracic condition comes from claimant's attending physician, Dr. Scoltock, and from Drs. Dinneen and Simpson who performed an independent medical examination (IME).

In their IME report, Drs. Dinneen, orthopedist, and Simpson, chiropractic physician, could not relate claimant's current condition to the June 5, 1985 injury. However, Dinneen and Simpson opined that claimant's current work activities would more reasonably be considered the major contributing cause of his need for treatment. Dinneen and Simpson presumed that claimant's current work activities contributed to symptoms but did not worsen his underlying condition. (Ex. 56-3).

Dr. Dinneen later opined that the June 5, 1985 injury was not the major or a material contributing cause of claimant's current need for treatment. Dinneen based his opinion on the fact that claimant lost no time from work as a result of the upper back injury. Dinneen opined that given the degree of injury and passage of seven years, the 1985 injury should have resolved and was not the major contributing cause of claimant's current condition. In addition, Dr. Dinneen found no objective findings of neurological or orthopedic impairment.

Dr. Scoltock became attending physician in 1990. Up to that time, claimant had been treated for the 1985 compensable injury by Dr. George, a chiropractor. The record contains no opinion from Dr. George regarding the causation of claimant's current condition.

In response to the IME report of Drs. Dinneen and Simpson, Dr. Scoltock initially related claimant's current back pain to the 1985 injury. (Ex. 57). Scoltock later indicated on a check-the-box form, that claimant's current work activities were the major contributing cause of his need for treatment. (Ex. 58A). However, after reviewing his records, Dr. Scoltock withdrew his opinion that claimant's current work activities were the major contributing cause of claimant's need for treatment and instead indicated that based on claimant's history, the major contributing cause of claimant's current back condition was the June 5, 1985 compensable injury. (Ex. 60). Dr. Scoltock stated that claimant gave a clear history of having no back problems prior to his injury and since the injury had required ongoing chiropractic treatment in order to keep working. Dr. Scoltock felt that if claimant had not been injured in 1985, he would not now be having back problems.

We generally defer to the treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Mission argues that Dr. Scoltock is not entitled to deference as a treating physician since most of claimant's treatment was provided by Dr. George. However, we note that Scoltock has been claimant's family physician for approximately 20 years and has followed claimant's treatment for his cervical and thoracic condition since becoming the attending physician. By contrast, Drs. Dinneen and Simpson saw claimant on one occasion. Mission also argues that Dr. Scoltock's opinion is weakened by his change of opinion regarding whether claimant's current work activities or the 1985 injury was responsible for his current cervical and thoracic condition. However, Dr. Scoltock offered an explanation for his change of opinion. On this record, we find no persuasive reasons not to defer to Dr. Scoltock's opinion that claimant's current cervical/thoracic condition is compensably related to the 1985 compensable injury. Accordingly, we agree with the Referee that claimant has established that his current cervical/thoracic condition is compensable.

Responsibility

The Referee found that responsibility remained with Mission since the record did not show that claimant had sustained a new compensable injury involving the same condition. We agree.

We have interpreted ORS 656.308(1) to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1402 (1991). Mission, as the last carrier against whom claimant had an accepted cervical/thoracic injury, remains presumptively responsible. In order to avoid responsibility, Mission has the burden of establishing that claimant sustained a new compensable injury involving the same condition while another carrier was on the risk.

On review, Mission challenges compensability of claimant's current condition, but does not seek to shift responsibility to any subsequent carrier. In addition, there is no persuasive evidence in the record that claimant sustained a new compensable injury or disease while a later carrier was on the risk. Accordingly, responsibility for the cervical/thoracic condition remains with Mission.

Penalties and Attorney Fees

Claimant has cross-requested review of that portion of the Referee's order which declined to assess penalties or attorney fees for an unreasonable denial.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

At the time it issued its denial, Mission had the report of Dr. Dinneen and Dr. Simpson which indicated that claimant's current condition was not related to the June 5, 1985 compensable injury and which suggested that claimant's current condition might be related to his work activities at the employer at a time when another carrier was on the risk. In addition, Mission had an opinion from Dr. Scoltock, the attending physician, which also indicated that claimant's work for the employer while a later carrier was on the risk was the major contributing cause of claimant's need for treatment. Based on this evidence, we conclude that Mission had a legitimate doubt as to its liability at the time it issued its denial. Accordingly, we do not find Mission's denial to be unreasonable and no penalties or fees are appropriate.

Attorney Fees/Hearings Level

The Referee awarded claimant's attorney an assessed fee of $3,500 for services at hearing. Mission seeks a reduction in the Referee's attorney fee award, while claimant seeks an increase in the award.

OAR 438-15-010(4) sets forth the following factors to be considered in determining a reasonable fee: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorney; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After reviewing the record and considering the factors listed above, we conclude that the Referee's attorney fee award is reasonable. In reaching this conclusion, we have particularly considered the complexity of the issue, the value of the interest involved and the risk that counsel's efforts might go uncompensated.

Attorney Fee Board Review

Claimant is entitled to an assessed attorney fee for prevailing over Mission's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, to be paid by Mission. 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. We further note that inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's attorney is not entitled to a fee for services on review regarding the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Likewise, claimant is not entitled to an attorney fee award for his unsuccessful efforts regarding the "penalty and attorney fee" cross-request.

ORDER

The Referee's order dated October 30, 1992 is affirmed. For services on review, claimant's attorney is awarded $500 payable by Mission.

In the Matter of the Compensation of
ALAN R. ROW, Claimant
WCB Case No. 92-08964
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Paul Roess, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Lipton's order that set aside its denial of claimant's medical services claim for a drug dependency program. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the exception of the last sentence found on page 2 of the Referee's order. Instead that sentence is replaced with the following sentence:

The August 26, 1988 compensable injury is the major contributing cause of claimant's drug dependency and need for a drug treatment program.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's drug dependency program compensable based on the finding that the compensable injury was a material contributing cause of the need for treatment. The Referee analyzed the case as a claim for medical services arising under ORS 656.245. The insurer, on the other hand, argues for application of ORS 656.005(7)(a)(C), which pertains to the use of illegal substances. We note, however, that ORS 656.005(7)(a)(C) is designed to address compensability of an initial injury. See Grace L. Walker, 45 Van Natta 1273 (1993). Here, claimant's drug dependency and need for treatment arose as a consequence of pain resulting from claimant's multiple surgeries for the compensable injury. Thus, the claim is best characterized as a consequential condition of the compensable injury under ORS 656.005(7)(a)(A). We therefore conclude that ORS 656.005(7)(a)(C) is not applicable under these circumstances.

Therefore, to establish compensability of claimant's medical services claim for the drug dependency program, claimant must prove that the original injury was the major contributing cause of his consequential drug dependency and need for treatment. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). The evidence is overwhelming that due to the compensable injury claimant has experienced considerable pain. In response to continuing pain complaints numerous surgical procedures were attempted. Those efforts met with little success. Ultimately, claimant's unremitting pain led to a below-the-knee amputation of the right leg in March 1992.

Throughout this period, claimant's attending physician, Dr. Wenner, continued to prescribe narcotic pain medication, primarily Vicodin. Claimant testified, however, there came a point in time when the prescription medication was not effective. In an effort to relieve pain claimant turned to "street drugs." This effort, however, met with little success. By July 1991 claimant was feeling overwhelmed and out of control in his failed efforts to control pain. Realizing he had a drug dependency problem he talked the matter over with his attending physician, Dr. Wenner, who agreed that a drug dependency program would be beneficial. (See Ex. 39A.) Shortly thereafter, claimant referred himself to Stepping Stones, a drug dependency program.

It was the opinion of Dr. Wenner that claimant had a significant chemical dependency problem involving the use of narcotic pain medicine. This addiction, he opined, was directly related to pain problems resulting from the compensable injury. Dr. Wenner's opinion was based on his discussions with claimant on this issue. (See Ex. 39A.) In addition, this opinion is supported by the opinion of claimant's counselor at Stepping Stones, Mr. Larson. In his October 1, 1992 letter, Mr. Larson indicated that claimant had sought treatment for addiction to pain medication. His letter clearly outlines the mechanism and course of this addiction. A fair interpretation of the above letter is that it is Larson's opinion that the addiction is related to the compensable injury. (See Ex. 40.) There are no contrary opinions in the record.

Although we acknowledge the presence of what has been termed "street drugs" the evidence does not establish that claimant's use of "street drugs," was the major cause of claimant seeking treatment at Stepping Stones. Accordingly, based on the evidence, we find that claimant has carried his burden of proof in establishing that the compensable injury was the major contributing cause of claimant's consequential drug dependency and related need for treatment. See Jeffrey M. Rubin, 43 Van Natta 2543 (1991).

Inasmuch as the insurer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to an assessed attorney fee in accordance with ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 12, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, payable by the insurer.

In the Matter of the Compensation of
CLOE L. WELLBORN, Claimant
WCB Case No. 92-08205
ORDER ON REVIEW
Malagon, et al., Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Black's order that: (1) upheld the insurer's denial of her injury claim for a right knee condition; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's accepted knee contusion injury was neither a material, nor the major contributing cause of her need for treatment and disability. The Referee further found that, although the insurer issued its notice of acceptance and partial denial late, there was no compensation due. On this basis, he declined to assess penalties or attorney fees.

Compensability

On February 18, 1992, claimant fell at work landing on her knees. Paramedics were called and both knees were treated for bruises. (Ex. 3). Claimant did not miss any time from work as a result of the injury. In late March or early April, 1992, claimant sought treatment for knee pain. Longstanding degenerative arthritis was diagnosed. On June 10, 1992, the insurer accepted claimant's claim for right and left knee contusions, but partially denied claimant's bilateral, degenerative arthritis of the knees.

If, in an initial claim, disability or need for treatment is due to the combination of a work-related injury and a preexisting, noncompensable condition, the injury is compensable only if it is 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), mod 120 Or App 590 (1993).

Here, there are two opinions concerning the cause of claimant's current right knee disability and need for treatment. Dr. Fuller, orthopedic surgeon, and Dr. Peterson, neurologist saw claimant for an independent medical examination. These physicians opined that the cause of claimant's current condition and need for treatment was postural degenerative arthritis of the lateral and patellofemoral compartment of her right knee. They indicated that the February 18, 1992 contusion injury was superimposed upon preexisting, moderate to severe arthritis of both knees. They further opined that the February 18, 1992 incident does not remain a major or material cause of her current condition. Finally, Peterson and Fuller opined that the injury did not worsen the preexisting condition.

Dr. Schachner, an orthopedic surgeon, treated claimant for her right knee problems. He noted degenerative arthritis of the right knee and explained that the arthritis was not only preexisting, but is due to the valgus deformities which have, over the course of years, overloaded the lateral compartment bringing about degeneration in that area. He opined that: "If indeed she was asymptomatic prior to the event then the incident, as described, is a source of aggravation which has brought a previously asymptomatic arthritic process to the surface." On June 1, 1992, Dr. Schachner concurred with the report of Drs. Fuller and Peterson, with the exception of Fuller's and Peterson's statement that Schachner had requested a total knee replacement for claimant. Dr. Schachner explained that he had advised claimant that a total knee replacement would be needed at some point.

We note that there are factual errors in the report of Drs. Fuller and Peterson. For instance, they report that claimant had previously injured her knees when she fell on ice in 1988 and had received medical treatment at that time for her knees. According to claimant's testimony, she injured her shoulder when she fell on ice in 1990 and received treatment for that body part, but did not injure her knees. (Tr. 6-7). In addition, Fuller and Peterson report that claimant was asymptomatic for a month after the February 1992 injury, whereas claimant testified that she had knee problems directly after the fall which did not go away. (Tr. 5; 7). Finally, Fuller and Peterson noted a history of preexisting knee problems, whereas claimant testified that she had no knee symptoms prior to the February 1992 injury. (Tr. 5).

Based on the record as a whole, we conclude that claimant's February 1992 injury combined with her preexisting arthritis to cause or prolong disability or need for treatment. Accordingly, claimant has the burden to prove that the February 1992 injury is the major contributing cause of her disability or need for treatment of the right knee. ORS 656.005(7)(a)(B); ORS 656.266.

Here, we conclude that claimant has not met this burden. Dr. Schachner does not opine that the February 1992 injury is the major contributing cause of claimant's disability or need for treatment of her right knee condition. His statement that the February 1992 incident may have brought the previously asymptomatic arthritis to the surface is not sufficient to persuade us that he believes that the February 1992 injury is the major contributing cause of claimant's current disability and need for treatment. In fact, Schachner concurred with the report of Fuller and Peterson which indicated that the February 1992 injury was not the major contributing cause of the right knee condition or the need for treatment. Under such circumstances, we conclude that claimant has not established compensability of her right knee condition.

Penalties and Attorney Fees

The Referee concluded that the insurer did not accept claimant's knee contusion injury within 90 days of notice of the event to the employer. The Referee also found that the insurer untimely issued its partial denial of claimant's bilateral degenerative knee arthritis. However, finding that there was no evidence that the insurer had not paid compensation as it became due, the Referee assessed no penalties or attorney fees. We agree.

Here, there is no evidence that compensation related to the accepted claim has not been paid. An insurer cannot unreasonably resist the payment of compensation that has been paid. SAIF v. Condon, 119 Or App 194 (1993). In addition, since we have found claimant's current right knee

condition not to be compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee as a result of that condition. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

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

In the Matter of the Compensation of
ESTHER M. ANDERSON, Claimant
Own Motion No. 92-0671M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our July 1, 1993 Own Motion Order in which we denied the reopening of her claim for temporary total disability benefits on the ground that she had not proved that she was in the work force at the time of her disability. Attached to the request for reconsideration is a July 23, 1993 letter from claimant's former employer. After further consideration, we remain of the opinion that claimant has failed to establish that she was in the work force at the time of her disability.

In our July 1, 1993 order, we found that claimant's condition worsened requiring surgery in March 1993. Therefore, in order to establish entitlement to temporary disability benefits, claimant must prove that she was in the work force as of March 1993. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). In addition, we found that the work injury made it futile for claimant to make a job search at the time of her March 1993 worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). However, we also found that claimant had not proved that, but for the work injury, she was willing to work. Without proof of that essential element, claimant failed to establish that she was in the work force. Id. In our prior order we stated that proof of willingness to work could include an AFFIDAVIT FROM CLAIMANT regarding her recent work history prior to her worsening and a statement as to whether she was willing to work if not for her work injury.

Subsequent to our prior order, claimant has obtained representation. In a letter dated July 23, 1993, in addition to requesting reconsideration of our prior order, claimant's attorney states that claimant was willing to work at the time of the March 1993 worsening. Claimant's attorney also states that claimant has signed his letter attesting to the truth of the facts assested in the letter. Claimant's signature, however, is not on the letter. In any event, even if claimant had signed the letter, that letter is not an affidavit from claimant. Claimant's attorney's bare assertions are not sufficient to meet claimant's burden of proof. Larry R. Ruecker, 45 Van Natta 933, 934 (1993).

In addition, claimant's attorney submits a letter dated July 23, 1993 from claimant's former employer. The letter, which is addressed to claimant's attorney states that claimant "has expressed a desire to return, but with her underlying condition it would be difficult to have her work even in a limited capacity." The letter, however, does not assign anytime frame to claimant's return to work attempt. As noted above, claimant must establish that she was in the work force at the time of her worsening in March 1993. The employer's July 1993 letter does not establish claimant's willingness to work at the time of her March 1993 worsening.

Accordingly, our July 1, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 1, 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
PATRICK J. CASEY, Claimant
WCB Case No. 92-09733
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The self-insured employer requests review of that portion of Referee Thye's order which set aside its denial of claimant's occupational disease claim for a low back condition. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty and attorney fee for the employer's allegedly unreasonable denial of the claim. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt that portion of the Referee's order which found claimant's occupational disease claim for a low back condition compensable, with the following supplementation.

The employer contends that claimant failed to carry his burden of proving legal causation because he did not initially believe his low back condition was work-related. We disagree.

It is immaterial whether claimant believes his work activities caused his condition. Legal causation is established by showing that claimant engaged in potentially causal work activities; whether those work activities did cause claimant's condition is a question of medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618, 621 (1981). The employer does not contest the Referee's finding that claimant established medical causation.

Regarding the issue of legal causation, claimant testified that his regular job as a janitor required repetitive use of his back, specifically in such activities as lifting 20 to 50-pound garbage bags, lifting floor scrubbing machines, and mopping, vacuuming and sweeping the store. (Tr. 3-4). After our review of the record, we agree with the Referee's finding that claimant's work activities required repetitive use of his back. Thus, we conclude that claimant exerted himself in performing his job as a janitor. Accordingly, we find that claimant established legal causation of his low back condition. Id.

Penalty/Attorney Fee

Claimant contends that because the employer failed to investigate his claim before denying it, the denial was unreasonable and he is entitled to a penalty and related attorney fee. We agree that the denial was unreasonable.

If the employer's denial was based upon a legitimate doubt, in light of the information available to it at the time of the denial, the denial is not deemed unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). However, a reasonable doubt does not exist where a decision is made quickly without independent investigation. Philip A. Parker, 45 Van Natta 728 (1993); Kenneth A. Foster, 44 Van Natta 148 (1992).

Here, at the time of its denial on June 22, 1992, the employer was in receipt of claimant's 801 form dated June 2, 1992. (Ex. 12). On the form, claimant indicated he injured his left hip and low back as a result of trying to free a trash bin cart that was wedged in among other carts. (Id).

In addition, the medical reports of Kaiser physicians Drs. Ushman and Corrigan were available prior to the issuance of the denial. Dr. Ushman indicated that claimant's condition was "possibly" work-related, noting on the form 827 that the cause of claimant's hip and low back pain was unknown. (Exs. 8, 10; see also Ex. 11). Dr. Corrigan's chart note and orthopedic consultation report, both dated June 2, 1992, also were available prior to the denial. (Exs. 13, 14). In his consultation report, Dr. Corrigan opined that claimant's low back condition was due, in major part, to his work activities. (Ex.

However, despite the availability of these medical reports, the employer denied the claim ten days after it was filed, without taking claimant's statement or scheduling an independent examination. We are persuaded that the evidence available to the employer prior to the denial should have prompted either further investigation or acceptance of the claim, based on Dr. Corrigan's report. Instead, the employer issued its denial without requesting any medical reports. Under these circumstances, we find that the employer had no legitimate doubt of its liability for the claim. See Philip A. Parker, supra at 729. 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. ORS 656.262(10).

Inasmuch as claimant is seeking a separate, penalty-related attorney fee under ORS 656.382(1) 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).

Claimant also seeks a penalty under ORS 656.382(3). This statute permits a referee to order a penalty to be paid to claimant under circumstances where the employer initiated the request for hearing and the referee found that the hearing request had no reasonable ground or was initiated for delay or other vexatious reason. This statute does not authorize the Board to order a penalty. Furthermore, claimant initiated the request for hearing, not the employer. Accordingly, we find there is no basis for awarding claimant a penalty under ORS 656.382(3).

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the assertion of frivolous defenses.

ORDER

The Referee's order dated December 1, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which declined to assess a penalty for an unreasonable denial is reversed. The self-insured employer is assessed a penalty in the amount of 25 percent of all compensation due at the time of the hearing, to be paid in equal shares to claimant and his attorney. The remainder of the Referee's order 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 A. GABILONDO, Claimant
WCB Case No. 92-08796
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Mills' order that: (1) affirmed an Order on Reconsideration awarding 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the right arm; (2) found that claimant was not entitled to be paid scheduled permanent disability at the rate of $305 per degree; and (3) declined to assess a penalty for the self-insured employer's allegedly unreasonable claim processing. On review, the issues are extent and rate of scheduled permanent disability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Order on Reconsideration awarded 5 percent permanent disability based on a chronic condition impairment. See former OAR 436-35-010(6) (WCD Admin. Order 2-1991). Claimant asserts that he is entitled to additional impairment for loss of strength in his right forearm and right arm. Specifically, claimant contends that, because the medical arbiter found equal grip strength bilaterally and claimant's dominant right grip should have been 10 percent stronger than the nondominant left grip, he has a 4/5 loss of strength in his right arm. In asserting that his right grip should be 10 percent stronger than his left grip, claimant relies on the pertinent portion of the AMA Guides to Evaluating Permanent Impairment.

In determining extent of permanent disability, the Board must apply the appropriate standards. ORS 656.295(5). Under the standards applicable to this case, loss of strength is based on a "preponderance of medical opinion." Former OAR 436-35-007(14). Here, there is an absence of medical opinion showing that claimant has less strength in his right arm in comparison to his strength before the injury. Furthermore, we find that the AMA Guidelines cited by claimant do not constitute "medical opinion" since they pertain to the average grip strength of a group of subjects rather than particularly to claimant.

In addition, loss of strength is rated only when the cause is a peripheral nerve injury, loss of muscle, or disruption of the musculotendonous unit. Former OAR 436-35-110(2). Even if the AMA Guidelines qualified as "medical opinion" under former OAR 436-35-007(14), claimant offers no evidence showing that any loss of strength was due to the factors cited above.

Consequently, we conclude that claimant failed to prove any additional impairment than that awarded by the Order on Reconsideration.

Rate of Scheduled Permanent Disability

We affirm and adopt the portion of the Referee's order relating to this issue. SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992).

Penalties

Finally, claimant asserts that he is entitled to a penalty under ORS 656.262(10), contending that the employer was unreasonable in failing to award him permanent disability in the Notice of Closure. We affirm and adopt the relevant portion of the Referee's order.

ORDER

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

In the Matter of the Compensation of
KIP S. HELM, Claimant
WCB Case No. 92-07227
ORDER ON REVIEW
Wallace & Klor, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Spangler's order that: (1) upheld the insurer's denial of his occupational disease claim for mental stress; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant's mental disorder was caused by the circumstances of his suspension with pay by the employer on October 31, 1991.

The October 31, 1991 suspension with pay was a cessation of employment. The actions of the employer were reasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee identified four stressful events as potentially causing claimant's mental disorder: (1) the July 1991 check scale; (2) the October 1991 search of claimant's home; (3) the resulting fear of criminal prosecution; and (4) the October 1991 job suspension. The first three of the four events he found to be actions of the federal government, and therefore, could not be attributed to the employer. As such, he concluded those events were not "employment conditions." The fourth he found work-related, but concluded that the circumstances and manner of the suspension did not cause the mental disorder. In the alternative, the Referee found claimant's suspension reasonable disciplinary or corrective action.

We disagree that the first three events noted above are not employment conditions, and thus, should not be considered in deciding compensability. As noted by the Referee, illness resulting from stress of actual or anticipated unemployment is not compensable. However, illness resulting from the circumstances and manner of cessation of employment can be regarded as events still intrinsic to the employment relationship before termination, and may be compensable.

Here, the evidence is persuasive that the mental disorder arose out of the circumstances and manner of claimant's job suspension on October 31, 1991 as opposed to the termination itself. The suspension was the culmination of a federal investigation conducted by the U. S. Forest Service into allegations of corruption concerning the scaling of logs off of federal land. Events personal to claimant began with the July 25, 1991 check scale. As part of his job duties, claimant was subject to federal inspection, known as check scales. The July 1991 check scale was one such occasion. During the inspection, some discrepancies were noted. It was the opinion of the federal inspector that claimant was fraudulent in scaling logs. The July 1991 check scale, in conjunction with allegations made by informants, led to the issuance of a search warrant of claimant's person, home, and vehicles. See Ex. A.

Sometime after October 25, 1991 the above search warrant was executed. On October 31, 1991 the U. S. Forest Service informed the employer in writing that it was suspended from scaling federal logs. The suspension was based, in part, on claimant's alleged fraudulent mis-scaling. Moreover, the letter stated that the suspension would remain in place until the employer implemented corrective action to include the removal of "all such people from any position which has access to, or control over, the scaling or processing of data relating to U. S. Government logs." Claimant was specifically mentioned in the letter as a cause of fraudulent mis-scaling. See Ex. 1.

Inasmuch as 20 percent of the employer's business involved the federal government, the employer felt compelled to comply with all aspects of the government's demands. Mr. Curtis testified that failure to do so would probably have put the employer out of business. See Tr. 114-119. On October 31, 1991, claimant was handed a copy of the above referenced suspension letter by his employer and was informed that effective immediately he was suspended with pay until further notice. Shortly thereafter, claimant sought medical care for a psychological condition from Dr. Van Veen. See Ex. 2-1.

The employer, through its representative, Mr. Curtis, persuasively testified that it was not the intention of the employer to discipline or correct claimant's job performance or behavior. On the contrary, the employer supported claimant. No independent investigation of claimant's performance was conducted by the employer. Rather, the employer's decision to suspend claimant was a direct result of the suspension letter from the U. S. Forest Service. See Tr. 98-103. Therefore, we find the employer's actions were not disciplinary or correction action, but a "cessation" of employment.

Based on the above facts, we find that claimant's cessation of employment was the culmination of fast moving events beyond either claimant's or the employer's control, and included the July 1991 check scale, search of claimant's home, and the U. S. Forest Services' ongoing investigation. Accordingly, we find these events are properly considered, not as independent elements of causation, but rather as an intrinsic part of the October 31, 1991 cessation of employment. Because we consider the cessation of employment work-related, it therefore follows that we consider the events leading up to the suspension sufficiently work-related as well. The evidence was persuasive that these circumstances led to claimant's mental disability and need for medical care. See Tr. 62-64, 82, 103, 134, 171, 183; Exs. 2, 8, 13.

Nonetheless, mental illness resulting from stress due to reasonable cessation of employment is subject to a statutory exclusion and is not compensable. See ORS 656.802(3)(b). Therefore, compensability turns on the reasonableness or unreasonableness of the actions taken by the employer. Given the circumstances, as described in detail above, we find the employer's suspension of claimant with pay was a reasonable cessation of employment. Accordingly, even though claimant experienced a mental disorder arising from employment conditions, the claim is not compensable because of the statutory exclusion. See ORS 656.802(3)(b).

Penalties and attorney fees

We adopt the Referee's reasoning and analysis with regard to this issue.

ORDER

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

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

Claimant requests reconsideration of the Board's June 30, 1993 Order on Reconsideration. Specifically, claimant seeks "clarification" of those portions of the Board's order which: (1) declined to address claimant's entitlement under his psychological claim to the payment of temporary disability benefits prior to May 21, 1991; and (2) declined to award claimant's attorney an assessed fee under ORS 656.382(2) for services on review because claimant's compensation (as granted by the Referee's order) had been reduced as a result of the Board's reconsideration order.

We deny the motion for reconsideration. Accordingly, the parties' rights of appeal shall continue to run from the date of the Board's June 30, 1993 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWIN H. SLATER, Claimant
WCB Case No. 92-11081
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) awarded 27 percent (86.4 degrees) unscheduled permanent disability, whereas an Order on Reconsideration had awarded 26 percent (83.2 degrees); (2) awarded an attorney fee under ORS 656.386 based on claimant's success in prevailing over its stipulated "de facto" denial of medical services; and (3) awarded an attorney fee, but did not specify the amount, under ORS 656.382(2) for claimant's successful defense against the employer's request that claimant's permanent disability award be reduced. Claimant cross-requests review, seeking: (1) a $750 attorney fee under ORS 656.382(2); and (2) a 28 percent unscheduled permanent disability award. On review, the issues are extent of unscheduled permanent disability and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of disability

We adopt the Referee's "Conclusions of Law and Opinion" on this issue, with the following exceptions and modification.

The Referee found that claimant is entitled to a +1 "education" value for lack of "a current license or certificate of completion necessary for employment in an Oregon job[.]" See former OAR 436-35-300(5) (WCD Admin. Order 6-1992). In reaching this result, the Referee reasoned that claimant's certificate indicating completion of an Operator Training Course, recommended by the Caterpillar Tractor Company, (Ex. 1-7), does not establish that the training claimant received would teach a non-operator how to operate a forklift. (O&O p. 5).

There is no evidence that claimant was a "non-operator" before completing this course. Moreover, the rule does not indicate that the worker must fail to be trained in a new skill, in order to qualify for a +1 value. Nonetheless, on this record, we conclude that claimant is entitled to the +1 "education" value, because the record does not indicate that claimant's certificate was necessary for employment, as required by the rule. (See Tr. 6).

The Referee found that claimant is entitled to impairment ratings for his L4-5 surgery (9 percent) and for an "additional disc" (1 percent). (O&O p. 6). See OAR 436-35-350(2)(a). Under the standards, claimant is entitled to ratings for "surgical procedures performed on the spine." (Id). Specifically, an injured worker receives a 9 percent rating for the first surgical procedure, "involving one disc and/or up to 2 vertebrae." (Id). In addition, the worker may receive a one percent rating for "additional disc(s) or vertebra treated within the same region/body part." (Id., emphasis added).

In this case, there is evidence that claimant had disc abnormalities at L-3 as well as L-4 and L-5. However, because we find no evidence that claimant's surgery involved treatment for disc and/or vertebra other than at L4-5, (see Exs. 4-2-3; 11-2), he is entitled only to a 9 percent rating for surgery at L4-5.

Finally, we do not adopt the Referee's finding that claimant's adaptability factor was not raised on reconsideration. (O&O p. 6; see Ex. 12-3). Although the issue was raised, we agree with the Referee's conclusion that claimant's proper adaptability factor is 2 ("medium to medium/light"), based on a preponderance of the evidence. Accordingly, when claimant's range of motion impairment rating (10 percent) is combined with his surgery rating, (9 percent), the result is 18 percent total impairment. When this sum is added to the non-impairment total, (8 percent), the result is 26 percent unscheduled permanent disability for claimant's low back condition.

Attorney fees

We adopt the Referee's "Conclusions of Law and Opinion" regarding the fee awarded under ORS 656.386(1). See Safeway Stores, Inc., v. Hayes, 119 Or App 319 (1993); Deborah K. Atchley, 44 Van Natta 1435 (1992); Lisa A. Hyman, 44 Van Natta 2258 (1992).

Claimant is also entitled to attorney fees under ORS 656.382(2), because the employer cross-requested a hearing and requested review and unsuccessfully sought to have claimant's permanent disability award reduced. 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 permanent disability issue is $500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, statement of services and the hearing record), the complexity of the issue, and the value to claimant of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for his efforts on review concerning the attorney fee issues. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The Referee's order dated November 23, 1992 is reversed in part, modified in part, and affirmed in part. That portion of the order that increased claimant's unscheduled permanent disability from 26 percent (83.2 degrees) to 27 percent (87.4 degrees) is reversed. The August 25, 1992 Order on Reconsideration which awarded 26 percent (83.2 degrees) unscheduled permanent disability is reinstated and affirmed in its entirety. In lieu of that portion of the Referee's order that awarded an unspecified attorney fee under ORS 656.382(2), and for services on review regarding the extent of permanent disability issue, claimant is awarded a $500 attorney fee, payable by the self-insured employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CLAIR A. HAND, Claimant
WCB Case No. 92-08702
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Peterson's order that: (1) directed the insurer to pay one-half of claimant's penalty, assessed under ORS 656.268(4)(g), to claimant's attorney; and (2) did not award a separate attorney fee under ORS 656.382(1) based on the insurer's allegedly unreasonable resistance to the payment of compensation. The insurer cross-requested review of the portion of the order that assessed a penalty under ORS 656.268(4)(g). The insurer has withdrawn its cross-request. On review, the issues are penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion" regarding the penalty assessed under ORS 656.268(4)(g), except for the last paragraph, with the following supplementation. See Kevin Northcut, 45 Van Natta 173 (1993).

The Referee directed the insurer to pay one-half of the penalty to claimant and one-half to claimant's attorney. However, because ORS 656.268(4)(g) expressly provides that this penalty shall be "paid to the worker," we modify the Referee's order so that the penalty is solely payable to claimant. See Beverly A. Kirk, 45 Van Natta 1078 (1993).

Finally, concerning claimant's request for a separate attorney fee, we note that 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). Under the statute, a fee is awarded if claimant establishes that the insurer unreasonably failed to pay compensation due or otherwise unreasonably resisted payment of compensation.[1]

Here, claimant contends that the magnitude of the increased compensation awarded on reconsideration itself justifies an attorney fee award. We disagree. In reaching this result, we note that the Notice of Closure's permanent disability award was reasonably based on the treating physician's concurrence with a report by independent examiners which was based on their closing examination. Under these circumstances, we do not find the insurer's conduct to have been unreasonable within the meaning of ORS 656.382(1). See Beverly A. Kirk, supra.

ORDER

The Referee's order dated October 20, 1992 is modified in part and affirmed in part. That portion of the order that directed the insurer to pay one-half of a 25 percent penalty to claimant and one-half to claimant's attorney is modified so that the penalty is payable solely to claimant. The remainder of the order is affirmed.

[1] Contrary to claimant's argument, the size of the mistake does not constitute unreasonable resistance. Claimant must show some activity by the employer that lead to the mistake and was unreasonable.

In the Matter of the Compensation of
MELVIN E. SCHNEIDER, JR., Claimant
WCB Case No. 92-03169
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Garaventa's order that affirmed an Order on Reconsideration which: (1) awarded 3 percent (9.6 degrees) unscheduled permanent disability for a compensable skin condition; and (2) awarded scheduled permanent disability equalling 3 percent (5.76 degrees) for loss of use or function of the left arm, 3 percent (5.76 degrees) for loss of use or function of the right arm, 3 percent (4.5 degrees) for loss of use or function of the left leg, and 3 percent (4.5 degrees) for loss of use or function of the right leg. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant is 40 years of age and has completed the 11th grade. Claimant's highest specific vocational pursuit (SVP) level in the last ten years was as a plasterer (DOT # 842.361-018).

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the extent of claimant's scheduled permanent disability.

Unscheduled Permanent Disability

The Referee affirmed the 3 percent unscheduled permanent disability awarded by the Order on Reconsideration. We modify.

Claimant became medically stationary on September 9, 1991, and his claim was closed by Determination Order on December 12, 1991. Since claimant became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Determination Order control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Determination Order. WCD Admin. Orders 2-1991, 7-1991 and 93-052.

The Referee found that claimant was entitled to a 3 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 (3). Therefore, we adopt this value when we calculate claimant's permanent disability and discuss only the value for adaptability.

To begin, we agree with the Referee that former OAR 436-35-310(1) does not contemplate a value for adaptability where, as here, claimant's strength is not affected by the compensable condition. Although claimant did not return to his at-injury job, he retained the residual functional capacity to perform his at-injury job. Therefore, under that former rule claimant's adaptability factor would be zero. However, subsequent to the Referee's order, the Supreme Court has held that a claimant's age, education and adaptability factors must be considered even if a claimant has an adaptability factor of zero under the Director's "standards."

In England v. Thunderbird, 112 Or App 324 (1992), the Court of Appeals had held that the Director's standards that do not rate age, education, and adaptability when claimant continues in her usual and customary work were valid under the director's statutory authority. Relying on Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992), the court concluded that former OAR 436-35-290(2)(a), OAR 436-35-300(2)(a), and OAR 436-35-310(2)(a) were not inconsistent with former ORS 656.214, the statute defining earning capacity.

Subsequently, the Supreme Court disagreed and reversed. In England v. Thunderbird, 315 Or 633 (1993), the Court held that pursuant to statutory directive (former ORS 656.214) age, education, impairment, adaptability to perform a given job, and factors with similar characteristics are to be considered in determining earning capacity. Further, the Court declared former OAR 436-35-290(2)(a), OAR 436-35-300(2)(a), and OAR 436-35-310(2)(a) to be contrary to the legislative intent, and thus, invalid. See England v. Thunderbird, 315 Or at 639.

In response to the Supreme Court's decision in England, supra, the Director amended OAR 436-35-280 through 436-35-310. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). OAR 436-35-280 now provides in relevant part:

> "The factors of age, OAR 436-35-290; education, OAR 436-35-300; and adaptability, OAR 436-35-310, shall be applied for losses identified in ORS 656.214(5) and described in OAR 436-35-320 through 436-35-500."

In conjunction with this provision, OAR 436-35-290 through OAR 436-35-310 (rules concerning age, education, and adaptability) now allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work following a compensable injury. As noted above, these amended temporary rules apply to all ratings of disability made on or after June 17, 1993, and thus, are applicable to the instant case. OAR 436-35-003(4); OAR 438-10-010.

OAR 436-35-310 governs adaptability. 436-35-310(2) provides for an adaptability value of 1 where, as here, the worker returns to the same job he held at the time of injury. Although claimant is restricted from working in certain environments, his residual functional capacity is the same as it was prior to the compensable injury. Accordingly, claimant is entitled to an adaptability value of 1. OAR 436-35-310(2)(Temporary Rules, June 17, 1993, WCD Admin. Order 93-052).

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7). Applying these rules to the instant case, when the total value for claimant's age and education (3) is multiplied by the adaptability value (1), the total is 3. When this value is added to the value for impairment (3), the result is 6. Therefore, claimant's unscheduled permanent disability is 6 percent.

ORDER

The Referee's order dated July 2, 1992 is modified in part and affirmed in part. In addition to the Order on Reconsideration's award of 3 percent (9.6 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total award to date of 6 percent (19.2 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
MATTHEW P. SMITH, Claimant
Own Motion No. 93-0117M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

On February 26, 1993, the SAIF Corporation submitted claimant's claim for an alleged worsening of his compensable right knee injury. Claimant's aggravation rights expired on March 17, 1992. SAIF recommended that the claim be reopened for own motion relief. On March 8, 1993 the Board issued an Own Motion Order reopening claimant's claim for temporary disability beginning the date of the proposed surgery. In a letter received by the Board on May 6, 1993, SAIF requested that our March 8, 1993 order be withdrawn because claimant's physician subsequently withdrew his request for surgery. We treat SAIF's request as a request for reconsideration.

In extraordinary circumstances we may, on our own motion, reconsider a prior order without regard to the time limits imposed by our rules regarding the reconsideration process. OAR 438-12-065(2). Under the facts of this case, we find that extraordinary circumstances exist that justify reconsideration of our prior order. In addition, we note that, although SAIF's request for reconsideration was received more than 30 days from the mailing date of our March 8, 1993 order, it was received within 60 days from the mailing date. Therefore, the request for reconsideration is timely if SAIF establishes "good cause" for failing to file its request within 30 days. We find that the facts of this support a finding of "good cause" for SAIF's failure to request reconsideration within 30 days of the date of mailing of the order. OAR 438-12-065(2). Therefore, we withdraw our prior order for purposes of reconsideration and issue the following order in its place.

We are authorized to award temporary disability in those cases where there has been 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.

Subsequent to the reopening of claimant's own motion claim, Dr. Hanley, claimant's treating orthopedic surgeon, withdrew his January 1993 request for arthroscopic surgery for claimant's right knee. In a March 2, 1993 chart note, received by SAIF on March 10, 1993, Dr. Hanley advised claimant that he was "not sure that arthroscopic surgery would lead to any significant benefit." Dr. Hanley noted that they would proceed along the lines of claimant returning to work, with the understanding that a recurrence of his symptoms may develop, and returning to Dr. Hanley "on a prn basis." On April 8, 1993, SAIF requested clarification as to whether Dr. Hanley was withdrawing his request for right knee surgery. Dr. Hanley responded that he doubted if surgery would provide any substantial benefit and would probably be primarily of diagnostic value. (Letter dated April 19, 1993). On this record, we find that Dr. Hanley has withdrawn his request for surgery.

Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. Therefore, the Board is without authority to reopen claimant's claim. ORS 656.278(1)(a). Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAY G. MILLER, Claimant
WCB Case Nos. 92-10041 & 92-13546
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Galton's order that set aside its denial of claimant's claim for a current low back condition. Claimant cross-requests review of that portion of the order that did not assess an attorney fee. On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant has worked for the insured since 1985. He suffered two work injuries, diagnosed as low back strains, on March 19, 1990 and April 24, 1992. The insurer accepted claimant's claims for both injuries. The first claim was closed by a May 14, 1992 Determination Order which awarded time loss compensation only.

On July 28, 1992, the insurer denied claimant's then current low back condition.

Claimant suffered from a low back degenerative condition which preexisted his compensable injuries. On May 17, 1989, Dr. Adams, treating physician, performed surgery on claimant's low back, due to claimant's longstanding intermittent pain.

CONCLUSIONS OF LAW AND OPINION

The Referee characterized this case as a responsibility dispute, found that the insurer had denied responsibility only, and set aside the denial because it did not comply with ORS 656.308 requirements for disclaimers of responsibility. We disagree. The sole issue is compensability. The ultimate question raised by the denial was causation.

On July 28, 1992, the insurer denied claimant's current low back condition, noting that it had previously accepted claimant's claim for a March 19, 1990 back injury. The denial states, in pertinent part:

> "Information in your file indicates that your current condition diagnosed as degenerative disc phenomenon is unrelated to your industrial injury of March 19, 1990 and that your original injury does not materially contribute towards your current disability or need for treatment. Therefore, [the insurer] denies responsibility for your current disability and/or medical treatment." (Ex. 60-1) (Emphasis supplied).

The same day, the insurer issued a second denial, noting that it had also accepted claimant's claim for an April 24, 1992 back injury. The second denial states, in pertinent part:

> "Information in your file indicates that your current condition diagnosed as pre-existing post-herniated disc L5-S1 and post-laminectomy and discectomy L5-S1 is unrelated to your industrial injury of April 24, 1992 and that your injury does not materially contribute towards your current disability or need for medical treatment. Therefore, [the insurer] denies responsibility for your current disability and/or medical treatment[.]" (Ex. 60B-1) (Emphasis supplied).

Despite the insurer's use of the word "responsibility," these are clearly denials of compensability for the lack of any causal contribution by claimant's compensable injuries to his current condition. The insurer's use of the term "responsibility" in the last sentence did not negate the impact and effect of the denials' specific assertion that there was no causal connection between the compensable injury and claimant's current condition.

In evaluating 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). In this case, we find no such reasons.

Dr. Adams, treating physician, opined that claimant's current back problems are due to preexisting degenerative disc disease, a 1989 ruptured disc and related surgery, but not to the work injuries. (See Exs. 65-8-9, 65-15). Adams' opinion is uncontroverted and we defer to it. Consequently, claimant has not proven that his current low back condition is compensable.

Finally, because claimant has not prevailed, he is not entitled to an attorney fee under ORS 656.386.

ORDER

The Referee's order dated November 9, 1992 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for a current low back condition is reversed. The denial is reinstated and upheld. The remainder of the order is affirmed.

In the Matter of the Compensation of
KAREN A. KING, Claimant
WCB Case No. TP-93007
THIRD PARTY DISTRIBUTION ORDER
Patrick K. Mackin, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant has petitioned the Board for approval of a third party compromise. ORS 656.587. In the event that we approve the settlement, claimant also seeks the determination of a "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). We approve the settlement and find that a distribution in which the paying agency receives $6,383.13 is "just and proper."

FINDINGS OF FACT

On March 2, 1992, claimant sustained a compensable injury when a freezer lid dropped on her head. Following the injury, she received conservative treatment for her neck sprain/strain. Crawford & Company (Crawford), the paying agency, accepted the claim and began providing compensation.

On May 5, 1992, claimant sought treatment for low back pain.

On September 8, 1992, claimant was examined by Dr. Farris, M.D., an independent medical examiner (IME). Dr. Farris diagnosed resolved cervical strain, lumbar strain by history and not related to the March 2, 1992 industrial injury, obesity and clinical depression. Dr. Farris reported that claimant's weight and conditioning were the major cause of her low back complaints. He found no evidence of a relationship between claimant's low back condition and the industrial injury, and he reported that claimant was medically stationary.

On September 15, 1992, claimant was released to regular work.

Claimant's claim was first closed on September 15, 1992 by a Notice of Closure which awarded temporary disability but no permanent disability.

In December 1992, claimant and her counsel began negotiations with the manufacturers of the freezer and freezer hinges that caused her injury. Other defendants included corporations (or their subsidiaries) that had designed, manufactured, or sold the freezers. Giesy, Greer & Gunn, the insurer of one of the corporations, was authorized to negotiate a settlement on behalf of all four defendants.

A January 15, 1993 amended Notice of Closure awarded claimant 7 percent unscheduled permanent disability.

On April 30, 1993, Giesy, Greer & Gunn, acting on behalf of all of the defendants, made claimant a final settlement offer in the amount of $15,000.

On May 5, 1993, Crawford issued a partial denial of claimant's low back condition. Claimant requested a hearing on the partial denial and a hearing was held before Referee Peterson on May 24, 1993.

On May 24, 1993, claimant petitioned the Board for approval of the third party settlement.

On May 25 and 27, 1993, claimant filed hearing requests on the issues of extent of disability and premature claim closure arising from the January 1993 Notice of Closure and the subsequent Order on Reconsideration.

Referee Peterson's order issued July 2, 1993. The referee found that claimant had failed to establish compensability of her low back condition as a consequential condition. The referee upheld the insurer's May 5, 1993 partial denial of claimant's current low back condition.

To date, Crawford has incurred actual claim costs totalling $7,824.35. These costs include medical benefits in the amount of $3,311.26 and indemnity benefits in the amount of $4,513.09. The costs also include an independent medical exam (IME) requested by Crawford, which was performed on September 8, 1992. The bill for the IME was $436.

The third party insurer and claimant have agreed to settle the action for $15,000. If the $15,000 settlement is approved, following the distribution of claimant's attorney fee, litigation expenses and statutory 1/3 share, Crawford would receive the remaining balance.

Crawford has declined to approve the settlement, contending that the amount of its lien is not yet certain as claimant has pending hearing requests. Crawford further asserts that the settlement offer is grossly unreasonable as claimant's counsel will receive a full 1/3 of the settlement amount while both Crawford and claimant "are expected to receive de minimus amounts." Crawford contends that the attorney fee is also unreasonable because claimant has filed hearing requests for approved and assessed attorney fees. Finally, Crawford contends that the settlement is grossly unreasonable as claimant is attempting to settle all claims against the manufacturers and designers of the freezer for the sum of $15,000. Crawford asserts that settlement negotiations have not been exhausted with regard to all defendants, thereby "prejudicing recovery by Crawford & Company."

In bringing her cause of action against the third parties, claimant has expended $425.30 in litigation costs. These expenses are composed of investigative services and telephone charges.

Claimant's counsel has submitted an affidavit in support of claimant's petition for approval of the settlement. Claimant's counsel conducted extensive negotiations with numerous defendants involved in the third party action. Contributions to the settlement were made by most, if not all, of the defendants. Defenses available to the third party defendants include the fact that the accident was unwitnessed, the freezer was controlled by different entities, claimant had experienced four prior similar injuries, and claimant was completely recovered four months after the accident.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $15,000 is reasonable. A distribution of settlement proceeds in accordance with ORS 656.593(1) is "just and proper."

CONCLUSIONS OF LAW

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. See Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

Here, Crawford objects to the settlement on the basis that such a settlement is "premature." Specifically, Crawford argues that the compensability issue regarding claimant's low back condition has not yet been resolved and, therefore, its potential expenditures cannot be fully determined.

We take administrative notice of the Referee's July 2, 1993 order which found that claimant had failed to establish compensability of her low back condition as a consequential condition. Accordingly, we do not agree with Crawford's contention that the settlement is premature based on the "unresolved" compensability issue.

Moreover, if Crawford's argument is construed as a contention that the settlement is "premature" because the issue of extent has not yet been finally litigated, we consider such an argument to be relevant in determining whether any settlement proceeds remaining after initial distribution for reimbursement of actual claim costs should be held in trust until Crawford's final claim costs could be determined. See John C. Adams, 40 Van Natta 1794 (1988) aff'd mem Liberty Northwest v. Adams, 97 Or App 587 (1989)(Where there has not been a final order determining the extent of the claimant's disability, it was appropriate to defer ruling on the question of the paying agency's entitlement to a lien for anticipated future expenditures).

We do not consider such a "premature" argument to be particularly helpful when analyzing whether the amount of a third party compromise is "grossly unreasonable." Were we to accept Crawford's "premature" rationale, it would follow that no settlement could be reached until a workers' compensation claim was fully closed and finally determined. We consider such an approach to be unrealistic as a practical matter, as well as inconsistent with the stated objective of the workers' compensation system to provide a fair and just administrative system for the delivery of financial benefits to injured workers, which reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable. See ORS 656.012(2)(b).

Crawford also contests the settlement on the basis that the third party action involved several defendants. Crawford asserts that claimant should have pursued the action against the other defendants listed in her complaint, rather than settling all claims for one sum. We do not find Crawford's argument to be persuasive.

We have previously held that, as the prosecutor of her third party action, a claimant is aware of the potential weaknesses of her case, as well as the statutory distribution scheme and her lienholders. Kathleen J. Steele, 45 Van Natta 21 (1993). Considering this accessibility to vital factual information and relevant statutory prerequisites, we have reasoned that the claimant is in the best position to make an informed and reasoned decision regarding the appropriateness of a settlement offer. Id. Moreover, with that knowledge, the claimant has the capacity to accurately calculate what her eventual net recovery will be, should she accept such an offer. Id.

Consequently, although there may have been reasons to proceed with litigation, we conclude that claimant and her counsel are in the best position to weigh the risks of litigation versus the certainty of a settlement. See e.g. John C. Lappen, supra (Paying agency's arguments that the claimant should have proceeded with litigation were not supported by the record, and in any event, costs attributable to further litigation would have been deducted from any third party recovery before the remainder would become subject to the paying agency's lien).

Here, claimant's counsel has provided an unrebutted affidavit stating that extensive negotiations were conducted with numerous defendants and contributions were made by most, if not all, of the defendants. Counsel has pointed out defenses available to the third party defendants, including the fact that the equipment was controlled by different entities, the accident was unwitnessed and claimant had experienced four prior similar injuries and was completely recovered four months after the accident. Under the circumstances, we conclude that claimant and her attorney are in the best position to weigh the advantages and disadvantages of a settlement, as opposed to continuing litigation.

Claimant's counsel has also stated that if claimant had chosen to proceed to trial, further filing, service, and expert witness costs would have all been incurred. Accordingly, the record does not support Crawford's inference that both claimant and Crawford would have increased their respective portions of the recovery had claimant proceeded with litigation.

Finally, we have previously held that where a paying agency would receive approximately 20 percent of its actual claim costs, its arguments for claimant proceeding with litigation were not persuasive, considering the risks of going to trial. John C. Lappen, supra. Here, Crawford stands to recover over $6,000, while its presently asserted lien amounts to $7,824.35. Thus, Crawford would receive approximately 75 percent of its current lien. Based on the foregoing reasons, we do not find the settlement amount of $15,000 to be "grossly unreasonable." Moreover, we conclude that the proposed settlement is reasonable. We, therefore, approve the settlement. ORS 656.587.

We proceed to a determination of a "just and proper" distribution of settlement proceeds. 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, 1001 (1982).

Crawford disagrees with the distribution on the ground that claimant's attorney will receive a full one-third of the settlement, while claimant and Crawford receive "de minimus" amounts. As previously noted, we generally apply the statutory formula for distribution of a third party judgment. Robert L. Cavil, supra.

In accordance with ORS 656.593(1)(a), litigation costs and attorney fees shall be initially disbursed. The attorney fees shall in no event exceed the advisory schedule of fees established by the Board. ORS 656.593(1)(a). The Board's advisory schedule of fees is set forth in OAR 438-15-095, which provides that, absent a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in a third party action is authorized.

Here, claimant proposes to distribute one-third of the $15,000 settlement to her counsel as an attorney fee. We find that the requested fee does not exceed the Board's advisory schedule of attorney fees in third party cases. See OAR 438-15-095. Consequently, we conclude that claimant's counsel is entitled to receive one-third of the $15,000 third party recovery.

Furthermore, we have previously rejected arguments that it would be more equitable to order a distribution essentially reducing a third-party attorney fee in order to increase the paying agency's recovery. See Lisa S. Brown, 41 Van Natta 1430 (1989). In doing so, we have reasoned that, in the long run, the results of such an approach would be random, standardless, and thus, inequitable. See John C. Adams, supra. Therefore, we hold that a one-third distribution of the settlement proceeds to claimant's attorney is "just and proper."

Crawford's lien totals $7,824.35 The only portion of the lien to which claimant objects is the $436 charge for a September 8, 1992 IME. After reviewing the record, we conclude that the IME report was generated for "claim evaluation" purposes. It is well-settled that expenditures for such reports cannot be included in a paying agency's lien. David G. Payne, 43 Van Natta 918 (1991); Carolyn G. Gant, 39 Van Natta 471 (1987); Darrell L. Rambeau, 38 Van Natta 144 (1986).

Notwithstanding the reduction of its lien by the aforementioned $436 IME expense, the remainder of Crawford's lien exceeds the $6,383.13 remaining balance of settlement proceeds. Consequently, Crawford is entitled to that balance.

Accordingly, the settlement proceeds shall be distributed in the following manner.

Settlement	$15,000.00
1/3 Attorney Fee	5,000.00
Subtotal	$10,000.00
Litigation Costs	- 425.30
Subtotal	$ 9,574.70
Claimant's 1/3 Share	- 3,191.57
Remaining Balance (Crawford's Share)	$ 6,383.13

Claimant's attorney is directed to distribute the settlement proceeds in accordance with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
NORMAN P. PRIVATSKY, Claimant
Own Motion No. 93-0456M
OWN MOTION ORDER DENYING CONSENT TO DESIGNATION OF PAYING AGENT
(ORS 656.307)
S. David Eves, Claimant Attorney
Saif Legal Department, Defense Attorney

The Compliance Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with SAIF Corporation expired January 12, 1984. Thus, that claim is subject to ORS 656.278.

Under OAR 438-12-032(3), the Board shall notify the Compliance Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if 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, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. Id.

On June 4, 1993, claimant underwent an independent medical examination conducted by Dr. Brown, neurologist, and Dr. Farris, orthopedic surgeon. Their report provides the only evidence in the record regarding claimant's need for treatment. They state that claimant's treating physician is providing no treatment at the present time. Also, they note that physicians conducting an earlier independent medical examination in January 1993 did not feel that surgery was indicated. Thus, the Board has no information indicating that surgery or hospitalization has been performed or requested. Therefore, the record fails to establish that there has been a worsening of his compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, based on this record, the Board may not authorize the payment of temporary disability compensation on its own motion.

Accordingly, the Board is without authority to consent to an order designating a paying agent for purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
SUZANNE E. STANLEY, Claimant
WCB Case No. 91-13122
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig, Gunn and Westerband.

Claimant requests review of Referee Brazeau's order, as supplemented and affirmed by Referee Daughtry, that: (1) dismissed her Request for Hearing; (2) set aside an Order on Reconsideration as invalidly issued; (3) found that jurisdiction over this matter remains with the Appellate Unit of the Workers' Compensation Division (WCD); and (4) found that the Hearings Division is without authority to remand this matter to the Appellate Unit. In her brief, claimant moves for remand to the Hearings Division for a hearing on the merits to consider the belatedly-received medical arbiter's report as evidence. On review, the issues are jurisdiction and remand. We deny the motion to remand and affirm.

We affirm and adopt the Referee's order as supplemented.

Subsequent to the hearing on this case, we 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, the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. ORS 656.268(7). Because the Director did not comply with the mandatory procedure set forth in the statute, and claimant objected to the order issued, the Referee correctly found the Order on Reconsideration to be invalid. See Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992). Further, the Referee did not have authority to "remand" the case to the WCD Appellate Unit. See Mickey L. Platz, 44 Van Natta 1056 (1992). Rather, since the Referee found the Order on Reconsideration to be invalid, jurisdiction over the dispute remained with the Department. If claimant objects to the Department's apparent refusal to "reopen the reconsideration process," that is for claimant to take up with the Department. See Carl R. Alatalo, 44 Van Natta 2097, on recon 44 Van Natta 2285 (1992).

Neither can we remand to the Hearings Division to consider the subsequent arbiter's report. For Requests for Reconsideration made on and after October 1, 1991, amended ORS 656.268(6)(a) provides that "[a]ny medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." See Or Laws 1991, ch. 502, §2. Therefore, this Board has remanded such cases to the Referee to rate extent of disability considering late-submitted arbiters' reports. See, e.g., Anne M. Younger, 45 Van Natta 68 (1993).

Here, however, claimant requested reconsideration on July 17, 1991. Accordingly, even if the Referee had jurisdiction to consider the permanent disability question, the extent of claimant's disability would be rated based on the evidence in the record on the date the Order on Reconsideration issued. See ORS 656.283(7). Teresa L. Erp, 44 Van Natta 1728 (1992). Consequently, the Referee would be unable to consider the arbiter's report.

In sum, the Referee had no authority to "remand" the case to the Department. Neither could he consider the arbiter's report which issued after the Order on Reconsideration. Accordingly, claimant's motion for remand is denied.

ORDER

The Referee's order dated December 18, 1991, as supplemented and adhered to December 2, 1992, is affirmed.

Board Member Westerband specially concurring.

I join with the majority in affirming the Referee's order, based on Olga L. Soto, supra and progeny. As time has passed however, I have developed considerable doubt about the Board's response in Olga L. Soto, supra to the Benzinger problem. My primary reason for doubt is an argument that no party, to my recollection, has made in any case.

Arguably, the fundamental question for the Board in Olga L. Soto, supra was not a question of legislative intent, because the legislature did not contemplate, let alone make any provision for the inability of the Appellate Unit to complete the reconsideration process within the time originally allowed by statute. Rather, the legislature simply presumed that medical arbiters would be appointed and reconsideration orders timely issued and everything would work just fine. The legislature was obviously wrong.

So, it could be argued that the question for the Board was not fundamentally, "what did the legislature intend?" Rather, the question was, what would the legislature have intended had the legislature contemplated the problem. Thus, to the extent the Board in Olga L. Soto, supra tried to find the legislature's intent, the Board's analysis went awry, because the legislature had none with respect.to the Benzinger problem.

As the majority opinion states, ultimately the legislature did develop a specific intention concerning the Benzinger problem. In 1991, the legislature amended ORS 656.268(6)(a) to specifically authorize Referees to receive in evidence at hearing medical arbiter reports that were not prepared in time for use in the reconsideration process. However, the amendment was specifically made applicable "to requests for reconsideration made on and after October 1, 1991." Or Laws 1991, Chapter 502, Sec. 2.

The request for reconsideration in the present case was made before October 1, 1991. Therefore, as the majority opinion states, the 1991 amendment to ORS 656.268(6)(a) does not apply to this case. Accordingly, it would stretch the rules of statutory construction beyond their considerable elasticity to argue that the 1991 amendment reflects the 1990 legislature's intent and controls the question presented. On the other hand, as previously discussed, the question here is, what would the legislature probably have intended had it foreseen the problem. Arguably, for that question, the 1991 amendment provides substantial guidance. In short, the 1991 legislature has told us that receiving medical arbiter reports in evidence at hearing would be a reasonable response to a problem that the 1990 legislature did not contemplate.

As a general rule, I am not one for changing direction in a major impact case while cases on a particular subject at issue are under active consideration by the appellate courts. For this reason, I join with the majority in affirming the Referee's order, based on Olga L. Soto and progeny, although had I known about the amendment to ORS 656.268(6)(a) when Olga L. Soto, supra was before the Board, I might have voted consistent with the analysis of this special concurrence. Furthermore, perhaps this argument is wrong and the Soto Board was right.

In the Matter of the Compensation of
WAYNE L. BARKER, Claimant
WCB Case No. CV-93003
CRIME VICTIM ORDER
Diane Brissenden, Assistant Attorney General

Wayne L. Barker, (hereinafter, "applicant"), has requested Board review of the Department of Justice's January 26, 1993 Order on Reconsideration. By its order, the Department affirmed a November 5, 1992 order which denied applicant benefits for failure to meet to the requirements of ORS 147.015(5), 146.105(3) and 147.125(3).

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of the record. The Department mailed a copy of its record to applicant on April 1, 1993. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record. OAR 438-82-030(2).

ISSUE

Whether applicant is entitled to benefits under ORS Chapter 147.

FINDINGS OF FACT

Applicant was physically assaulted on February 27, 1992. As a result of the assault, he sustained an injury to his right jaw. He was treated at the emergency room at Good Samaritan Hospital for a fractured mandible. Applicant underwent surgery. As a result of the treatment and subsequent surgery, claimant was hospitalized from February 28, 1992 through March 1, 1992.

In his February 27, 1992 statement to the police, applicant stated that he had been assaulted by Bill Mandriquez, another resident in the same apartment complex. Applicant reported that, while at applicant's apartment, Mandriquez had struck him in the face with his hand and fists. Insisting that no argument had preceded the assault, applicant further stated that the assault was unprovoked.

In his March 23, 1992 application for crime victims' compensation, applicant reiterated that he had been assaulted by Mandriquez. In addition, applicant indicated that Mandriquez was becoming loud and obnoxious causing applicant to ask him to leave the apartment. Applicant stated that Mandriquez initially refused to leave, but that applicant finally got Mandriquez to move to the door. Applicant further stated that while Mandriquez was moving toward the door, he suddenly assaulted applicant without provocation.

Pursuant to applicant's March 27, 1992 hospital bill a $5,921.21 balance had been satisfied by a "charity adjustment." (Ex. 3-16). However, in its April 10, 1992 verification of medical expenses for the Department, Good Samaritan indicated that applicant had an outstanding balance of $5,921.21. (Ex. 3-1).

On September 28, 1992, the Department wrote applicant noting that the emergency room report made reference to an unidentified person who had accompanied him to the hospital. The Department asked applicant to have the witness contact the Department or furnish the witness' name and phone number.

On November 5, 1992, the Department issued an order denying applicant's claim for benefits. The Department concluded that there were inconsistencies between applicant's statement to police and his statements to the Department concerning the assault. Relying on ORS 147.105(3), the Department also concluded that applicant had not supplied the Department with requested information substantiating his claim.

On December 1, 1992, the Department received applicant's request for reconsideration. In his request, applicant stated that he had not received the Department's September 28, 1992 letter asking him to supply the name of the witness. Applicant supplied the name (Vernon Skipworth) and address of the witness. Applicant noted that he had moved several times since his application. Applicant also disagreed that there were inconsistencies in his statements and contended that no such inconsistencies were "pinpointed" in the Department's order.

On December 2, 1992, the Department wrote a letter to Mr. Skipworth asking him to contact it regarding the assault on applicant. No response was received.

On January 26, 1993, the Department issued an Order on Reconsideration which affirmed its prior order denying applicant benefits. In the order, the Department stated:

> "At your request, the department has conducted a review of the order entered in your case dated November 5, 1992. The department sent a letter to the witness at the address you supplied. The witness has not contacted the department as requested. Therefore, if you can locate Mr. Skipworth and have him contact us, the department will be happy to re-open your application for further reconsideration."

On March 25, 1992, the Board received applicant's request for review. Applicant indicated that he had tried to locate Mr. Skipworth, but that Skipworth had moved and applicant did not know his current whereabouts. Applicant also indicated that Mr. Mandriquez had recently died.

CONCLUSIONS OF LAW AND OPINION

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

The Department concluded that applicant's claim lacked sufficient information to satisfy the eligibility criteria. Specifically, the Department found inconsistencies in applicant's statements and a failure to supply requested information. We disagree.

Pursuant to ORS 147.015(5), applicant is entitled to an award if the death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation 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 accordingly. ORS 147.125(1)(c).

Here, applicant's statement to the police indicates that Mandriquez assaulted him. Applicant stated that no argument preceded the assault and that the assault was unprovoked. In his statement to the Department, applicant described Mandriquez's behavior as loud and obnoxious causing him to ask Mandriquez to leave. Applicant further stated that he had opened the apartment door and had gotten Manriquez to the door when Manriquez assaulted him without provocation.

We do not find these statements to be inconsistent. The first statement describes an unprovoked assault on applicant by Mandriquez. Similarly, the second statement, albeit with further detail, also describes an unprovoked assault by Mandriquez. While the second statement provides more details, it does not provide any evidence on which to conclude that claimant substantially provoked the assault by Mandriquez.

The Department also denied applicant's claim on the basis that he had not provided the information it requested.

ORS 147.105(3) provides:

> "If the department finds that the application does not contain the required information or that the facts stated therein have not been substantiated, it shall notify the applicant in writing of the specific additional items of information or materials required and that the applicant has 30 days from the date of mailing in which to furnish those items to the department. Unless an applicant requests and is granted an extension of time by the department, the department shall reject with prejudice the claim of the applicant for failure to file the additional information or materials within the specified time."

On September 28, 1992, the Department wrote applicant asking him to have a possible witness contact it or furnish it with the witness' name and address. Applicant did not respond at that time. Following the issuance of the Department's November 5, 1992 order, applicant asked for reconsideration. In his request, applicant stated that he had not received the Department's September 28, 1992 letter. In addition, applicant supplied the name and address of Vernon Skipworth, the possible witness.

While applicant did not initially respond to the Department's request, he did eventually provide the information requested by the Department. Moreover, it appears that the Department's letter was mailed to an address where applicant no longer resided. Under these circumstances, we conclude that applicant's claim cannot be denied on this basis. We parenthetically note that the applicant's statement to the police and to the Department did not indicate any witnesses to the assault. Thus, it appears that Vernon Skipworth only drove claimant to the emergency room and that the Department's suggestion that Skipworth was a "witness" was mere speculation. Under these circumstances, we conclude that applicant has established that his injury was not attributable to his own wrongful act or substantial provocation and he has fully cooperated in the investigation.

Finally, applicant is eligible for benefits if he has suffered a compensable loss of more than $100. ORS 147.015(1). In addition, the Department is required to deduct the amount of benefits, payments, or awards payable from any source and which the victim has received. See ORS 147.125(1)(d).

Here, the hospital bill initially noted that applicant's $5,921.21 outstanding balance had been fully satisfied by means of a "charity adjustment." Nevertheless, in a subsequent response to the Department for verification of medical expenses, the hospital reported the aforementioned outstanding balance. In light of such circumstances, it is apparent that whatever gratuitous dispensation applicant had been anticipating from the hospital no longer exists. Consequently, the record establishes that applicant has sustained a compensable loss resulting from his injury exceeding $100 and that this loss has not been resolved by payments from other sources.

Accordingly, applicant has established entitlement to benefits. Therefore, the Department's order is reversed and the claim is remanded to the Department for processing in accordance with law.

ORDER

The November 5, 1992 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered January 26, 1993, is set aside. Applicant's claim is remanded to the Department of Justice for processing in accordance with law.

August 5, 1993 Cite as 45 Van Natta 1557 (1993)

In the Matter of the Compensation of
MOWENA J. MARTIN, Claimant
WCB Case No. C3-1663
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Westmoreland & Shebley, Claimant Attorneys

Reviewed by Board Member Gunn and Westerband.

On June 22, 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.

On July 1, 1993, the Board requested that the parties submit an addendum instructing us to remove a Settlement and Release Agreement which was attached to the CDA. On July 30, the Board received an addendum stating only that "paragraph 6 of the Settlement and Release Agreement will be omitted from the agreement."

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 it 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, attached to the proposed agreement is a Settlement and Release Agreement. This agreement recites several provisions concerning claimant's employment with the employer, in addition to paragraph 6 which the parties have acknowledged should be omitted from the agreement.

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 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, supra. 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. 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
JUANA A. SUACEDO, Claimant
WCB Case No. 92-06636
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Quillinan's order that awarded 15.25 percent (48.8 degrees) unscheduled permanent disability award for a low back injury, whereas an Order on Reconsideration granted no award. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks entitlement to an increased award of unscheduled permanent disability. Claimant's disability is rated based on the last closure. In this case that is the November 7, 1991 Determination Order with found claimant medically stationary on September 23, 1991. Therefore, the permanent rules effective April 1, 1991 (WCD Admin. Order 1-1991), as amended October 1, 1991 (WCD Admin. Order 7-1991), and June 17, 1993 (WCD Admin. Order 93-052) apply to the rating of the claim.

Claimant argues for an increased disability award based on: (1) a finding that claimant was released for and returned to modified work; (2) a finding that the Referee miscalculated claimant's range of motion values; and (3) a finding of reduced right leg strength. The insurer, on the other hand, requests that we affirm the Referee's order in its entirety.

The rating of unscheduled permanent disability shall be impairment as modified by age, education (including formal education and skills), and adaptability to perform a given job. If there is no measurable impairment, no award of unscheduled permanent disability shall be allowed. OAR 436-35-270(1). Thus, a finding of impairment is a threshold inquiry.

Impairment is established by the preponderance of the evidence. Timothy W. Reintzell, 44 Van Natta 1534 (1992). On September 27, 1991, claimant was examined by independent medical examiner, Dr. Duff. He considered claimant medically stationary. In addition, he found no permanent impairment due to the work injury and placed no restrictions on employment. (Ex. 8). On October 10, 1991, claimant's attending physician, Dr. Mitchell, concurred with Dr. Duff's report. (Ex. 9). He reiterated this view again when he saw claimant on October 25, 1991. (Ex. 10). It was on this basis the Determination Order issued, which found no permanent disability. (Ex. 11).

Claimant appealed the Determination Order, disagreeing with the rating of unscheduled permanent disability, including impairment findings. (Ex. 13). A medical arbiter examination was performed by Dr. Gritzka on April 25, 1992. On exam, he found reduced range of motion in the lumbar spine, significant right leg atrophy, and right leg weakness (3/5). Still, he concluded claimant probably had no permanent impairment, to include a chronic condition which would prevent repetitive use of her low back. In Gritzka's opinion, the examination was compromised by claimant's "embellishments, exaggerations, and inconsistencies." (Ex. 14). Based on this evidence, the Order on Reconsideration issued affirming the Determination Order. (Ex. 15).

Subsequent to the Order on Reconsideration, Dr. Gritzka was deposed. (Ex. 18). The Referee, relying on the deposition, determined claimant's reduced range of motion in the lumbar spine was due to the compensable injury. Consequently, she decided claimant's permanent disability award of 15.25 percent.

Previously, we have held that with the exception of a medical arbiter's report under ORS 656.268(6)(a), any medical evidence generated after the Order on Reconsideration cannot be used to

evaluate the extent of permanent disability. ORS 656.268(7); Nancy A. Worth, 44 Van Natta 2345 (1992); Teresa L. Erp, 44 Van Natta 1728 (1928); Tor J. East, 44 Van Natta 1654 (1992). Thus, although the insurer does not reassert its objection to the admissibility of the deposition (exhibit 18) on appeal, the appropriateness of relying on the deposition to determine claimant's impairment remains at issue.

However, in this case, it is not necessary for us to decide the evidentiary issue because the admission of the deposition does not affect our reliance on the arbiter's findings. In the deposition, Dr. Gritzka testified to his limited recollection of the exam, how he performed the various tests, what he found on testing, and how he interpreted the findings. On cross-examination, Dr. Gritzka did admit that on one occasion in reporting claimant's "inconsistencies and embellishments" he overstated the matter. (Ex. 18, pages 26-27). Nonetheless, he stood by his original conclusion that claimant probably had no permanent impairment due to the injury. (Ex. 18, pages 33-36, 38-39, 41-42).

As Dr. Gritzka explained in his report, and again in the deposition, it was his opinion that the medical arbiter examination was compromised due to inconsistencies when claimant was asked to perform tests. Thus, although he recorded reduced range of motion, right leg atrophy, and right leg weakness, he was unable to verify these findings as reliable measurements of injury-related impairment. Accordingly, we find that the deposition, even assuming its admissibility, does not support a finding of permanent impairment. Therefore, its consideration does not alter our decision in this matter. Noemith Giron, 45 Van Natta 93 (1993), on recon 45 Van Natta 144 (1993).

To conclude, the preponderance of the evidence does not establish that claimant has ratable permanent impairment. Accordingly, we do not reach and decide claimant's other issues involving adaptability and miscalculation of the range of motion values. Inasmuch as the insurer has not sought a reduction in claimant's permanent disability, the Referee's award shall not be disturbed.

ORDER

The Referee's order dated October 7, 1992, is affirmed.

In the Matter of the Compensation of
THOMAS L. BARNETT, Claimant
Own Motion No. 93-0215M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable lumbar injury. Claimant's aggravation rights expired on June 30, 1983. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

By an Opinion and Order dated August 13, 1992, Referee Emerson found that the 1978 low back injury was the major contributing cause of claimant's January 5, 1990 fall and resultant aggravation of the cervical spondylosis which necessitated surgery. Referee Emerson concluded that claimant's current cervical spine condition is a compensable consequence of the accepted 1978 low back condition. That order was not appealed and has become final by operation of law.

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 May 15, 1990, Dr. Campagna, claimant's treating neurologist, requested authorization to perform cervical surgery. As noted above, subsequent litigation determined that claimant's current cervical spine condition is compensable. On April 29, 1993, following the compensability determination, claimant underwent surgery regarding his cervical condition. On this record, we find that, on May 15, 1990, claimant's compensable condition worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current worsening or the time of surgery. Claimant has the burden of proof on this issue and must prove that he was in the work force on May 15, 1990, the time of disability. Weyerhaeuser v. Kepford, supra.

Claimant submitted tax statements showing earnings in 1988 and 1989. Although these statements establish that claimant was in the work force in 1988 and 1989, they do not establish that he was in the work force in May 1990, the relevant period in question here.

Claimant also submitted a copy of his August 26, 1991 Social Security disability decision. In that decision, the Administrative Law Judge determined that claimant was able to perform several jobs prior to his January 5, 1990 cervical injury but that claimant was disabled following that injury and as a direct result of that injury. The Administrative Law Judge also determined that, following the January 1990 injury, claimant was unable to perform his past work or any other jobs existing in the national economy. We find the Administrative Law Judge's decision persuasive evidence that, following the January 1990 injury, it would have been futile for claimant to make any reasonable work search efforts. Furthermore, as noted above, the January 1990 cervical injury is compensable. Thus, we conclude that, at the time of claimant's disability, the compensable injury made a work search futile.

However, in order to prove that he was in the work force at the time of disability, claimant must prove that he is willing to work, even if efforts to find work would be futile. Dawkins v. Pacific Motor Trucking, supra. The Administrative Law Judge found claimant "highly motivated to work" based on his past work history and his testimony at the Social Security disability hearing that he would return to his past work at that time, if his former employer would rehire him. However, we do not find the Administrative Law Judge's findings regarding motivation to work in the past or at the time of the August 1991 Social Security hearing to be persuasive evidence that claimant was willing to work at the time of his May 1990 worsening. Unlike the Administrative Law Judge's findings regarding claimant's ability to work, which we find to be persuasive evidence that claimant became unable to work due to the work injury in January 1990 and remained unable to work through the time of the May 1990 worsening requiring surgery, his findings regarding claimant's motivation to work do not provide persuasive evidence that claimant was willing to work at the relevant time period.

In addition, in an April 16, 1990 chart note, Dr. Campagna stated that claimant "is retired." That statement constitutes some evidence that claimant was not willing to work at the time of his disability. Claimant offers no other evidence regarding his willingness to work at the time of his worsening. Given the fact that claimant has proved that, due to the compensable injury, any reasonable work search would have been futile, proof of willingness to work could include an affidavit from claimant regarding his recent work history prior to his worsening and his willingness to work if not for his work injury.

Accordingly, claimant's request for temporary disability compensation is denied. See 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 pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANTIAGO A. CRUZ, Claimant
WCB Case No. 91-02209
CORRECTED ORDER ON REMAND (REMANDING)
Welch, et al., Claimant Attorneys
Steven R. Cotton (Saif), Defense Attorney

On August 5, 1993, we issued an Order on Remand (Remanding). It has come to our attention that our order contained a clerical error. Specifically, although our order made reference to a footnote, that footnote was inadvertently deleted from our order. To correct this oversight, we withdraw our August 5, 1993 order and replace it with the following order. The parties' rights of appeal shall begin to run from the date of this order.

This matter is before the Board on remand from the Court of Appeals. SAIF v. Cruz, 120 Or App 65 (1993). The court has reversed that portion of the Board's order in Santiago A. Cruz, 44 Van Natta 1226 (1992), which declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable failure to provide discovery of claimant's pre-hearing statement until the completion of his testimony. Relying on SAIF's counsel's unrebutted assertion that the only purpose of claimant's written statement was for its use as impeachment evidence, the Board held that SAIF had a reasonable belief that the written statement was relevant and material only for impeachment purposes. See OAR 438-07-017.[1]

The court concluded that SAIF's counsel's unsworn representation merely explained the legal rationale for SAIF's refusal to provide claimant with his statement. Inasmuch as there was no indication that the Board had determined (based on an evaluation of the record and the withheld evidence) whether SAIF had a reasonable belief that claimant's pre-hearing statement was relevant for only impeachment purposes, the court has remanded for reconsideration. In the event that we find that SAIF violated OAR 438-07-017, the court has further mandated that we determine whether SAIF's action was unreasonable.

We must first determine whether the record regarding this discovery/impeachment evidence issue is sufficiently developed to conduct our review. We may remand to the Referee if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

Here, the "evidence" concerning this "impeachment evidence" issue is, at best, sparse, if not nonexistent. The fact that the issue arose following claimant's cross-examination and that no continuance of the hearing was requested by either party provides some explanation for this record. As discussed in the Board's prior order, as well as the court's opinion, the record consists only of SAIF's counsel's representation that the purpose of claimant's written statement was for its use as impeachment evidence, and claimant's counsel's assertion that SAIF's conduct was unreasonable.

Under such circumstances, we conclude that the record regarding this issue has been insufficiently developed for us to determine whether SAIF "could reasonably have believed that the evidence was relevant only for purposes of impeachment" as required by OAR 438-07-017 and the court's mandate. See ORS 656.295(5).

Accordingly, this "discovery/impeachment evidence" issue is remanded to Referee Holtan for further proceedings. The Referee is instructed to take additional evidence from the parties to determine whether SAIF could reasonably have believed that the withheld evidence was relevant only for purposes of impeachment and, in the event that SAIF did not have the aforementioned reasonable belief, whether its conduct was unreasonable, justifying a penalty-related attorney fee award. SAIF v. Cruz, supra, at page 69. The proceeding to present this additional evidence shall be conducted in any manner that the Referee determines will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] We recognize that the Board has previously concluded that the exception relating to non-disclosure of impeachment evidence should not apply to a claimant's written or taped statements made to the carrier in the course of investigation before obtaining legal representation. See Suzanna M. Tirone, 38 Van Natta 828, 829 (1986). Nonetheless, the Tirone holding was based on an analysis of former OAR 438-07-015(2). Subsequent to Tirone, the "reasonable belief/impeachment" exception to the Board's discovery rules was added. See OAR 438-07-017. Because this case (which is subject to the amended rules) is being returned to the Referee for further development, the parties should address the effect, if any, the Tirone rationale has on this current dispute.

In the Matter of the Compensation of
JOHN N. GOTTLIEB, JR., Claimant
WCB Case No. 91-15771
ORDER ON REVIEW
Michael B. Dye, P.C., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Brown's order that set aside its "back-up" denial of claimant's claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the employer did not sustain its burden of proving by clear and convincing evidence that claimant's carpal tunnel syndrome is not compensable. On review, the employer contends that: (1) because it revoked its claim acceptance and issued its denial within the 90 days allowed for processing the claim, it is not subject to the requirement in ORS 656.262(6) that it prove noncompensability by clear and convincing evidence; and (2) even it has the burden of proving noncompensability by clear and convincing evidence, it has sustained that burden.

We recently rejected the employer's first contention in Brian W. Andrews, 45 Van Natta 1515 (1993) (on reconsideration). We held in Andrews that a revocation of claim acceptance, if challenged, must be supported by "clear and convincing evidence" pursuant to ORS 656.262(6), even if the revocation occurred within the 90 day statutory period for claims processing.

We also reject the employer's second contention. As the Referee stated, to be "clear and convincing," the 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).

The medical evidence concerning the relationship between claimant's work activities and the development of his carpal tunnel syndrome is divided. Dr. Machado examined claimant and indicated, without explanation, that the carpal tunnel syndrome is "work related." (Ex. 9).

Dr. Nathan, hand surgeon, examined claimant and found severe and chronic slowing of both median nerves. Nathan opined that none of claimant's work activities would have caused or worsened the median nerve slowing. (Ex. 13-5). Nathan explained that the median nerve slowing represents an underlying entrapment neuropathy which causes a constellation of symptoms called carpal tunnel syndrome. (Tr. 34). Nathan opined that the underlying disease (i.e., neuropathy) probably preexisted claimant's employment and could be attributed to non-employment factors such as his age, obesity and relatively light off-work activity. (Tr. 58-59, 66-67). He added that claimant's neuropathy probably would have become symptomatic even if he had not been working. (Tr. 108).

Dr. Jewell, hand surgeon, reviewed the medical records and opined that claimant's work activities were not the major contributing cause of the carpal tunnel syndrome. (Ex. 18). Dr. Zirschky, orthopedic surgeon, also reviewed the medical records and opined that claimant's work activity was the most probable cause of the carpal tunnel syndrome. (Ex. 20-3).

The employer relies on Dr. Nathan's opinion to sustain its burden of proving that work activities were not the major contributing cause of the carpal tunnel syndrome. Although Dr. Nathan's opinion is the most fully developed in the record, we are not persuaded by it.

Even if we accept Dr. Nathan's opinion that claimant has an underlying "entrapment neuropathy," which preexisted and is unrelated to his employment, claimant seeks compensation for

carpal tunnel syndrome, (i.e., the symptoms caused by oxygen deprivation of the median nerves), not the median nerve slowing. See Georgia-Pacific Corp. v. Warren, 103 Or App 275, 278-79 (1990) (upheld Board's finding that symptoms of carpal tunnel syndrome are the occupational disease, notwithstanding existence of underlying neuropathy).

On the issue of the relationship between the syndrome and employment activities, Dr. Nathan's opinion is somewhat inconsistent. On the one hand, he stated that the probability of claimant developing carpal tunnel syndrome would have been the same, if not greater, if claimant had not been working. He explained that the better physical conditioning which attends employment usually helps to protect the median nerves against development of the underlying neuropathy. (Tr. 108-109). On the other hand, however, Dr. Nathan acknowledged that physical activity can cause the emergence of carpal tunnel syndrome. He explained that increased physical activity, when coupled with an underlying neuropathy, can result in oxygen deprivation of the nerves. (Tr. 125-28).

On this record, we do not find it "highly probable" that claimant's carpal tunnel syndrome is not related, in major part, to his work activities. Therefore, we agree with the Referee that the "back-up" denial must be set aside. See ORS 656.262(6).

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 back-up denial is $1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by 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 $1,500 for services on Board review, to be paid by the self-insured employer.

August 6, 1993 Cite as 45 Van Natta 1563 (1993)

In the Matter of the Compensation of
PATRICIA A. HINSEN, Claimant
WCB Case No. 91-08725
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Merry Maids, the noncomplying employer, requests reconsideration of our July 15, 1993 Order on Review which: (1) set aside the SAIF Corporation's June 25, 1991 "back-up" denial issued on Merry Maids' behalf pursuant to ORS 656.054; and (2) awarded claimant's counsel an assessed attorney fee of $5,000. More specifically, on reconsideration, Merry Maids asks that we address its compensability challenge to the June 25, 1991 denial. Claimant and SAIF have submitted responses to Merry Maids' motion.

In our prior order we set aside SAIF's denial on the basis that the "back-up" denial was impermissible in accordance with ORS 656.262. Since we found that issue dispositive, we specifically declined to address the issue of whether or not the November 26, 1990 Proposed and Final Order precludes Merry Maids and SAIF from litigating the issue of subjectivity. On further reflection, however, we agree with Merry Maids that it is necessary to further address the issue of compensability.

On November 26, 1990, the Department issued, with the appropriate appeal rights, a Proposed and Final Order of Noncompliance. The order found claimant to be a subject worker and Merry Maids to be a subject employer. In addition, the order found Merry Maids had failed to provide coverage in

accordance with ORS 656.017. (Ex. 12). That same day, the Department directed SAIF to process the claim pursuant to ORS 656.054. (Ex. 11). Merry Maids did not appeal the order of noncompliance and it became final as a matter of law. See ORS 656.740(1), (3). SAIF initially accepted the claim, but later issued a "back-up" denial. Subsequent to these events, Merry Maids requested a hearing on the issues of noncompliance and compensability.

The issues of noncompliance and compensability are two separate issues. The former is an inquiry into the status of the employer. The compensability question, on the other hand, concerns whether or not claimant was acting within the course of her employment when she was injured. In order to contest noncompliance, the employer must timely appeal the order of noncompliance. ORS 656.740. In this case, the appeal was not timely. With respect to compensability, however, Merry Maids is not time barred, but may raise this issue at any time. See Blain v. Owen, 106 Or App 285 (1991). Merry Maids raised "compensability" as an issue in its pleadings on October 8, 1991. Nevertheless, at hearing Merry Maids argued the claim was not compensable because claimant was not a subject worker. In other words, although Merry Maids describes its challenge to the claim as compensability, its objection is based on a subjectivity ground; i.e., claimant was not a subject worker for Merry Maids.

Relying on the Blain case, we find Merry Maids was entitled to litigate compensability. See Blain v. Owen, supra. However, for reasons expressed below, its challenge does not alter our prior conclusion.

As previously noted, the Department found claimant was a subject worker and Merry Maids was a subject employer. This finding, in conjunction with the failure of Merry Maids to provide coverage, served the basis for the order of noncompliance. Thus, a finding of subjectivity was a necessary prerequisite to finding Merry Maids noncomplying. ORS 656.005(18); 656.017; 656.023; 656.027. Since that order was not timely appealed and became final, we find that the law of the case is that Merry Maids was a subject employer of a subject worker, claimant.

In Gary L. Redden, 43 Van Natta 1525 (1991) we found that the employer was not barred by principles of res judicata from litigating subjectivity despite a final order of noncompliance. Of importance to the Redden decision was the fact the Board could not determine whether it was essential to the Director's order of noncompliance that claimant be found to have been a subject worker. In Redden, the Board noted that the employer could have been found to have been a subject employer as a result of employing other workers. Here, in contrast to Redden, the Director's order specifically states that claimant was a subject worker for Merry Maids. In light of such circumstances, we conclude that the finding was essential to the Director's determination that Merry Maids was a noncomplying subject employer. Thus, we do not find the Redden holding to be controlling.

Applying the law of the case to these facts, we find that claimant was a subject worker and that Merry Maids was a subject employer. Therefore, on this basis as well, we find that the June 25, 1991 denial must be set aside.

Claimant is entitled to an additional attorney fee for services on reconsideration. See ORS 656.382(2); Rene G. Gonzalez, 45 Van Natta 499 (1993). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on reconsideration is $855, to be paid by the SAIF Corporation, on behalf of the noncomplying employer. 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, the Board's July 15, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish the Board's July 15, 1993 order. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HENRY WILLIAMS, Claimant
Own Motion No. 90-0313M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cigna Insurance, Insurance Carrier

Claimant requests review of the insurer's May 25, 1993 Notice of Closure which closed his claim with an award of temporary disability compensation from April 14, 1990 through May 12, 1993. The insurer declared claimant medically stationary as of May 10, 1993. 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). It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 25, 1993 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

Following his compensable right knee injury, claimant relocated to Texas and has continued to receive medical treatment there. As a result of claimant's failed right total knee arthroplasty, Dr. Landon, treating orthopedic surgeon, replaced claimant's right knee prosthesis with a metal type prosthesis on September 14, 1991. Following this surgery, claimant had ongoing problems with right knee pain and developed a skin condition on his right knee. In a letter dated June 29, 1992, Dr. Landon reported that further surgery was not indicated at that time. Dr. Landon stated that claimant's only surgical option would be arthrodesis, an option that claimant did not want to pursue. Stedman's Medical Dictionary, 25th edition, defines "arthrodesis" as "artificial ankylosis; syndesis; the stiffening of a joint by operative means."

Dr. Landon referred claimant to Dr. Rotman, dermatologist, regarding the skin condition on claimant's right knee. Dr. Rotman diagnosed contact dermatitis secondary to the nickel or chromium in the metallic total knee prosthesis. (Letter dated September 2, 1992 from Dr. Rotman to Dr. Landon). Dr. Rotman advised Dr. Landon that he would have to replace the prosthesis with a nonmetallic type if the contact dermatitis affected the tissue of the knee joint. Id. Claimant continued to treat with Dr. Rotman regarding the contact dermatitis.

Claimant continued to have chronic pain in his right knee. On October 19, 1992, Dr. Landon reported that claimant's options were to continue as he was or to consider a knee arthrodesis. Dr. Landon reported that claimant did not think that his pain was severe enough to warrant repeat surgery at that time. Claimant returned to Dr. Landon on January 28, 1993 with continued right knee pain. Dr. Landon noted that claimant's skin condition remained and that he would continue to observe claimant with a follow up in three months. Dr. Landon also noted that claimant was "still disabled."

In a letter to the insurer dated May 10, 1993, Dr. Landon, treating orthopedist, reported that claimant remained symptomatic. Dr. Landon also stated that, although it was not clear whether claimant would require more surgery, his condition remained stationary. A follow up appointment was planned and Dr. Landon indicated that he would be happy to inform the insurer of claimant's progress at that time and give an impairment rating if one was desired. Based on this letter, the insurer issued its May 25, 1993 Notice of Closure and declared claimant medically stationary as of May 10, 1993.

On June 2, 1993, claimant returned to Dr. Landon for the first time since the January 28, 1993 examination. At that time, Dr. Landon reported that claimant was having continued pain in his right knee which was so severe that it interfered with his sleep. Dr. Landon also reported that claimant's physical examination was unchanged. Dr. Landon stated that claimant's options were: (1) leave things "as is;" (2) have an arthrodesis; or (3) have a revision surgery. Dr. Landon reported that claimant was unwilling to accept arthrodesis and instead wanted to have the revision surgery. Dr. Landon stated that he planned to preform the revision surgery, "probably replacing the femoral and possibly the tibial component."

We find the facts in this case similar to those in Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987). In Scheuning, the claimant's condition had not changed between the date of closure and the date of surgery, a treatment that had not previously been proposed. The court found that the claim had been prematurely closed because the condition had not changed and the newly proposed treatment was offered with a reasonable expectation of further medical improvement. Id. at 626.

As in Scheuning, claimant's condition had not changed between the date his claim was closed and the recommendation of a new surgical treatment eight days later. Before claim closure, Dr. Rotman had reported that the pain in claimant's right knee was interfering with his sleep. Therefore, Dr. Landon's statement about pain interfering with claimant's ability to sleep does not represent a change in claimant's condition.

Furthermore, although the possibility of a need for a prosthesis replacement was presented to Dr. Landon by Dr. Rotman prior to claim closure, there is no evidence that Dr. Landon considered a prosthesis replacement as an option until the June 2, 1993 examination. Also, there is no evidence that claimant was presented with the option of replacing the metal prosthesis with a nonmetal one until the June 2, 1993 examination. As noted above, the only options Dr. Landon considered prior to claim closure were for claimant to continue "as is" or to undergo an arthrodesis.

Therefore, because claimant's condition had not changed since claim closure and Dr. Landon offered treatment that had not been proposed before and did so with a reasonable expectation of medical improvement, we conclude that claimant was not medically stationary when his claim was closed. Scheuning v. J. R. Simplot & Company, supra.

Accordingly, we set aside the insurer's May 25, 1993 Notice of Closure and direct the insurer to resume payment of temporary disability compensation commencing on May 13, 1993. When claimant is medically stationary, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. CORNETT, Claimant
Own Motion No. 93-0338M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation, as insurer for ACCO Construction (SAIF/ACCO), submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights expired on January 17, 1983. SAIF/ACCO recommends that we authorize the payment of temporary disability compensation. Claimant requests the Board award penalties and attorney fees for SAIF/ACCO's unreasonable resistance to payment of compensation in this claim.

Temporary Disability Compensation

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

We are persuaded that claimant's compensable injury worsened requiring surgery as of March 23, 1993. At that time, Dr. McNeill, treating orthopedic surgeon, recommended a left total knee arthroplasty as the only procedure that would relieve claimant's pain due to the severe osteoarthritis caused by the 1976 work injury. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF/ACCO shall close the claim pursuant to OAR 438-12-055.

Penalty and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF/ACCO's alleged unreasonable delay in processing his own motion claim for temporary disability compensation.

Claimant sustained a second compensable injury on May 28, 1992 while working for Ross Island Sand & Gravel, a subsequent employer which was also insured by SAIF (SAIF/Ross). SAIF/Ross accepted the May 28, 1992 injury as a lumbosacral strain. However, when claimant began to seek treatment for his left knee, SAIF/Ross issued a disclaimer of responsibility for claimant's current left knee condition on December 15, 1992, and again on April 20, 1993.

Claimant first requested the reopening of his own motion claim in writing on December 24, 1992. By letter dated December 24, 1992, claimant's attorney informed SAIF/ACCO that claimant was filing a claim regarding the November 26, 1976 work injury. Claimant's attorney stated that the claim was being filed as a result of a disclaimer of responsibility made by SAIF/Ross. Furthermore, by letter dated December 29, 1992, claimant's attorney enclosed a copy of an 801 form signed by claimant in which he made a claim relating to the 1976 work injury.

SAIF/ACCO did not respond to these requests from claimant to reopen his own motion claim. In addition, the record shows that claimant's attorney wrote to SAIF/ACCO reminding it of its duty to process claimant's own motion claim on April 22, 1993, May 18, 1993, and May 27, 1993. SAIF/ACCO continued to disregard claimant's attorney's requests to reopen claimant's own motion claim. Finally, by letter dated June 8, 1993, claimant's attorney notified the Board of claimant's December 1992 request to have his own motion claim reopened and SAIF/ACCO's refusal to process the own motion claim. This was the Board's first knowledge that claimant had requested SAIF/ACCO to reopen his own motion claim.

By letter dated June 30, 1993, the Board inquired as to the status of the claim. Specifically, the Board asked whether claimant's current condition was being processed under the 1992 claim with SAIF/Ross or the 1976 claim with SAIF/ACCO. On July 2, 1993, SAIF/ACCO submitted a carrier's own motion recommendation recommending that the Board reopen claimant's claim.

Effective December 31, 1990, within 90 days of an own motion claim, the own motion insurer is required to notify claimant and the Board in writing of its recommendation as to whether the claim should be reopened or denied by the Board. OAR 438-12-025(2) (WCB Admin. Order 11-1990).

This record establishes that SAIF/ACCO failed to submit a recommendation to the Board until July 2, 1993, more than six months after claimant's initial December 24, 1992 request. The purpose of the Workers' Compensation Law is to provide prompt compensation to injured workers. Edward Hines Lumber Co. v. Kephart, 81 Or App 43 (1986). Own motion jurisdiction provides a mechanism by which a claimant who no longer has aggravation rights may obtain additional temporary disability compensation. However, the Board is unable to exercise its own motion jurisdiction absent a request to do so. By failing to timely submit a recommendation to the Board, SAIF/ACCO delayed the prompt payment of benefits which are now due. We conclude that this delay was an unreasonable resistance to the payment of compensation. Thomas L. Abel, 44 Van Natta 1039, on recon 44 Van Natta 1189 (1992); John D. McCollum, 44 Van Natta 2057 (1992).

However, a penalty may not be assessed under ORS 656.262(10)(a) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. Wacher Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). At the time claimant requested temporary disability compensation, his claim was closed and could only be reopened under our own motion jurisdiction. When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, because no compensation was due at the time of SAIF's unreasonable delay, a penalty cannot be assessed under ORS 656.262(10)(a). See Thomas L. Abel, supra; Fredrick D. Oxford, 42 Van Natta 476 (1990). On the other hand, where, as here, we find that an insurer has unreasonably resisted the payment of compensation, we may assess an attorney fee even in the absence of amounts of compensation "then due." See ORS 656.382(1); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Accordingly, for SAIF/ACCO's unreasonable resistance to the payment of compensation, we assess an attorney fee of $1,000.

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/ACCO directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONNA L. LONG, Claimant
Own Motion No. 91-0058M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's April 5, 1993 Notice of Closure which closed her claim with an award of temporary disability compensation from January 23, 1991 through April 4, 1993. SAIF declared claimant medically stationary as of April 5, 1993. Claimant contends that she is entitled to additional benefits as she 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). It is claimant's burden to establish that she was not medically stationary when the claim was closed. 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 (1991).

On March 4, 1992, Dr. Watson, treating orthopedic surgeon, performed surgery on claimant, consisting of a lumbar fusion L4 to the sacrum. Subsequently, claimant relocated from California to Medford, Oregon. As a result, Dr. Watson referred claimant to Dr. Henderson, treating orthopedist, for follow-up of her lumbar spine surgery. On September 3, 1992, Dr. Henderson first examined claimant

and diagnosed that she "had a failed back syndrome status post fusion, with question of nonunion." Dr. Henderson recommended that claimant enter a work hardening program and suggested that, if she was unable to continue in the program or developed increased symptoms, the only other option would be to re-explore the fusion and remove the hardware.

Claimant entered a work hardening program and developed thoracic pain. On October 27, 1992, Dr. Henderson examined claimant and diagnosed a "thoracic sprain, possibly myofascial syndrome." He injected the area with cortisone and recommended claimant continue her work hardening therapy. Subsequently, Dr. Henderson ordered a MRI of the thoracic spine. This MRI was negative. On December 28, 1992, Dr. Henderson reported that claimant chose not to continue with the work hardening program after the MRI was scheduled and did not return to the program after she was informed the MRI was normal. He found claimant poorly motivated and recommended that a physical capacities evaluation (PCE) be scheduled. He opined that, pending the results of the PCE, claimant would be declared medically stationary. (Letter dated October 27, 1992).

On January 25, 1993, claimant returned to Dr. Watson and reported problems of increasing back pain above the area of lumbar surgery in the lower thoracolumbar junction. Dr. Watson recommended waiting six months to see how claimant would do. He opined that there may be some spontaneous improvement, although he did not think that there was much possibility of bone formation at that time. If claimant was not better in six months, Dr. Watson would consider further testing with the possibility of surgically removing the hardware, exploring the fusion and, if it was not solid, trying an anterior interbody fusion. (Letter dated January 25, 1993).

On February 16, 1993, a PCE was performed. The PCE found claimant capable of sedentary work. It also indicated that claimant made an equivocal effort during the examination and had moderate pain behavior but had no nonorganic signs of impairment. On April 5, 1993, Dr. Henderson opined that claimant was medically stationary with no additional treatment required. Based on this report, SAIF closed claimant's claim on April 13, 1993, declaring claimant medically stationary as of April 5, 1993.

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, the record contains the opinions of two treating physicians. However, we find persuasive reasons not to defer to the opinion of Dr. Henderson. The record indicates that Dr. Henderson examined claimant on September 3, 1992 and on October 27, 1992, although he subsequently scheduled and evaluated a thoracic MRI. Without examining claimant again, Dr. Henderson found her medically stationary about five months after his last examination.

However, in the interim, claimant was examined by Dr. Watson who indicated that there was a reasonable chance of improvement over time or with further treatment. Although Dr. Watson did not explicitly state that claimant was not medically stationary when he examined her in January 1993, his report as a whole indicates that she was not. "Medical opinions need not recite or mimic specific statutory language in order to provide substantial evidence to support the Board's decision." Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992), as cited in U Haul of Oregon v. Burtis, 120 Or App 353 (1993). Furthermore, Dr. Watson scheduled a follow up appointment with claimant to determine whether her condition had improved or she needed additional surgery.

On this record, we find that claimant's claim was prematurely closed. Accordingly, SAIF's April 13, 1993 Notice of Closure is set aside. 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 directly to claimant's attorney by SAIF. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD L. MOREHOUSE, Claimant
WCB Case No. 91-06564
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Hoguet's order which: (1) found that claimant was a subject worker for Liberty's insured (Daniel E. Ward); and (2) set aside its denial of claimant's low back injury claim. In his brief, claimant contends that: (1) the Referee erred in the admission of testimonial evidence; and (2) claimant is entitled to an attorney fee for Liberty's allegedly unreasonable "back-up" denial. On review, the issues are admissibility of evidence, subjectivity, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Evidence

On review, claimant argues that the Referee erred by admitting, over claimant's relevancy objections, the testimony of Ms. Sickler, assigned risk supervisor for the National Council on Compensation Insurance (NCCI), and the testimony of Mr. Tischler, assigned risk supervisor for Liberty. We disagree.

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau, II, 43 Van Natta 541 (1991).

Liberty offered the testimony of Ms. Sickler and Mr. Tischler in order to provide information on Liberty's workers' compensation insurance dealings with Daniel E. Ward and his two businesses: Willamette Painting Company, of which Daniel Ward was a sole proprietor; and Willamette Central Corporation (WCC), in which Daniel E. Ward was 100 percent shareholder. Liberty sought to use the information to show that claimant was not employed by any business of Daniel Ward that Liberty insured.

According to Ms. Sickler, Liberty was assigned to insure Daniel E. Ward, dba Willamette Painting Company through the assigned risk pool. Daniel E. Ward did not apply for, nor did Liberty ever provide, workers' compensation insurance for WCC. (Tr. 32-35). Mr. Tischler's testimony reiterated that WCC was not insured by Liberty, and Tischler also explained that it is not possible to determine, from an insurance policy, the names of specific employees of the insured. (Tr. 71).

After our review of the testimony, we conclude that the evidence is not particularly relevant to, and certainly not determinative of, the issue of whether Daniel E. Ward, dba Willamette Painting Company or WCC, is claimant's employer. Nevertheless, this evidence does lend some background information concerning the assigned risk pool and its function in the workers' compensation system. In addition, this testimony does provide additional information regarding Liberty's procedures concerning its insurance policies. Finally, claimant has not referred us to, nor have we uncovered, a portion of the testimony which would be prejudicial to claimant or his interests. Under such circumstances, we conclude that the Referee did not abuse his discretion by admitting the testimonial evidence.

Subjectivity

Claimant worked for Willamette Painting Company. Daniel E. Ward ran two separate businesses under the assumed business name "Willamette Painting Company." One, a sole proprietorship, had legally registered the assumed business name with the Secretary of State. The other business, WCC, a corporation, was operated under the same assumed business name.

Liberty argues that claimant was employed by WCC, (which was not insured by Liberty), rather than by Liberty's insured, Daniel E. Ward, sole proprietor. The Referee concluded that claimant was employed by Willamette Painting Company (an assumed business name for Daniel E. Ward, sole proprietor). Alternatively, the Referee reasoned that even if Willamette Painting Company was owned by WCC, Liberty's insured (Ward) was still claimant's employer. We affirm the Referee's ultimate conclusion, but base our decision on the following reasoning.

The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the services. ORS 656.005(13). Castle Homes v. Whaite, 95 Or App 269 (1989). The test requires an application of the traditional "right to control" analysis.

The principal factors in the traditional test of the right to control 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. Henn v. SAIF, 60 Or App 587, 591, (1982), rev den 294 Or 536 (1983); Castle Homes v. Whaite, supra, 95 Or App at 272.

Direct evidence of the right to, or the exercise of, control

While working for another employer, claimant was approached by Daniel Ward, for whom claimant had worked previously. Ward asked claimant to come back to work for Willamette Paint Company, and claimant agreed to do so. (Tr. 125). Claimant was instructed where to go and what to do by Ward, or by two others, whom claimant knew to be long-time employees of Willamette Paint Company. (Tr. 138). All the evidence indicates that Willamette Paint Company (through Ward or company employees), exercised complete control over claimant's work.

Method of payment

Claimant was issued pay checks from the corporation, WCC. (Tr. 90).

Furnishing of equipment

Claimant testified that shirts provided for his use, all equipment, signs for his truck and all contracts or plans that he viewed, had the name "Willamette Painting Company" on them. (Tr. 125-138).

Right to fire

Willamette Painting Company (through Ward) had the right to fire claimant.

Conclusion

After considering all of the factors of the "right to control" test, we conclude that claimant worked for "Willamette Painting Company." Thus, the issue becomes who owned the entity known as "Willamette Painting Company"?

ORS 648.010(1) provides that each person who conducts business under an assumed business name must submit an application to register the assumed business name to the Office of the Secretary of State. The application must state the real and true name of each person who intends to conduct business under the assumed business name. ORS 648.010(2)(b).

"Willamette Painting Company" is an assumed business name registered in Oregon by Daniel E. Ward. Furthermore, Ward, personally (not as a representative of WCC), obtained workers' compensation coverage with Liberty on behalf of Willamette Painting Company.

In light of such circumstances, we conclude that Willamette Painting Company was owned by Daniel E. Ward. Inasmuch as Liberty provided workers' compensation insurance to Daniel E. Ward on behalf of Willamette Painting Company, we further hold that Liberty is responsible for claimant's injury claim.

Unreasonable Denial

We agree with, and adopt, the Referee's reasoning and conclusion that Liberty's denial was not unreasonable under the unusual circumstances presented by this case.

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 concerning the subjectivity issue is $1,500, 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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 21, 1992 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $1,500, payable by Liberty.

In the Matter of the Compensation of
JO WANDA ORMAN, Claimant
Own Motion No. 91-0707M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Olson, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the March 9, 1993 Notice of Closure issued by the SAIF Corporation, as the insurer for Universal Rubber Company (SAIF/Universal). The Notice of Closure closed claimant's claim with an award of temporary disability compensation from July 7, 1990 through July 9, 1990. SAIF/Universal declared claimant medically stationary as of July 10, 1990. Claimant contends that she is entitled to additional benefits.

Claimant has an accepted injury claim with SAIF/Universal relating to December 22, 1976 work injuries to her neck, shoulders, and upper back. On August 20, 1990, claimant filed a claim for an occupational disease of mental stress with DIF, a subsequent employer which was also insured by SAIF (SAIF/DIF). On November 20, 1990, SAIF/DIF denied the mental stress claim. On March 12, 1991, SAIF/Universal denied compensability of claimant's psychological/psychiatric condition. Claimant requested a hearing on both denials. (WCB Case Nos. 90-20297, 91-03270).

By Opinion and Order issued on September 18, 1991, as reconsidered on October 25, 1991, Referee Holtan held that claimant's psychological condition was not compensable. However, he also held that SAIF/Universal was responsible for psychological treatment as reasonable and necessary care for the accepted neck, shoulder, and upper back conditions. Claimant requested Board review of Referee Holtan's order. On September 29, 1992, the Board affirmed Referee Holtan's order.

In the meantime, claimant had been hospitalized on July 7, 1990 for treatment of her psychological condition. By Own Motion Order dated October 16, 1992, as reconsidered on November 25, 1992, the Board reopened claimant's claim for own motion relief beginning July 7, 1990, the date she was hospitalized for treatment of her psychological condition. The Board based this reopening on the fact that claimant's treatment for her psychological condition was found compensable and necessary for her to recover from the effects of her accepted physical condition and the psychological treatment required hospitalization. Therefore, the Board reasoned, it was the accepted condition which ultimately necessitated the psychological treatment.

At the time of her hospitalization on July 7, 1990, Dr. Hall, M.D., was claimant's treating physician. Dr. Hall followed claimant's progress and signed her discharge summary. On March 29, 1993, Dr. Hall opined that claimant was medically stationary upon her release from the hospital on July 10, 1990. We find Dr. Hall's opinion persuasive. Therefore, we find that claimant became medically stationary on July 10, 1990 and conclude that SAIF's closure was proper.

Accordingly, SAIF's March 9, 1993 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT D. PECK, Claimant
Own Motion No. 89-0233M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Black, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant requests review of the insurer's August 5, 1992 Notice of Closure which closed his claim with an award of temporary disability compensation from January 1, 1988 through July 27, 1992. The insurer declared claimant medically stationary as of July 27, 1992. Claimant contends that he is entitled to additional benefits as he is not medically stationary.

On November 10, 1992, we postponed action concerning claimant's request for review of the insurer's August 5, 1992 Notice of Closure. We took this action because litigation was pending before the Hearings Division regarding whether claimant had timely filed an aggravation claim prior to the expiration of his aggravation rights. (WCB Case No. 92-12850).

On January 27, 1993, Referee Mongrain issued on order in which he concluded that claimant was barred by the res judicata doctrine of claim preclusion from litigating the issue of whether he had timely filed an aggravation claim. Initially, claimant requested Board review of Referee Mongrain's order. However, subsequently, claimant withdrew his request for review. As a result, on May 28, 1993, the Board dismissed claimant's request for review, and Referee Mongrain's order has become final by operation of law. Therefore, because claimant has no open aggravation claim and his aggravation rights have expired, his claim is within the Board's Own Motion jurisdiction.

As a preliminary matter, in addition to disputing the insurer's August 5, 1992 Notice of Closure, claimant contends that his Own Motion claim should have been reopened in September 1986 with payment of temporary disability benefits retroactive to that date. However, we deal only with the claim that is before us. Furthermore, all Own Motion claims shall first be directed to and processed by the Own Motion insurer, with the Own Motion insurer making a written recommendation to the Board whether the claim should be reopened or denied. OAR 438-12-025; 438-12-030.[1] Here, there is no evidence that claimant made an Own Motion claim in 1986. Instead, the claim that is before us relates to the insurer's voluntary reopening of claimant's claim on January 1, 1988. On May 17, 1989, the Board issued an Own Motion Order which formally reopened claimant's claim. It is that reopened claim that claimant argues was prematurely closed by the insurer's August 5, 1992 Notice of Closure.

The propriety of the closure turns on whether claimant was medically stationary at the time of the August 5, 1992 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

On June 24, 1992, claimant underwent an independent medical examination performed by Dr. Smith, orthopedic surgeon. Dr. Smith opined that claimant was medically stationary. On July 13, 1992, claimant returned to his treating orthopedist, Dr. Chamberlain, complaining of knee pain. Dr. Chamberlain noted that claimant's current bone scan was essentially the same as the January 1992 bone

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[1] We note that the relevant rules in effect on January 1, 1988, the date the insurer voluntarily reopened this claim, contain the same language as the current rules with the exception that an insurer was allowed 60 days in which to submit a written recommendation to the Board whereas the current rules allow 90 days. Compare the former and current versions of OAR 438-12-025 and 438-12-030 (WCB Admin Orders 5-1987 and 11-1990).

Also, we note that the version of the relevant rules in effect in September 1986, the date from which claimant requests retroactive payment, permitted a claimant to request Own Motion relief directly to the Board. Former OAR 438-12-005. However, there is no evidence that claimant requested Own Motion relief directly to the Board in 1986.

scan. On July 27, 1992, Dr. Chamberlain concurred with Dr. Smith's June 24, 1992 report in its entirety. Thus, Dr. Chamberlain agreed that claimant was medically stationary. There is no other medical opinion regarding claimant's medically stationary status. Relying on Dr. Chamberlain's concurrence, the insurer closed claimant's claim on August 5, 1992 with a medically stationary date of July 27, 1992.

Claimant argues that he was not medically stationary when his claim was closed because: (1) on July 13, 1992, he returned to Dr. Chamberlain for treatment; (2) on September 10, 1992, Dr. Chamberlain scheduled him for a diagnostic arthroscopy of the left total knee arthroplasty; and (3) on September 21, 1992, he underwent an arthroscopy with a limited debridement of the left total knee arthroplasty.

However, as noted above, Dr. Chamberlain concurred with Dr. Smith's medically stationary finding after Chamberlain examined claimant on July 13, 1992. Therefore, Dr. Chamberlain evidently considered claimant's July 13, 1992 visit in making his concurrence. In any event, Dr. Chamberlain offers no opinion as to claimant's medically stationary status other than his concurrence with Dr. Smith's report. Furthermore, the fact that claimant required surgery after claim closure reflects a subsequent change in claimant's condition which is not relevant to claimant's medically stationary status at closure. Sullivan v. Argonaut Ins. Co., supra; Alvarez v. GAB Business Services, supra.

Based on the unrebutted medical evidence in this record, we find that claimant was medically stationary on July 27, 1992 and conclude that the insurer's closure was proper. Accordingly, the insurer's August 5, 1992 Notice of Closure is affirmed in its entirety.[2]

IT IS SO ORDERED.

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[2] Regarding the September 21, 1992 arthroscopy, the insurer has submitted a recommendation that the Board deny reopening claimant's claim on the basis of its contention that claimant was not in the work force at the time of the disability. This new claim is addressed in a separate order issued this date. (Own Motion No. 92-0587M).

In the Matter of the Compensation of
ROBERT D. PECK, Claimant
Own Motion No. 92-0587M
OWN MOTION ORDER
Black, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

The insurer submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights have expired. The insurer recommends that we deny reopening the claim for payment of temporary disability compensation based on its contention that claimant was not in the work force at the time of the current worsening.

On November 10, 1992, we postponed action concerning claimant's request for review of the insurer's August 5, 1992 Notice of Closure. We took this action because litigation was pending before the Hearings Division regarding whether claimant had timely filed an aggravation claim prior to the expiration of his aggravation rights. (WCB Case No. 92-12850).

On January 27, 1993, Referee Mongrain issued on order in which he concluded that claimant was barred by the res judicata doctrine of claim preclusion from litigating the issue of whether he had timely filed an aggravation claim. Initially, claimant requested Board review of Referee Mongrain's order. However, subsequently, claimant withdrew his request for review. As a result, on May 28, 1993, the Board dismissed claimant's request for review, and Referee Mongrain's order has become final by operation of law. Therefore, because claimant has no open aggravation claim and his aggravation rights have expired, his claim is within the Board's Own Motion jurisdiction.

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).

On August 5, 1992, the insurer issued a Notice of Closure which closed claimant's previously reopened claim with an award of temporary disability compensation from January 1, 1988 through July 27, 1992. The insurer declared claimant medically stationary as of July 27, 1992. By an order issued on today's date, we affirmed the insurer's August 5, 1992 Notice of Closure. (Own Motion Case No. 89-0233M).

On September 10, 1992, Dr. Chamberlain, claimant's treating orthopedist, scheduled claimant for a diagnostic arthroscopy of his left knee. On September 21, 1992, claimant underwent an arthroscopy with a limited debridement of his left total knee arthroplasty. We are persuaded that, on September 10, 1992, claimant's compensable injury worsened requiring surgery.

Thus, in order to be entitled to temporary disability compensation, claimant must establish that he was in the work force on September 10, 1992, the time of his disability. Weyerhaeuser v. Kepford, supra. Claimant was found to be in the work force and, therefore, eligible for Own Motion benefits when the Board previously reopened his claim on May 17, 1989. He remained in the work force, although he was unable to work due to his compensable injury, from January 1, 1988 through July 27, 1992, the time he received temporary total disability benefits on his previous claim.

Less than seven weeks passed between the time claimant became medically stationary and the time his condition worsened on September 10, 1992. However, claimant (approximately 64 years of age) presents no evidence as to his work search efforts or his ability to work at the time of his disability. Neither Dr. Chamberlain nor the independent medical examiner, Dr. Anthony Smith, give any opinion regarding claimant's ability to work. Furthermore, even if the work injury made a reasonable job search futile, claimant still must prove that, but for the work injury, he would be willing to work. Dawkins v. Pacific Motor Trucking, supra. The record contains no evidence regarding claimant's willingness to work. As noted above, claimant has the burden of proof on the work force issue.

On this record, we find that claimant has not established that he was 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.

In the Matter of the Compensation of
MARVIN H. BARSTAD, Claimant
WCB Case No. 92-02754
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mills' order that found that the Hearings Division lacked jurisdiction to rate the extent of claimant's unscheduled permanent disability. In his brief, claimant requests that this matter be held in abeyance pending the appeal of Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992). On review, the issue is jurisdiction.

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

We deny claimant's request to hold this matter in abeyance. See John B. Gordon, 44 Van Natta 1601 (1992).

ORDER

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

Board Member Westerband specially concurring.

I join with the majority in affirming the Referee's order, based on Olga L. Soto, supra and progeny. As time has passed however, I have developed considerable doubt about the Board's response in Olga L. Soto, supra to the Benzinger problem. My primary reason for doubt is an argument that no party, to my recollection, has made in any case.

Arguably, the fundamental question for the Board in Olga L. Soto, supra was not a question of legislative intent, because the legislature did not contemplate, let alone make any provision for the inability of the Appellate Unit to complete the reconsideration process within the time originally allowed by statute. Rather, the legislature simply presumed that medical arbiters would be appointed and reconsideration orders timely issued and everything would work just fine. The legislature was obviously wrong.

So, it could be argued that the question for the Board was not fundamentally, "what did the legislature intend?" Rather, the question was, what would the legislature have intended had the legislature contemplated the problem. Thus, to the extent the Board in Olga L. Soto, supra tried to find the legislature's intent, the Board's analysis went awry, because the legislature had none with respect to the Benzinger problem.

As the majority opinion states, ultimately the legislature did develop a specific intention concerning the Benzinger problem. In 1991, the legislature amended ORS 656.268(6)(a) to specifically authorize Referees to receive in evidence at hearing medical arbiter reports that were not prepared in time for use in the reconsideration process. However, the amendment was specifically made applicable "to requests for reconsideration made on and after October 1, 1991." Or Laws 1991, Chapter 502, Sec. 2.

The request for reconsideration in the present case was made before October 1, 1991. Therefore, as the majority opinion states, the 1991 amendment to ORS 656.268(6)(a) does not apply to this case. Accordingly, it would stretch the rules of statutory construction beyond their considerable elasticity to argue that the 1991 amendment reflects the 1990 legislature's intent and controls the question presented. On the other hand, as previously discussed, the question here is, what would the legislature probably have intended had it foreseen the problem. Arguably, for that question, the 1991 amendment provides substantial guidance. In short, the 1991 legislature has told us that receiving medical arbiter reports in evidence at hearing would be a reasonable response to a problem that the 1990 legislature did not contemplate.

As a general rule, I am not one for changing direction in a major impact case while cases on a particular subject at issue are under active consideration by the appellate courts. For this reason, I join with the majority in affirming the Referee's order, based on Olga L. Soto and progeny, although had I known about the amendment to ORS 656.268(6)(a) when Olga L. Soto, supra was before the Board, I might have voted consistent with the analysis of this special concurrence. Furthermore, perhaps this argument is wrong and the Soto Board was right.

August 12, 1993 Cite as 45 Van Natta 1577 (1993)

In the Matter of the Compensation of
CALVIN E. BIGELOW, Claimant
WCB Case Nos. 91-11633 & 91-02765
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) set aside its partial denial of claimant's chronic anxiety/adjustment reaction with mixed emotional features; and (2) awarded an assessed attorney fee. On review, the issues are propriety of the employer's denial 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.

As of the February 8, 1991 partial denial, the employer was on notice of a possible claim for chronic anxiety/adjustment reaction with mixed emotional features.

CONCLUSIONS OF LAW AND OPINION

The Referee found that no claim had been made for claimant's diagnosed chronic anxiety/adjustment reaction condition and consequently, that the employer's partial denial of that condition was premature. Consequently, the Referee set aside the denial and awarded an assessed attorney fee for prevailing against it. We disagree.

Where no "claim" for compensation has been made by claimant or someone on the claimant's behalf pursuant to ORS 656.005(6), the issuance of a denial is generally considered to be premature. See Dorothy M. Jackson-Duncan, 42 Van Natta 1122 (1990). Nevertheless, an employer is free to partially deny any condition which it reasonably believes could be a claim. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989).

When a treating physician investigates an unrelated condition coincidentally with the treatment of an accepted condition, the issuance of a "precautionary" denial is appropriate. See Sidney M. Brooks, 38 Van Natta 925, 926 (1986). Where the report which evoked the denial was generated by a treating physician, in the context of treatment for an accepted condition, a partial denial of the unrelated condition may be procedurally proper. See Jack Allen, 43 Van Natta 190 (1991); Shannon M. Evans, 42 Van Natta 227 (1990). For example, where medical evidence indicated that the claimant had a degenerative condition which might account for his symptoms, we found that that evidence put the insurer "on notice of a possible claim" for the degenerative condition and concluded that the insurer's subsequent partial denial was a permissive precautionary denial. See Henry Martin, 43 Van Natta 2561 (1991), aff'd mem 115 Or App 757 (1992).

In this case, Dr. Grant examined and treated claimant in 1990 for multiple physical complaints, particularly bilateral upper extremity difficulties. Grant twice listed "chronic anxiety/adjustment reaction with mixed emotional features" among his "Impressions" regarding claimant. (See Exs. 23-2; 26-2). He apparently recorded these observations before reviewing claimant's complete history. (See Ex. 34).

In light of Dr. Grant's impressions, we conclude that the partial denial of claimant's chronic anxiety/adjustment reaction was proper. See William H. Waugh, 45 Van Natta 919 (1993). (Where the worker's treating physician suspected that the claimant's skin condition might be work related and requested a "rule out" examination on that basis, the employer reasonably believed that workers' compensation liability was possible, thereby obligating it to accept or deny the claim).

First, claimant was previously diagnosed as suffering from a chronic anxiety/adjustment reaction condition, in 1988. (See Exs. 4, 4A). Second, there is no evidence that any such present or preexisting psychological condition is or was work-related.[1]

In addition, because claimant takes the position that he does not have a "chronic anxiety/adjustment" condition, (Tr. 3), the denial must be upheld. See Robert L. Mowry, 43 Van Natta 1007 (1991). Finally, since claimant acknowledges that he is not seeking compensation for any such condition, he would not have prevailed against a denial of a claim for compensation. See ORS 656.386. Consequently, no attorney fee is warranted. See Cindy L. Smith, 44 Van Natta 1660 (1992).

ORDER

The Referee's order dated November 5, 1992, as reconsidered December 17, 1992, is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of chronic anxiety/adjustment reaction is reversed. The denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

[1] In this regard, we note that Grant's eventual (post-denial) familiarity with claimant's ten-year history of physical complaints apparently caused him to question their "true etiology." (See Ex. 34; see also Ex. 33).] Under these circumstances, we find that Grant's diagnosis of a psychological condition, in light of claimant's prior history, reasonably caused the employer to suspect potential workers' compensation liability. Accordingly, we conclude that the employer's precautionary partial denial was procedurally proper.

In the Matter of the Compensation of
ANN C. GASSERT, Claimant
WCB Case No. 93-02999
ORDER OF DISMISSAL
Hollis Ransom, Claimant Attorney
Charles Lundeen, Defense Attorney

Claimant requested review of Referee Schultz' order that affirmed an Order on Reconsideration which 5 percent (16 degrees) unscheduled permanent disability for a back injury. The parties have submitted a proposed "Stipulation and Order," which is designed to resolve all issues raised or raisable in this matter. Specifically, the parties agree that the permanent disability issue is controlled by the Board's holding in Raymond L. Mackey, 45 Van Natta 776 (1993), which determined that a party's failure to contest adaptability during the reconsideration proceeding precluded that party from contesting that value at a subsequent hearing.

Inasmuch as the Mackey decision is currently pending judicial review, the parties stipulate that the ultimate decision in Mackey shall govern their dispute. In other words, if the Mackey holding is affirmed, the parties agree that claimant will not be entitled to additional unscheduled permanent disability. On the other hand, should the Mackey holding be reversed, the parties stipulate that claimant's award shall be increased from 5 percent (16 degrees) unscheduled permanent disability to 11 percent (35.2 degrees).

We have approved the agreement, thereby fully and finally resolving this dispute. In granting this approval, we have concluded that, notwithstanding the contingent nature of the stipulation, claimant's entitlement to additional permanent disability as a result of the ultimate determination in Mackey will be readily ascertainable. See Shirley A. Roth, 43 Van Natta 1802 (1991). Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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 OF DISMISSAL
Scheminske & Lyons, Claimant Attorneys
O'Connell, et al., Attorneys
Larry D. Schucht (Saif), Defense Attorney

On June 9, 1993, we denied claimant's motion to dismiss a request for Board review of a Referee's order filed by Spitulski Enterprises, an alleged noncomplying employer. Since issuance of our order, we have received a motion to dismiss Spitulski's request for review from the Department of Insurance & Finance. We treat the submission as a motion for reconsideration of our June 9, 1993 order.

In denying claimant's motion to dismiss, we reasoned that the hearing before the Referee included matters concerning a claim in addition to review of the Director's noncompliance order. See ORS 656.704(3), (4)(c); Donna M. Hooper, 41 Van Natta 373 (1989). Specifically, those matters involved Spitulski's denial of the claim, as well as penalties and attorney fees regarding that denial.

Citing Clark v. Linn, 98 Or App 393, 396-97 (1989), the Department contends that only the SAIF Corporation, as statutory claim processor for the alleged noncomplying employer under ORS 656.054, has authority to issue a claim denial. Since Spitulski's denial was issued without statutory authority and because compensability of the claim had been conceded at the hearing, the Department reasons that Spitulski's appeal of the Department's noncomplying employer order was not contested at the same hearing as a matter concerning a claim. Under such circumstances, the Department contends that the Board lacks appellate jurisdiction to review the Referee's order. See ORS 656.740(4).

We agree with the Department's reasoning. Matters concerning a claim are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3). After further review of this issue, we conclude that claimant's hearing request from Spitulski's invalid "subjectivity" denial did not constitute a matter concerning a claim. In accordance with Clark, it is SAIF's statutory responsibility to accept or deny a claim against an alleged noncomplying employer. Clark, supra, at page 396. If SAIF denies the claim, claimant has the right to request a hearing; if SAIF accepts the claim, the employer has that right. Id.

Here, SAIF accepted the claim. Nevertheless, Spitulski did not request a hearing from that acceptance. Rather, the alleged noncomplying employer issued its own denial, contending that it was not a subject employer. Since such a denial lacks statutory authority, it follows that a hearing request from this invalid denial does not involve a matter concerning a claim because the denial will have no affect on claimant's right to receive compensation, or the amount therof. See ORS 656.704(3). Moreover, Spitulski's denial raised the same issue (subjectivity) which was being contested pursuant to its appeal of the Department's noncomplying employer order.

Under such circumstances, Spitulski's appeal from the Department's noncomplying employer order was not contested at the same hearing as a matter concerning a claim. ORS 656.740(4). Consequently, appellate review of the Referee's order rests with the Court of Appeals, not this forum.

Accordingly, on reconsideration, we dismiss Spitulski Enterprises' request for Board review. In doing so, we recognize that the Referee's order contained a statement concerning the parties' rights of appeal which indicated that review requests should be directed to the Board. Although this statement was unfortunate, our appellate jurisdiction is statutory and cannot be expanded through an inaccurate statement of appeal rights. Larry J. Powell, 42 Van Natta 1594 (1990).

Finally, claimant's counsel has submitted a statement of services, seeking an attorney fee for services rendered before this forum. Notwithstanding these efforts, when a request for Board review is dismissed without a decision on the merits, we are without authority to award attorney fees under ORS 656.382(2). Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990). Therefore, claimant's request for an attorney fee award is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRUCE SULLIVAN, Claimant
Own Motion No. 93-0219M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our April 29, 1993 Own Motion Order which reopened claimant's claim for payment of temporary disability benefits beginning the date he undergoes the proposed surgery. We deny SAIF's request as untimely.

A motion for reconsideration shall be denied if not timely submitted to the Board. OAR 438-12-065(2). To be timely, the motion must be filed within 30 days of the date of mailing of the final order, or within 60 days of that mailing date if the party requesting reconsideration establishes to the Board's satisfaction that there was good cause for the failure to file the request within 30 days of that date. Id.

Here, the order was mailed April 29, 1993. The Board received SAIF's request for reconsideration on July 16, 1993, more than 60 days after the mailing of our order. In addition, we do not find that "extraordinary circumstances" exist in this case which would justify our reconsidering our prior order notwithstanding the filing deadlines. Id. Therefore, SAIF's motion for reconsideration is denied as untimely.

As a parenthetical note, we observe that the basis of SAIF's request for reconsideration is legally deficient. SAIF requests reconsideration on the ground that it had "only recently learned that [the] requested surgery was performed on an outpatient basis and therefore does not qualify for Own Motion reopen[ing]." However, outpatient surgery does qualify a claim for reopening under the Board's own motion jurisdiction.

In relevant part, ORS 656.278(1)(a) provides that the Board may, on its own motion, reopen a claim where:

> "[t]here is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board. . ." (Emphasis added).

Thus, the clear statutory language authorizes the Board to reopen an own motion claim where the compensable injury worsens requiring outpatient surgery, as was the case here.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANA HAFMANN, Claimant
Own Motion No. 93-0411M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable low back injury. Claimant's aggravation rights expired on December 22, 1981. SAIF initially opposed reopening of the claim solely on the basis of its contention that claimant was not in the work force at the time of the current worsening. However, SAIF subsequently indicated that CareMark Comp, the MCO that SAIF contracts with, determined that the proposed lumbar surgery was not appropriate medical treatment for claimant. Thus, in addition to the work force issue, SAIF is also contending that the proposed surgery is not reasonable and necessary treatment 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.

Here, the MCO in this case has determined that the proposed surgery is not appropriate medical treatment. In addition, Dr. Treible, consulting orthopedic surgeon, has appealed the MCO's 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
STEVEN K. BAILEY, Claimant
WCB Case Nos. 92-05890, 92-04226 & 92-05367
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Farmers Insurance Group has requested reconsideration of our July 29, 1993 Order on Review. Specifically, Farmers objects to that portion of our order that reinstated Liberty Northwest's denial of claimant's low back condition and set aside Farmers' denial of claimant's condition and remanded the claim to Farmers for acceptance and processing in accordance with the workers' compensation law.

In order to allow sufficient time to consider the motion, the July 29, 1993 Order on Review is abated and withdrawn. The parties are requested to file their responses within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
EILENE E. HARDING, Claimant
WCB Case No. 92-04801
ORDER OF ABATEMENT
Royce, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer moves to abate and reconsider our July 19, 1993 Order on Review. In order to allow sufficient time to consider the motion, the above-noted Board order is 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
CARLOS S. COBIAN, Claimant
WCB Case No. 92-04779
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Crumme's order that increased claimant's scheduled permanent disability award for loss of use or function of the left arm from 34 percent (65.28 degrees), as awarded by an Order on Reconsideration, to 55 percent (105.6 degrees). In his brief, claimant contests that portion of the Referee's order that affirmed the Order on Reconsideration's award of 5 percent (16 degrees) unscheduled permanent disability for a left shoulder injury. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant is 33 years old. He has completed 8 years of school. Claimant's highest job skill level is SVP 3, based on employment as a bag-machine operator. His highest job strength requirement, during the ten years preceding determination, was "medium." His residual functional capacity is "light."

CONCLUSIONS OF LAW AND OPINION

Scheduled disability

We adopt that portion of the Referee's order addressing the extent of claimant's scheduled permanent disability, with the following supplementation and modifications.

At the outset, we agree with the Referee that the opinion of Dr. Fitzsimmons, medical arbiter, is the most persuasive medical evidence in this case. (See Ex. 22). However, we note that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (Impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior relevant impairment findings); Timothy W. Reintzell, 44 Van Natta 1534 (1992). Rather, we conclude that the arbiter's report provides the most thorough, complete and well-reasoned evaluation of claimant's injury-related permanent impairment and residual functional capacity. Consequently, we rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

The Referee found claimant entitled to a value of 8 percent of the left arm as a result of reduced left elbow flexion. (O&O p. 4). Instead, we find that claimant is entitled to a 6 percent rating for this loss. We base this conclusion on the following reasoning.

OAR 436-35-007(16) provides, in part, that the range of motion or laxity in the injured joint shall be compared to the contralateral joint, except under circumstances not present in this case. The arbiter measured right elbow flexion of 140 degrees and left elbow flexion of 120 degrees. Accordingly, upon valuing the injured left elbow joint impairment proportionately to the full motion of the contralateral joint, claimant is entitled to a value of 6 percent for injury-related lost flexion in his left elbow. See former OAR 436-35-007(16) & 436-35-100(1).

We agree with the Referee that claimant is entitled to values of 50 percent for lost grip strength due to injury to his brachial plexus; 5 percent for a chronic condition limiting repetitive use of his left arm; and 4 percent for loss of palmar flexion of the left wrist. When these values are combined with the 6 percent value for lost left elbow flexion, the result is 57 percent. See OAR 436-35-120(2)&(4). However, because claimant sought a 55 percent scheduled permanent disability award at hearing and does not contest that award on review, we do not disturb the Referee's award. See Daniel M. Alire, 41 Van Natta 752, 759 (1989).

Unscheduled disability

The Referee found claimant entitled to 5 percent unscheduled permanent disability for a chronic condition limiting repetitive use of the left shoulder. In reaching this result, the Referee reasoned that claimant is not entitled to values for age, education and adaptability under the standards, because claimant was released to his regular work after his injury. We modify.

Claimant became medically stationary on May 20, 1991, and his claim was closed by Determination Order on July 17, 1991. Because claimant became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Determination Order control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. Thus, the applicable "standards," as amended by the temporary rules, are those that became effective April 1, 1991.

However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Determination Order. (WCD Admin. Orders 2-1991, 7-1991 and 93-052).

Claimant contends that he is entitled to no value under the standards for his age (33); a +1 value for education (no high school diploma or GED); a +3 skills value (bag-machine operator, DOT 649.685-014); a +1 value for lack of training certification; and 5 percent impairment for a chronic condition limiting repetitive use of his left shoulder. In response, the insurer argues that claimant is not entitled to nonimpairment values under the standards, because his treating physician released him to return to regular work after the injury. We disagree with the insurer, for two reasons.

First, we acknowledge that Dr. Laubengayer, treating physician, believed that claimant was able to return to work without restrictions. However, because claimant unsuccessfully attempted to return to his job-at-injury, (see Tr. 5-6), we do not find that Laubengayer's work release accurately represents claimant's residual functional capacity. Moreover, as we have stated, we find the opinion of the medical arbiter (Dr. Fitzsimmons) more persuasive than that of the treating physician. Accordingly, based on Dr. Fitzsimmon's thorough, well-reasoned report, we find that claimant is limited to lifting 25 pounds occasionally or ten pounds repetitively and precluded from repetitive lifting above shoulder level. (See Ex. 22-4). Consequently, claimant's residual functional capacity is "light." See former OAR 436-35-280.

Second, and most importantly, rules governing adaptability have changed since the Referee's order. See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993). Under the former version of OAR 436-35-310, a worker's adaptability value depended upon a comparison between the strength requirement of the job at the time of injury and the strength requirement of the post-injury work or the worker's residual functional capacity. Under the amended rule, a worker's adaptability depends upon "a comparison of the highest strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination as compared to the worker's maximum residual functional capacity at the time of determination." OAR 436-35-310(1).

Here, claimant's highest strength requirement, based on the jobs performed in the ten years preceding determination, was "medium" (potato packer; see DOT 920.687-134; bag machine operator see DOT 649.685-014). His residual functional capacity is light, (see Ex. 22-4). See OAR 436-35-310(1). Under these circumstances, OAR 436-35-310(2) provides for an adaptability value of 3. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Therefore, under either theory, claimant's adaptability value is 3. Having reached a conclusion regarding claimant's adaptability value, we proceed with a determination of claimant's permanent disability under the standards.

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the resultant sum is then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age, education, and skills, and training (5) is multiplied by the adaptability value (3), the total is 15. When this value is added to the value for impairment (5), the result is 20. Therefore, claimant's unscheduled permanent disability is 20 percent.

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 scheduled disability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 20, 1992 is modified in part and affirmed in part. In addition to the Order on Reconsideration's award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 15 percent (48 degrees), for a total award to date of 20 percent (67.2 degrees) unscheduled permanent disability for his left shoulder condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total "out-of-compensation" attorney fees granted by this order and the Referee's order shall not exceed $3,800. For services on review concerning the insurer's request for review regarding the Referee's scheduled disability award, claimant's attorney is awarded an attorney fee of $750, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID C. CORREIA, Claimant
WCB Case No. 92-06251
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Menashe's order that increased claimant's unscheduled permanent disability award for a back condition from 22 percent (70.4 degrees), as awarded by an Order on Reconsideration, to 42 percent (134.4 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable back injury on July 19, 1988. At the time of his back injury, claimant was performing temporary work in a modified position (flagger), due to a prior wrist injury, incurred while he was working as a construction worker.

Claimant's regular construction work is classified as "heavy." His modified job as a flagger is classified as "medium/light."

Claimant was medically stationary on September 27, 1991. He has the residual functional capacity to perform medium/light work.

Claimant's low back injury claim was closed by an October 23, 1991 Notice of Closure. He was awarded 22 percent unscheduled permanent disability.

Based on the physical demands of claimant's jobs performed during the ten years preceding the time of determination, his highest prior strength was "heavy."

CONCLUSIONS OF LAW AND OPINION

The Referee determined claimant's adaptability factor to be 4, based on the heavy strength requirement of claimant's regular construction work and his residual functional capacity (medium/light). The Referee relied on former OAR 436-35-310(1). In light of this "adaptability" reasoning, the Referee increased claimant's award from 22 percent to 42 percent. We reach the same result, based on the following reasoning.

Claimant became medically stationary on September 27, 1991, and his claim was closed by Notice of Closure on October 23, 1991. Because claimant became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Notice of Closure control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. Thus, the applicable "standards," as amended by the temporary rules, are those that became effective April 1, 1991.

However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Notice of Closure. (WCD Admin. Orders 2-1991, 7-1991 and 93-052).

The parties do not dispute the values assigned for claimant's age and education (5) or his impairment (22 percent). Therefore, we adopt these values when we calculate claimant's permanent disability and discuss only the value for adaptability.

The insurer argues that the Referee erred in refusing to apply former OAR 436-35-310(2), contending that the rule's reference to "the worker's job at time of injury" means claimant's temporary flagging work, rather than his regular construction work. We need not address the insurer's argument, because the applicable rule has changed.

To begin, we recognize that former OAR 436-35-310(1) does not contemplate a value for adaptability where a worker's strength is not affected by his compensable condition. Thus, under that rule, claimant's adaptability factor would be zero, because he has the residual functional capacity to perform his "at-injury" flagging job. However, subsequent to the Referee's order, the Supreme Court has held that a claimant's age, education and adaptability factors must be considered under the Director's "standards." See England v. Thunderbird, 313 Or 633 (1993).

In response to the Court's decision in England, supra, the Director amended OAR 436-35-280 through 436-35-310. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). OAR 436-35-280 now provides in relevant part:

> "The factors of age, OAR 436-35-290; education, OAR 436-35-300; and adaptability, OAR 436-35-310, shall be applied for losses identified in ORS 656.214(5) and described in OAR 436-35-320 through 436-35-500."

In conjunction with this provision, OAR 436-35-290 through OAR 436-35-310 (concerning age, education, and adaptability) now allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work following a compensable injury. In addition, a worker's residual functional capacity to perform his at-injury job no longer obviates values for age, education and adaptability. Since these amended temporary rules apply to all ratings of disability made on or after June 17, 1993, the current versions are applicable. OAR 436-35-003(4). See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

OAR 436-35-310 governs adaptability. Under the former version, a worker's adaptability value depended upon a comparison between the strength requirement of the job at the time of injury and the strength requirement of the post-injury work or the worker's residual functional capacity. Under the amended rule, a worker's adaptability depends upon "a comparison of the highest strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination as compared to the worker's maximum residual functional capacity at the time of determination." OAR 436-35-310(1).

Here, claimant's highest strength requirement, based on the jobs performed in the ten years preceding determination, was heavy (construction worker). Furthermore, his residual functional capacity is medium/light (Exs. 31-4, 32). See OAR 436-35-310(1). Under these circumstances, OAR 436-35-310(2) provides for an adaptability value of 4. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Having reached a conclusion regarding claimant's adaptability value, we proceed with a determination of claimant's permanent disability under the standards.

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the resultant sum is then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (5) is multiplied by the adaptability value (4), the total is 20. When this value is added to the value for impairment (22), the result is 42. Therefore, claimant's unscheduled permanent disability is 42 percent. Thus, we affirm the Referee's award.

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 permanent disability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 16, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $750, payable by the insurer.

In the Matter of the Compensation of
DONNA L. JOHNSON, Claimant
WCB Case No. TP-93004
THIRD PARTY DISTRIBUTION ORDER
Gary M. Carlson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant has petitioned the Board for resolution of a dispute regarding the SAIF Corporation's share of proceeds from a third party judgment. ORS 656.593(1)(c). Specifically, the dispute involves whether SAIF's entire $984.22 lien is recoverable from claimant's $3,300.86 judgment. We conclude that SAIF is entitled to recover $523.41 of its lien.

FINDINGS OF FACT

On November 4, 1991, claimant sustained a compensable injury when she was involved in a motor vehicle accident (MVA) with another vehicle driven by a third party. The van claimant was operating was struck on the right front section by the other vehicle.

Claimant complained of neck and left hand pain. On November 5, 1991, Dr. McDonald diagnosed cervical strain and left hand contusion.

On November 21, 1991, Dr. McDonald reported that claimant was "much improved," but still had "mild residual pain in neck." McDonald's diagnosis was "cervical strain resolving [;] LBS resolved [;] lumbosacral strain resolved. Contusion LT hand resolved."

On December 24, 1991, Dr. McDonald concluded that claimant's cervical strain had resolved. Recommending no further treatment, Dr. McDonald found no impairment.

In March 1992, Dr. Martens examined claimant on referral from Dr. McDonald. Claimant (47 years of age at the time) reported a history of recurrent neck pain since childhood, but especially in the past 11 years. In addition, claimant mentioned recurrences of low back pain one to four times per year dating back to a 1972 slip and fall injury. Dr. Martens diagnosed chronic cervical/thoracic strain (no neurologic loss), recurrent lumbosacral strain (no neurologic loss), minimal preexisting C6-7 spondylosis, and mild preexisting thoracolumbar spondylosis. Martens concluded that claimant was medically stationary with no permanent impairment from the November 1991 MVA.

Claimant returned to Dr. McDonald in April 1992. Reporting that claimant's lumbosacral strain had resolved, Dr. McDonald concluded that claimant had suffered no permanent impairment.

Claimant retained counsel to initiate a lawsuit against the third party driver. A complaint seeking damages for negligence was subsequently filed. Claimant alleged injuries to her neck, back, face, and left hand causing cervical strain, lumbosacral strain, contusions, pain, anxiety, and discomfort. She requested $599.70 for medical bills and medication, $277.45 for lost wages, and $7,500 for general damages.

In June 1992, SAIF, who had accepted claimant's injury claim and provided benefits, notified claimant's counsel of its lien. Specifically, SAIF sought recovery of $984.22 in medical bills.

In December 1992, claimant's third party complaint was presented to an arbitrator. The third party's position was that claimant's medical expenses ($984.22) until December 24, 1991 (when Dr. McDonald found claimant medically stationary without permanent impairment) were reasonable and related to the November 1991 MVA. However, the third party asserted that subsequent medical bills were not necessitated by the MVA, but rather were attributable to claimant's preexisting chronic condition.

Following the hearing, the Arbitrator reached the following conclusions. The November 1991 MVA aggravated claimant's preexisting neck and upper back condition. Claimant did not prove that the MVA aggravated her preexisting low condition. The third party was responsible for 3 days of lost wages ($277.45) and medical expenses ($523.41). In addition, the Arbitrator granted claimant $2,500 in "non-economic" damages.

In January 1993, SAIF notified claimant's attorney that it was unwilling to waive any part of its share of claimant's gross recovery. Consequently, SAIF sought full satisfaction of its $984.22 lien. In February 1993, SAIF reiterated its position that it was entitled to full recovery of its $984.22 lien from the $3,300.86 third party judgment.

Thereafter, claimant petitioned the Board for resolution of the dispute. Asserting that the Arbitrator found that only $523.41 in medical bills were related to the November 1991 MVA, claimant contends that SAIF's recovery should be limited to that amount (less 1/3 for attorney fees).

CONCLUSIONS OF LAW

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.693(1).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, 84 Or App 616 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a) costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(10(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Since claimant elected to seek recovery from a third party for damages resulting from her compensable injury, her cause of action became subject to SAIF's lien as a paying agency. ORS 656.580(2); 656.593(1); Gale E. Charlton, 43 Van Natta 1356 (1991); Kenneth Owens, 40 Van Natta 1049 (1988). This lien attaches to general damages, as well as to special damages. Kenneth Owens, supra, at pages 1050-51. However, a paying agency's lien is limited to claim costs attributable to injuries for which claimant has received damages from the third party. ORS 656.593(1)(c); Clifford S. Brush, 44 Van Natta 954 (1992).

As previously discussed, following distribution of claimant's attorney fee, litigation costs, and claimant's 1/3 statutory share, SAIF is entitled to retain the balance of the third party recovery "to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794." ORS 656.593(1)(c). "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8).

Claimant does not contest SAIF's assertion that it paid $984.22 in medical bills while processing her November 1991 injury claim. Rather, relying on the Arbitrator's refusal to award damages for claimant's low back condition and the Arbitrator's conclusion that claimant's neck and upper back condition was related to the November 1991 MVA until December 24, 1991, claimant argues that SAIF's recovery should be limited to the medical bills ($523.41) granted by the Arbitrator.

In response, SAIF does not oppose claimant's contention that her medical bills through December 24, 1991 totalled $523.41. Instead, arguing that the Arbitrator awarded damages for the same injuries for which it provided compensation, SAIF asserts that it is entitled to full reimbursement for its medical expenses ($984.22).

We hold that SAIF is entitled to recover reimbursement for its claim costs which are attributable to injuries for which claimant has received damages from the third party; i.e., $523.41. In reaching this conclusion, we draw on the reasoning expressed in Clifford S. Brush, supra.

In Brush, the dispute involved whether a paying agency was entitled to recover from a third party judgment claim costs expended for a low back condition and surgery when the judgment granted damages for a wrist and knee injury. Noting that the trial judge had expressly concluded that the low back condition was unrelated to the third party injury, we concluded that the paying agency's lien was limited to its claim costs attributable to the wrist and knee injuries. Relying on ORS 656.593(1)(c), we reasoned that such an approach would permit the paying agency to retain the balance of the third party recovery "to the extent that it is compensated for its expenditures for compensation" resulting from the compensable injuries for which the claimant has received damages from the third party. Clifford S. Brush, supra.

Here, as in Brush, the paying agency has expended claim costs for an injury (low back) for which claimant has not received damages from the third party. Inasmuch as claimant's damages from the third party judgment were limited to a "November 4, 1991 to December 24, 1991" neck and upper back condition, we conclude that SAIF's lien should be similarly limited to claim costs attributable to those conditions during that period. Based on the Arbitrator's award, we find that those reimbursable claim costs total $523.41.

Finally, claimant contends that SAIF's recovery should be further reduced by 1/3 for "attorney fees." As we stated in Brush, we have consistently held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. See Theresa J. Lester, 43 Van Natta 338 (1991). Finding no support for claimant's request, we decline to further limit SAIF's recovery.

Accordingly, we hold that SAIF is entitled to recover $523.41 as its share from the third party judgment. ORS 656.593(1)(c). Claimant's attorney is directed to distribute to SAIF $523.41. Any remaining balance from the third party judgment shall be paid to claimant. ORS 656.593(1)(d).

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. NICHOLLS, Claimant
WCB Case No. MS-93003
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review under ORS 656.327(1)(b) of a Director's order finding no bona fide medical dispute. We set the order aside and remand.

FINDINGS OF FACT

Claimant has an accepted back injury as a result of an April 30, 1990 accident. On January 25, 1991 and March 29, 1991, the insurer denied chiropractic treatment on the basis that such treatment had not been approved by an attending physician, was not causally related to claimant's accepted condition, and was palliative in nature. Claimant requested a hearing from the denials.

Referee Davis found that the chiropractic treatment was not compensable because it had not been authorized by an attending physician or carried out under a written treatment plan. Claimant requested Board review of the Referee's order. On review, we concluded that, because the parties disputed whether or not chiropractic treatment was approved by an attending physician and should be characterized as palliative or curative, original jurisdiction of the matter rested with the Director. Therefore, we vacated those portions of the Referee's order determining that the disputed medical treatment was not approved by an attending physician and dismissed claimant's request for hearing.

We subsequently abated the order and issued an Order on Reconsideration to address whether the chiropractic treatment was causally related to claimant's accepted back injury, a question which the Board has original jurisdiction to consider. Concluding causation was proved, we modified our Order on Review only to the extent that it dismissed claimant's request for hearing with regard to the issue of causation.

After the Referee issued his Opinion and Order but before the Board issued its Order on Review, the parties entered into a Disputed Claim Settlement (DCS). That agreement expressly stated:

> "The issue of the compensability of chiropractic care denied by carrier's denials of January 25, 1991, and amended denial of March 29, 1991 was tried before Referee Robert Davis on August 22, 1991, resulting in an Opinion and Order dated November 20, 1991. This Stipulated Order in no way disposes of the dispute before Referee Davis in Case Number 91-01349. However, this Stipulated Order does dispose of issues relating to the compensability of claimant's current condition and the need for treatment therefore on and after the date of approval of this Stipulated Order." (Emphasis added).

The agreement also provided that "[c]laimant agrees to pay all unpaid bills for medical care rendered by a provider out of resources available to him, and to satisfy all claims or liens which may be asserted by any provider or insurer under ORS 656.289(4)." On December 31, 1991, the stipulation received referee approval.

Following the issuance of the Board's Order on Reconsideration, the insurer sought review by the Director under ORS 656.327 regarding the appropriateness of the disputed treatment. The Director's order stated:

> "When an insurer requests Director review, it is generally because the treatment is in dispute and the insurer wishes to be absolved of financial responsibility for that treatment. Here, the DCS appears to have done precisely that since [claimant] agreed to pay all unpaid bills for medical care rendered and to indemnify and hold harmless employer and carrier from all such claims."

Thus, the Director concluded that no bona fide dispute existed. Claimant requests Board review of the Director's order.

CONCLUSIONS OF LAW AND OPINION

Review by the Director of medical treatment may be requested by any party or the Director. ORS 656.327(1)(a). The Director is required to review the matter "[u]nless the director issues an order finding that no bona fide medical services dispute exists[.]" ORS 656.327(1)(b). Appeal of any order finding no bona fide medical services dispute exists is directly to the Board. Id. "The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding." Id.

Applying the statute to this case, we consider whether the Director's finding that the DCS made "moot" the issue of the appropriateness of medical treatment, resulting in no bona fide medical services dispute, is supported by substantial evidence. We conclude that the record does not permit a reasonable person to make such a finding.

We agree with the parties that the Director misconstrued the DCS. As stated above, the agreement disposed of claimant's medical treatment on and after the date of the DCS but exempted the chiropractic treatment litigated before Referee Davis. Although the DCS also stated that claimant would "pay all unpaid bills for medical care", we conclude that "unpaid bills" could not have included the chiropractic treatment denied on January 25, 1991 and March 29, 1991. In other words, in view of the agreement's express intent to exempt the issue of chiropractic treatment tried before Referee Davis, no reasonable person would construe the agreement as disposing of any issue regarding these medical services. Therefore, we conclude that the Director's order is not supported by substantial evidence.

The insurer, although agreeing that the Director misconstrued the DCS, argues that we should nevertheless affirm the order because substantial evidence exists to support the finding that it is not liable for the disputed chiropractic treatments. In particular, the insurer contends that this "substantial evidence" consists of the reasoning provided by Referee Davis' order that the medical services were not compensable because they were not approved by an attending physician or carried out under a written treatment plan.

Pursuant to this approach, ORS 656.327(1)(b) would be construed as allowing the Board to affirm an order if substantial evidence supported a theory leading to the result reached by the Director, even though that theory was not considered by the Director. In other words, the insurer is implying that we could affirm an order from the Director based on findings that were not included in the Director's order. We find no authority in the statute supporting this approach.

ORS 656.327(1)(b) first provides that the Board set aside or remand a Director's order finding no bona fide medical services dispute if the Board finds that the order is not "supported by substantial evidence in the record." Although that language is sufficiently general that it could support the insurer's construction of the statute, it is followed by the provision that "[s]ubstantial evidence exists to support a finding in the order" when the record would permit a reasonable person to make "that finding." We find that this definition of "substantial evidence" is proof of a legislative intent to limit our review of a Director's order finding no bona fide medical services dispute to those findings contained in the order.

This construction is also supported by our holdings regarding the Board's original jurisdiction over medical services disputes under ORS 656.327(1)(a). We have construed this provision, in conjunction with ORS 656.327(2) and 656.704(3), as placing original jurisdiction of disputes concerning medical treatment that allegedly is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" exclusively with the Director. See Stanley Meyers, 43 Van Natta 2643, 2645 (1991). In particular, we have found that objections regarding whether medical treatment has been approved by an attending physician or is palliative were within the scope of disputes included in ORS 656.327(1)(a) and, therefore, had to initially be determined by the Director. See Julie M. Harper, 44 Van Natta 820 (1992); Gladys M. Theodore, 44 Van Natta 905 (1992).

In this case, the Director made no findings regarding the appropriateness of the chiropractic treatment since the order found that the issue was made "moot" by the DCS. Were we to nevertheless address the merits of the compensability of the chiropractic treatment, in effect, we would be addressing an issue that has not been considered by the Director and thereby asserting original jurisdiction. In view of our previous holdings to the contrary, we decline to take this approach.

Consequently, having found that the Director's order is not supported by substantial evidence, we set it aside and remand to the Director for further proceedings consistent with this order. See ORS 656.327(1)(b).

ORDER

The Director's order dated February 4, 1993 is set aside. This case is remanded to the Director for further proceedings consistent with this order.

In the Matter of the Compensation of
NANCY E. O'NEAL, Claimant
WCB Case No. 91-12978
SECOND ORDER ON REMAND
Gatti, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our July 19, 1993 Order on Remand which directed SAIF to pay claimant's attorney an "out-of-compensation" fee and, in the event that such a payment created an overpayment, authorized SAIF to recover the overpayment against claimant's future permanent disability awards. Asserting that claimant's attorney should seek the fee from claimant, SAIF argues that it is not obligated to pay the fee because it has already paid claimant her compensation. See Gabriel M. Gonzales, 44 Van Natta 2399 (1992); Kenneth V. Hambrick, 43 Van Natta 1636 (1991); Gerald L. Billings, 43 Van Natta 399 (1991). On reconsideration, we adhere to our prior decision.

The relevant facts are as follows. On October 23, 1991, claimant, through her counsel, filed a "supplemental" hearing request.[1] Claimant sought additional temporary disability, as well as penalties and attorney fees for SAIF's failure to pay temporary disability at the correct rate. SAIF received a copy of this supplemental hearing request on October 24, 1991. On October 28, 1991, SAIF recalculated the rate of claimant's temporary disability and paid her increased benefits.

SAIF did not pay a portion of these increased benefits to claimant's attorney. SAIF's claim adjuster had an October 10, 1991 conversation with claimant's employer concerning claimant's actual wage rate. On October 14, 1991, SAIF received written confirmation of that wage rate from the employer. Although SAIF had received a copy of the supplemental hearing request by October 24, 1991, the request did not affect SAIF's claim adjuster's decision to recalculate claimant's temporary disability.

As held by the court (O'Neal v. Tewell, 119 Or App 329 (1993)) and repeated in our decision on remand, claimant's counsel's entitlement to an "out-of-compensation" attorney fee is not dependent on whether counsel was "instrumental in obtaining compensation." Rather, since the rate of claimant's temporary disability was increased without a hearing, counsel is entitled to an attorney fee payable from this increased compensation, equal to 25 percent of that increase, not to exceed $1,050.

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[1] On September 12, 1991, claimant, through her counsel, had filed an initial hearing request. Claimant sought increased temporary disability, as well as penalties and attorney fees for SAIF's allegedly unreasonable failure to timely pay temporary disability.

SAIF does not contest claimant's counsel's entitlement to an attorney fee. Instead, it objects to our decision requiring SAIF to pay that fee to claimant's counsel and receive authorization to recover this overpayment against claimant's future permanent disability awards. Noting that it already paid the increased compensation in advance of the hearing, SAIF asserts that claimant's counsel must collect the attorney fee from claimant. In support of its contention, SAIF relies on the Board's holdings in Hambrick, Billings, and Gonzales. We find each of these holdings to be distinguishable from the present situation.

In Hambrick, a referee's order granted increased compensation, but neglected to award an "out-of-compensation" fee from that increase. On review, following several reconsideration orders, we ultimately held that, although the claimant's counsel was entitled to an attorney fee, it would be inequitable to require the carrier to pay the fee "as a result of the Referee's error and claimant's failure to timely request correction of the error. Hambrick, supra, at page 1637.

In Gonzales, an Order on Reconsideration granted increased compensation, but did not award an "out-of-compensation" attorney fee because the claimant's counsel had not submitted a retainer agreement. By the time the claimant's counsel submitted an agreement and an amended order issued granted an "out-of-compensation" fee, the carrier had already fully paid the claimant's increased award. Reasoning that the initial order's failure to award an "out-of-compensation" attorney fee was attributable to the claimant's counsel's failure to submit a retainer agreement, we held that the counsel must seek payment from the claimant rather than the carrier.

In Billings, the parties had entered into a stipulation in which the carrier agreed to voluntary reopen the claimant's "own motion" claim under ORS 656.278 and pay temporary disability. The parties further agreed to submit an attorney fee dispute for resolution. The dispute concerned whether the fee would be "out-of-compensation" or carrier-paid. Pending resolution of that dispute, all compensation was paid to the claimant. We held that the fee was payable from the claimant's compensation. However, because the claimant's temporary disability had already been paid, we reasoned that the carrier was not obligated to reimburse the claimant's attorney.

Our review of these three holdings reveals a common theme. In each case, there was an action which the claimant's attorney could have taken to secure the attorney's receipt of an "out-of-compensation" fee. In Hambrick, the claimant's counsel could have sought reconsideration of the referee's order which omitted the "out-of-compensation" fee. In Gonzales, the claimant's counsel could have timely submitted a retainer agreement prior to issuance of the Department's Order on Reconsideration. In Billings, the claimant's counsel could have requested that an "out-of-compensation" fee been paid to the counsel pending resolution of the attorney fee dispute.

Since the claimants' counsels in those decisions failed to take such preventive actions, we reasoned that it would be inequitable to require the carriers to reimburse the claimants' counsels and create an overpayment. Instead, we determined that it would be appropriate for the counsels to seek reimbursement from their clients.

Here, in contrast, there was no preventive action that claimant's attorney could have taken to secure the "out-of-compensation" fee. Rather, the sole action available had been pursued; i.e., claimant's counsel filed a hearing request / executed retainer agreement and provided copies of those materials to SAIF. Moreover, those documents were received by SAIF prior to its payment of claimant's increased compensation prior to the hearing. Under these particular circumstances, we do not consider it inequitable to require SAIF to pay claimant's attorney the "out-of-compensation" fee with the accompanying authorization to recover the overpayment resulting from this order against claimant's future permanent disability awards on this claim.

Accordingly, our July 19, 1993 order is withdrawn. On reconsideration, as supplemented herein, we republish our July 19, 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
PEGGY A. OWEN, Claimant
WCB Case No. 92-11295
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Hoguet's order that upheld the SAIF Corporation's denial of her occupational disease claim for a psychological condition. On review, the issue is compensability.

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

On review, claimant contends that, although the Referee found that work was not the major cause of her psychological condition, he did not address whether work was the major contributing cause of her need for treatment in 1992.

We agree that a worker may prove either that employment conditions were the major contributing cause of the disease, or that work conditions were the major contributing cause of the worsening of the disease. ORS 656.802(2). However, in the present case, we do not find that claimant has met her burden of proof in this regard. Although "magic words" are not required, see McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), we agree with the Referee's conclusion that, in addition to the other deficiencies undermining Dr. Morganstern's opinion, the opinion does not establish that work is the major cause of claimant's disease or its worsening.

Finally, we agree with the Referee's conclusion that Dr. Parvaresh's opinion is based upon a complete history and contains a discussion of claimant's work and off-work stressors. Like the Referee, we rely upon Dr. Parvaresh's opinion and we, therefore, conclude that claimant has failed to establish a compensable psychological condition or a worsening of the condition. Consequently, we affirm the Referee's order.

ORDER

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

In the Matter of the Compensation of
DEBORAH G. PORTENIER, Claimant
WCB Case No. 92-02114
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Lipton's order that set aside its denials of claimant's current right wrist (superficial radial nerve injury) condition/surgery. On review, the issue is compensability.

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

The Referee relied on claimant's treating physician, Dr. Layman, to conclude that claimant had established the compensability of her right wrist condition as a consequence of her compensable bilateral de Quervain's disease and ensuing surgery. See ORS 656.005(7)(a)(A). On review, the insurer contends that the Referee neglected the opinions of Dr. Nathan and Dr. Stephens. After consideration of these opinions, we agree with the Referee that claimant's compensable de Quervain's disease is the major contributing cause of her current right wrist condition.[1]

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[1] In reaching this conclusion, we note that Dr. Stephens did not offer an opinion regarding causation and, in fact, could offer no explanation for claimant's symptoms. He merely advised claimant to return to Dr. Nathan if the symptoms persisted.

Dr. Layman, claimant's current treating physician, believes that claimant has an injury to the superficial radial nerve on the right side as a result of surgery to correct the compensable de Quervain's syndrome. Dr. Layman explained that claimant's findings of a Tinel sign (or tingling paresthesias radiating to the site of the distribution of the superficial radial nerve), coupled with decreased sensibility of the area supplied by the superficial nerve, was clinical evidence of a superficial radial nerve neuroma. According to Dr. Layman, claimant's July 1990 injury was the major contributing cause of both her de Quervain's syndrome and her present need for treatment.

Dr. Nathan performed claimant's December 1990 right wrist surgery. Determining that claimant's subjective complaints could not be substantiated, Nathan concluded that claimant had no organic problems in her hands and had recovered well from the de Quervain's release surgery.

Dr. Button performed an independent medical examination. Finding no evidence of a neuroma, Dr. Button concluded that claimant's complaints were not caused or aggravated by her work activity or the prior surgical procedures.

We generally defer to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we agree with the Referee that there are no persuasive reasons not to defer to Dr. Layman. Dr. Layman has treated claimant since November 1991, and is familiar with her symptoms. In addition, his reports are well reasoned and his opinion is explained and supported by the tests he has performed. Somers v. SAIF, 77 Or App 259 (1986).

On the other hand, Dr. Button saw claimant on only one occasion and was not aware until his deposition that Dr. Layman had performed a Tinel's test with positive results. Furthermore, when confronted with the positive "Tinel" finding, Dr. Button suggested that claimant may have become "streetwise" and learned how to give a positive result on the test. (Ex. 52-15). Since Dr. Layman has a greater familiarity with claimant's pattern of complaints and her behavior during the test, we defer to his observations and conclusions.

Dr. Nathan performed claimant's right de Quervain's release surgery in December 1990. Yet, Dr. Nathan has not seen claimant since August 1991. Since Dr. Layman has been treating claimant since November 1991 and has had the more recent opportunity to examine and treat claimant, we consider his observations to be more persuasive. Moreover, we find Dr. Nathan's opinion that claimant's complaints are unsubstantiated to be conclusory in comparison to Dr. Layman's thoroughly explained opinion. In any event, we note that Dr. Nathan was somewhat supportive of Dr. Layman's conclusion to the extent that Nathan stated that claimant's symptoms may be caused by a mechanical irritation of some fibers of the radial nerve, (although Dr. Nathan did not feel the symptoms indicated a disruption of the nerve severe enough to warrant surgery).

Finally, in denying claimant's right wrist condition, the insurer asserted that claimant's current complaints were neither caused nor "aggravated" by her work activities or her December 1990 compensable surgery. (Ex 48). Furthermore, at hearing, claimant raised aggravation as an issue. (Tr. 3). Inasmuch as the Referee did not address an aggravation issue, we proceed with our review of this issue.

In the absence of the proposed surgery, the record does not establish that claimant's current compensable right wrist condition represents a worsening of her compensable condition. (Ex. 41). Consequently, based on the present record, (one that was developed before resolution of the proposed surgery), we are unable to conclude that claimant's compensable condition has worsened. See Gary L. Waldrupe, 44 Van Natta 702 (1992). Such a conclusion should not be interpreted as a holding that, in the event claimant underwent surgery as a result of her compensable condition, such a procedure would not constitute a compensable aggravation claim.

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

ORDER

The Referee's order dated November 17, 1992 is affirmed.

In the Matter of the Compensation of
DONNIE D. TOMBERLIN, Claimant
WCB Case No. 92-10303
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Gruber's order that decreased claimant's unscheduled permanent disability award from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 12 percent (38.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant is 56 years old and has a high school diploma. At the time of his injury, claimant was a truck driver. Claimant's highest specific vocational pursuit (SVP) in the last ten years was as a truck driver, with an SVP of 4, DOT # 905-663-014.

CONCLUSIONS OF LAW AND OPINION

The Referee decreased claimant's unscheduled permanent disability award from 24 percent (76.8 degrees) awarded by the Order on Reconsideration to 12 percent (38.4 degrees). We modify.

Claimant became medically stationary on September 9, 1991, and his claim was closed by Determination Order on February 12, 1992. Since claimant became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Determination Order control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Determination Order. WCD Admin. Orders 2-1991, 7-1991 and 93-052.

The Referee concluded that since claimant had returned to his regular work after the injury, claimant was not entitled, under the Director's disability rating standards (former OARs 436-35-290(2); 436-35-300(2); 436-35-310(2)), to consideration of the "non-impairment factors" of age, education and adaptability in rating his disability.

Subsequent to the Referee's order, the Supreme Court held that a claimant's age, education and adaptability factors must be considered even if a claimant has an adaptability factor of zero under the Director's "standards." England v. Thunderbird, 315 Or 633 (1993).

In response to the Supreme Court's decision in England, supra, the Director amended OAR 436-35-280 through 436-35-310. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). OAR 436-35-280 now provides in relevant part:

> "The factors of age, OAR 436-35-290; education, OAR 436-35-300; and adaptability, OAR 436-35-310, shall be applied for losses identified in ORS 656.214(5) and described in OAR 436-35-320 through 436-35-500."

In conjunction with this provision, OAR 436-35-290 through OAR 436-35-310 (rules concerning age, education, and adaptability) now allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work following a compensable injury. As noted above, these amended temporary rules apply to all ratings of disability made on or after June 17, 1993, and thus, are applicable to the instant case. OAR 436-35-003(4); OAR 438-10-010; Melvin E. Schneider, 45 Van Natta 1544 (1993). Accordingly, we apply the amended rules.

Age

Claimant is 56. Accordingly, he is entitled to a value of 1 for age under the standards. OAR 436-35-290(2).

Education

Claimant has earned a high school diploma for a value of 0. OAR 436-35-300(2)(a). Claimant's highest SVP during the ten years preceding the time of determination is 4, as a truck driver (DOT # 905-663-014). Accordingly, claimant is entitled to a value of 3 under the standards. OAR 436-35-300(3)(e). Claimant does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less. Therefore, he is entitled to an additional value of 1. OAR 436-35-300(4). Claimant's education value is 4. OAR 436-35-300(5).

Adaptability

On review, claimant disagrees with the Referee's conclusion that he returned to his regular work. Former OAR 436-35-270(3)(c) defines "regular work" as substantially the same job held at the time of injury. Claimant testified that his treating physician released him to regular work after his industrial injury. Claimant avoids lifting a 100 pound tarp when the loads he carries require a tarp and occasionally gets help tightening binders when they have to be extremely tight. However, we agree with the Referee that claimant's job and job duties have not been modified in any substantial way. See also Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992) (holding that a worker returned to his usual and customary work when the only variation in his job was that it was occasionally necessary for him to have assistance replacing lumber that had fallen from a conveyor belt). Claimant performs substantially the same job that he performed at injury. Accordingly, we agree that claimant has returned to his regular work.

OAR 436-35-310 governs adaptability. 436-35-310(2) provides for an adaptability value of 1 where, as here, the worker returns to the same job he held at the time of injury. See Melvin E. Schneider Jr., supra. Claimant's physician released him to regular work and the strength requirement for his regular work as a truck driver is medium. Therefore, claimant's residual functional capacity (RFC) is the same as it was prior to the compensable injury. See OAR 436-35-270(3)(d) (maximum residual functional capacity is the greatest capacity evidenced by the attending physician's release, a preponderance of medical opinion which includes, but is not limited to a second level PCE or WCE, or the strength of any job at which a worker has returned to work). Accordingly, claimant is entitled to an adaptability value of 1. OAR 436-35-310(2)(Temporary Rules, June 17, 1993, WCD Admin. Order 93-052).

Impairment

While the parties agree that the Referee correctly used the medical arbiter's impairment findings to rate claimant's impairment, SAIF contends that the Referee applied the incorrect subsections of former OAR 436-35-360. The insurer contends that the Referee applied former OAR 436-35-360 subsections (7),(8) and (9), which are to be used when the loss of motion is measured by a goniometer. Here, SAIF contends, the medical arbiter measured claimant's loss of motion using an inclinometer. Former OAR 436-35-360 subsections (19),(20) and (21) are used when the loss of range of motion is measured by inclinometer. We agree with SAIF.

Accordingly we apply the correct subsections of former OAR 436-35-360. Based on the medical arbiter's findings, claimant has 50 degrees flexion in the lumbar spine, which entitles him to a value of 2 percent. Former OAR 436-35-360(19). Claimant has 8 degrees of extension for a value of 5.4 percent. Former OAR 436-35-360(20). Claimant has 10 degrees right flexion for a value of 3 percent and 20 degrees left flexion for a value of 1 percent. Former OAR 436-35-360(21). These values are added for a total impairment value of 11.4. Former OAR 436-35-360(22).

OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the values for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Applying these rules to the instant case, when the total value for claimant's age and education (4) is multiplied by the adaptability value (1), the total is 4. When this value is added to the value for impairment (11.4), the result is 15.4 which is rounded to 15. Former OAR 436-35-007(11). Therefore, claimant's unscheduled permanent disability is 15 percent.

ORDER

The Referee's order dated October 30, 1992, as reconsidered November 20, 1992, is modified. In lieu of the Order on Reconsideration and in addition to the Referee's award of 12 percent (38.4 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) which gives him a total award of unscheduled permanent disability to date of 15 percent (48 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

August 18, 1993 Cite as 45 Van Natta 1597 (1993)

In the Matter of the Compensation of
NEIL M. WALKER, Claimant
WCB Case No. 92-09908
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Spangler's order that: (1) dismissed claimant's hearing request concerning the compensability of an occupational disease claim for a low back condition; and (2) declined to address the compensability issue. On review, the issues are the propriety of the dismissal order and compensability. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in September 1988. In April 1992, the insurer issued a denial of claimant's current condition and need for treatment under the 1988 claim. Claimant appealed the denial and a hearing was held in July 1992. By order dated August 10, 1992, an earlier referee found that claimant's current condition was compensable as an aggravation of the September 1988 injury. On April 30, 1993, we affirmed the August 10, 1992 referee's order.

At the prior hearing concerning the aggravation claim, the specific issue was whether claimant's current back condition remained causally related to his 1988 compensable injury. At that hearing, claimant's attorney also "reserved" a potential occupational disease claim for later litigation. Without objection from the insurer, the prior referee bifurcated the occupational disease claim and assigned it a new WCB case number.

The present hearing involves claimant's attempt to litigate the "reserved" occupational disease claim. The present Referee concluded that, since the 90 day period in which to accept or deny the claim had not expired when the compensability issue was "reserved" at the prior hearing, the issue of compensability of claimant's back condition as an occupational disease was not ripe. Reasoning that there was no valid hearing request regarding the occupational disease claim, the Referee dismissed. We disagree.

At the prior hearing in July 1992, claimant's attorney acknowledged that the insurer was still within the 90 day statutory period in which to accept or deny claimant's occupational disease claim (which had been made only a month before the July 1992 hearing). Consequently, claimant's attorney sought to "reserve" the issue. The insurer was not prepared to deny the claim at the July 1992 hearing,

but it did not object when the prior referee created a new WCB number for the occupational disease claim and reserved that issue for later litigation. Moreover, when the insurer requested review of the prior referee's order deciding the other issues raised by claimant's request for hearing, it did not request review of that portion of the prior referee's order which had bifurcated and preserved the occupational disease claim and assigned it a separate WCB case number.

The "reservation" or "preservation" of issues raised by a request for hearing amounts to a dismissal of those issues without prejudice when the referee issues a final order addressing other issues raised by the request for hearing. See e.g., Claudia I. Hamilton, 42 Van Natta 600 (1990). The parties then have leave to raise the issues that were "reserved" at any time within the time limits set out by ORS 656.319. Id. In Hamilton, certain issues (arising from a Determination Order) were "reserved," as a prior referee finally resolved other "nonreserved" issues raised by the claimant's hearing request. The prior referee did not assign the "reserved" issues a new WCB case number. When the claimant subsequently sought to litigate the "reserved" issues, we held that the Determination Order had become final because there had been no timely appeal.

Here, as in Hamilton, claimant sought to reserve an issue raised by his hearing request. Specifically, the compensability of his occupational disease claim. However, unlike Hamilton, the "occupational disease" hearing request was expressly bifurcated and assigned a new WCB case number. Furthermore, the insurer did not raise an objection to this bifurcation and reassignment. Under such circumstances, we hold that claimant's appeal was preserved and he was not required to re-request a hearing on the compensability issue in order to preserve his appeal of that issue.

Our holding in Laura L. Brumfield, 45 Van Natta 796 (1993), supports this conclusion. In Brumfield, with the agreement of the parties, a prior referee preserved a compensability issue for later adjudication. A second referee declined to consider the compensability issue on the grounds that the hearing request on that issue was initially premature, then untimely. We held that since the actions of the first referee had preserved the appeal, no new hearing request was required to give the second referee jurisdiction over the question of compensability.

Here, although the compensability issue was premature at the July 1992 hearing, the 90 day period in which to accept or deny the claim expired prior to the October 1992 hearing. Therefore, the claim has been "de facto" denied. See Barr v. EBI Companies, 88 Or App 132 (1987). As a consequence, the occupational disease claim was ripe for adjudication and was properly before the Referee for hearing on October 20, 1992.

The Referee did not dismiss the case until he issued his order. Therefore, claimant's testimony was taken and exhibits were admitted concerning the occupational disease issue. However, in light of his dismissal decision, the Referee did not render findings concerning claimant's credibility (demeanor) as a witness or evaluate the evidence concerning the occupational disease issue. Under such circumstances, we consider the current record to be insufficiently developed. See ORS 656.295(5); Refugio Guzman, 39 Van Natta 808 (1987). Accordingly, we find it appropriate to remand this matter to the Referee for reconsideration.

Before issuing his order on remand, the Referee shall permit the parties an opportunity to submit their respective arguments regarding the compensability of claimant's occupational disease claim. Those arguments should address the question of whether claimant's occupational disease claim is barred by the previous litigation which determined that claimant's low back condition was compensable as an aggravation. See, e.g., Derek J. Schwager, 45 Van Natta 428 (1993); Christopher H. Peppler, 44 Van Natta 856 (1992); Chella M. Morton, 43 Van Natta 321 (1991). These arguments may be presented in any matter that the Referee determines will achieve substantial justice. After completion of this argument phase of the remand procedures, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated October 30, 1992 is vacated. Claimant's hearing request is reinstated. This matter is remanded to Referee Spangler for further proceedings consistent with this order.

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 92-09437
ORDER ON REVIEW
Doblie, et al., Claimant Attorneys
Bottini, et al., Defense Attorneys

Claimant requests review of Referee Hoguet's order that found he was not entitled to temporary disability benefits as a result of a compensable TMJ surgery claim. On review, the issue is temporary disability benefits.

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

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of his worsened condition. 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).

At the outset, we note that claimant contends that since Dr. Merrill initially requested the TMJ surgical procedure in October 1989, that is the "time of his worsening" for purposes of determining whether he was in the work force. We disagree. While Dr. Merrill did recommend surgery at that time, the surgery was not performed, nor was there any evidence suggesting that claimant's TMJ condition had worsened. Moreover, to the extent that claimant did claim a worsened condition at that time, the employer issued an aggravation denial on June 4, 1990. That denial has not been set aside. In addition, assuming arguendo that October 1989 is the proper time to evaluate claimant's work force status, for the reasons set forth below concerning claimant's willingness to work, we would still find that claimant was not in the work force.

Accordingly, the proper time at which to determine whether claimant was in the work force is March 1992, the date of his most recent worsening. At the time of his March 1992 worsened condition, claimant was not engaged in regular gainful employment. In addition, claimant was not seeking employment at that time. Therefore, in order to prove entitlement to temporary disability benefits, claimant must show that he was willing to work, but not seeking work at that time because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, supra.

In a prior proceeding (WCB Case No. 89-02361) arising from a February 1989 Determination Order, the Board concluded that claimant was not permanently and totally disabled. Dean L. Watkins, 43 Van Natta 527 (1991). In reaching this conclusion, the Board stated that:

> "Claimant stopped working after his first TMJ surgery in April 1984. He has not sought work since a failed attempt to perform dispatching work. Claimant quit that work for reasons unrelated to the injury. He is not motivated to return to the work force. Moreover, there is no evidence to establish that a work search would be futile." Id. at 536.

While a prior finding does not irrevocably commit claimant to retirement for purposes of workers' compensation benefits, he must show that he is presently willing to seek work and that it is presently futile to seek work. Wausau Ins. Companies v. Morris, 103 Or App 270 (1990) on remand 42 Van Natta 2820 (1990).

The only evidence with regard to claimant's willingness to work comes from his testimony. Claimant testified that he felt he could have performed a truck dispatching job during the previous two years, had such job been offered to him. (Tr. 20). Claimant also testified that he would like to go back to driving truck or other employment in the trucking field after he recovered from surgery. (Tr. 18). However, neither statement establishes that claimant was willing to work in March 1992, the date of his worsening. In addition, the Referee found, and we agree, that claimant is not a credible witness.

Finally, the Board found that claimant was not motivated to work at the time of his 1989 claim closure. Dean L. Watkins, supra at 536. Thus, lacking persuasive evidence to demonstrate that claimant's attitude toward returning to the labor market has changed since the Board's earlier order, we consider claimant's statements inadequate to satisfy the requisite burden of proof for entitlement to temporary disability benefits. Wausau Ins. Companies v. Morris, supra.[1] Furthermore, given the adverse credibility findings made by Referees and the Board in prior cases, we have considerably less cause than we might otherwise have to depart from the Board's policy of deferring to credibility findings made by the Referee based on the witness' demeanor. Here, the Referee made a specific demeanor/credibility finding.

As to the exception expressed by the dissent to the Supreme Court's holding in Dawkins v. Pacific Motor Trucking, supra (that a willingness to work must be shown even if a reasonable work search would be futile), it is the majority's view that the Court's decision constitutes the law, and as a lesser agency of the executive branch, we have no alternative but to obey it.

ORDER

The Referee's order dated December 15, 1992 is affirmed.

---

[1] Claimant contends that the insurer conceded that he was in the work force at an earlier hearing. While counsel for the insurer indicated that she "thought" time loss would commence at some point in the future, there is no concession pertaining to claimant's work force status. (Ex. 239AA-6). Moreover, the hearing at which this "concession" took place did not involve the surgery/aggravation claim that is presently disputed. Rather, it involved claimant's entitlement to temporary disability benefits allegedly payable after March 13, 1991 pursuant to a prior Referee's order that had been appealed to the Board. Accordingly, we do not find that the insurer previously conceded that claimant was in the work force as of March 1992. In addition, even if the insurer had made such a concession, it is not now precluded from making that contention as it could not and did not intentionally relinquish its right to assert that claimant was not a member of the work force in March 1992. See Drews v. EBI Companies, 310 Or 134 (1990); Michael J. Eby, 42 Van Natta 2604 (1990).

Board Member Gunn, dissenting.

To begin, I agree with the Referee and my respected colleagues that claimant's condition has worsened and that it would be futile for claimant to seek work. Where I part from the Referee and the majority is the determination that claimant is not "willing" to work and therefore not in the work force under Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The Dawkins court attempted to set forth a test for determining whether or not a claimant was in the work force and therefore entitled to temporary disability benefits. It is the last prong of the Dawkins test which is the most puzzling and problematic as is illustrated by this case. Under Dawkins, supra, a claimant may establish that it is futile for him to seek work. However, unless he also establishes that he is willing to work (even though a finding of futility has been made), he is not entitled to temporary disability benefits. Requiring that a claimant satisfy both of these requirements does not make any sense.

The concept of a "futile" work search has long been used in permanent total disability cases. By statute, a worker seeking permanent total disability must establish that he is "willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment." ORS 656.206(3). However, a worker is not required to literally satisfy this provision, if he establishes that a work search would be futile. Butcher v. SAIF, 45 Or App 313 (1980). This approach recognizes that there are situations where it would be unrealistic to make a worker establish that he was motivated to work even though his compensable injury precludes gainful employment. As the court in Butcher stated:

> "We do not believe that the legislature intended that every injured worker, regardless of capacity to do so, must demonstrate an effort to become employed even where it is clear that such an effort would be in vain." Id. at 577.

Although this approach makes good sense and reflects an understanding of real life, the court decided it wasn't enough. In SAIF v. Stephens, 308 Or 41 (1989), the Court held that a worker not only had to prove that because of the compensable injury a work search was futile, but also establish that but for the compensable injury, he is or would be willing to seek work. Id. at 48. Thus, a worker not only had to prove futility, but also prove a hypothetical. "Assuming you didn't have the compensable injury, would you be willing to work?" Finally, by way of a Cf. cite, the Dawkins court grafted this concept into cases involving entitlement to temporary disability benefits which brings us to the present case. Dawkins, supra at 258.

Here, the Referee and the majority find that it would be futile for claimant to seek work. However, claimant is denied temporary disability benefits because of his lack of credibility and lack of change in attitude with regard to the hypothetical question. While I understand that the majority is constrained to follow the Court's decision in Dawkins, I question the wisdom of denying benefits solely based on the "wrong" answer to a hypothetical question. This is particularly evident where, as here, the denial of benefits is based, at least in part, on finding that claimant did not credibly answer the hypothetical question. This is particularly strange when you consider that the basis for the question is not true. That is, claimant does have a compensable injury.

In truth I never quite understood why when after finding that looking for work is futile we continue to seek a worker's willingness. I myself have never been willing to work. It was always thrust upon me by my craven desires for food, clothing and shelter. Certainly if due to injury or illness any such effort would be futile, I would find it nigh impossible to be willing to work. It would be oxymoronical to expect both conditions to even co-exist.

This man has not worked since his industrial injury. I am unable to ascertain from this record why he hasn't. I am inclined to believe that five surgeries and two years trapped inside the worker compensation legal system are enough reasons. Like the Referee, I find the claimant has worsened and that to look for work would be futile. Whether or not claimant is hypothetically willing to work, had he not suffered the compensable injury, should not be a relevant consideration and certainly not a basis to deny benefits. For these reasons, I dissent.

In the Matter of the Compensation of
RUBY S. WHITTLEY, Claimant
WCB Case No. 91-11913
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Michael V. Johnson's order which: (1) upheld the self-insured employer's "de facto" denial of claimant's current psychological condition; (2) declined to assess a penalty or related attorney fee for the employer's alleged failure to timely accept or deny the claim; and (3) dismissed claimant's request for hearing on an Order on Reconsideration for lack of jurisdiction. On review, the issues are compensability, jurisdiction, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. We do not adopt the last paragraph in the Referee's Findings of Fact section, on page 3 of the order.

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

The Referee analyzed claimant's psychological condition claim as a secondary consequence of her compensable knee and ankle injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Saura C. Stewart, 44 Van Natta 2595 (1992). To establish the compensability of such a claim, claimant

must prove by a preponderance of the evidence that her compensable injury is the major contributing cause of the psychological condition. ORS 656.005(7)(a)(A). We agree with the Referee's analysis. However, after our review of the record, we conclude that the record as a whole establishes the compensability of claimant's psychological condition.

Dr. Pitchford, claimant's treating psychologist, opined that claimant's inability to ambulate is the major contributing cause of the onset of her psychological condition. (Ex. 88-21 to -22). Dr. Pitchford explained that claimant's compensable knee injury "triggered" her depression by breaking down her coping mechanisms (i.e., staying very busy), which had been working well for claimant up until her compensable injury. (Ex. 88-16, 88-53 to -55).

Dr. Pitchford acknowledged that in treating claimant's psychological condition, she did not distinguish between claimant's compensable knee condition and her non-compensable hip, back and obesity conditions with regard to their respective contribution to claimant's inability to ambulate. Thus, Dr. Pitchford could not state whether claimant's compensable knee condition was more the cause of her inability to ambulate than all non-compensable factors combined. (Ex. 88-57 to -58).

However, we find that the question of the relative contribution of compensable and non-compensable conditions to claimant's inability to ambulate is a medical question that is beyond the scope of Dr. Pitchford's expertise as a psychologist. Therefore, we look to the opinions of the medical doctors for assistance in resolving this question.

Dr. Mayhall, claimant's treating orthopedist, believed that claimant developed a reactive depression related to her work injury. (Ex. 77). Dr. Burr, orthopedist, and Dr. Mead, neuropsychiatrist, conducted an independent medical examination and opined that claimant suffered from "[a]adjustment disorder with mixed features of depression and anxiety - related to injury and sequelae." (Ex. 64-5). We find no contrary medical opinion regarding causation of claimant's psychological condition. Accordingly, we conclude that the medical physicians' reports identify claimant's work injury as the sole causal factor in the development of claimant's psychological condition.

In addition, claimant testified that after her second or third knee surgery, she became "nervous," tearful, and panic-stricken due to feeling that she could not move quickly enough in an emergency situation. (Tr. 15-16). Prior to her work injury, claimant testified that she had been physically very active. (Tr. 11-13).

Accordingly, based on the record as a whole, we find that the preponderance of evidence establishes that claimant's compensable knee and ankle conditions are the major contributing cause of her psychological condition. Therefore, we set aside the employer's "de facto" denial of claimant's psychological condition.

Premature Closure

A Determination Order issued December 19, 1990, closing claimant's claim with an award of scheduled permanent disability for loss of use or function of her legs, and finding claimant to be medically stationary on August 28, 1990. (Ex. 78). Claimant's psychological condition was not rated, nor was it accepted at that time. Claimant requested reconsideration, alleging that her claim was prematurely closed because her psychological condition was not yet medically stationary. (Ex. 82A). An Order on Reconsideration issued on August 30, 1991, affirming the Determination Order in all respects. (Ex. 86). Claimant requested a hearing on the Order on Reconsideration.

We have herein found claimant's psychological condition to be compensable. We further find that Dr. Pitchford, claimant's treating psychologist, opined that claimant was not yet medically stationary with respect to her psychological condition on December 9, 1991. (Ex. 88-26). Therefore, we find that claimant's psychological condition was neither rated nor ratable at the time the Determination Order issued on December 19, 1990. Accordingly, since the Determination Order did not consider a compensable component of her claim, and since claimant was not yet medically stationary with respect to her compensable psychological condition, we set aside the Determination Order as premature.

In doing so, we reject the employer's argument that we lack jurisdiction to set aside the Determination Order because a medical arbiter's report was not submitted to the Director prior to issuance of the Order on Reconsideration. See ORS 656.268(7); Mary A. Dyer, 44 Van Natta 1527 (1992). While it is true that claimant requested reconsideration of the Determination Order based on a disagreement with her attending physician's impairment findings, we find that she subsequently waived her objection.

In her reconsideration request, claimant stated: "Request is made for medical arbiter to rate the knees and psychological component if medically stationary." (Ex. 82A-2). (Emphasis added). Based on that statement, we find that claimant's request for appointment of a medical arbiter (and, hence, her objection to impairment findings) was conditioned on the determination that her compensable condition is medically stationary. We have found that claimant was not medically stationary at the time of claim closure and, therefore, her claim was prematurely closed. Under such circumstances, we conclude that claimant has effectively waived her objection to the impairment findings. In view of claimant's waiver, we conclude that the Order on Reconsideration is procedurally valid for our review and that we have jurisdiction to set aside the premature Determination Order. See Mark A. Pendell, 45 Van Natta 1040 (1993); Brenton R. Kusch, 44 Van Natta 2222 (1992).

Penalties/Attorney Fees

Because we have found claimant's psychological condition compensable, we address claimant's request for penalties and attorney fees for the employer's alleged failure to timely accept or deny the claim by creating a "de facto" denial of the claim. On review, the employer concedes it failed to timely deny claimant's psychological claim, and it offers no explanation for its delay. We find the employer's unexplained delay in accepting or denying the claim to be unreasonable. See ORS 656.262(10). Accordingly, we assess a penalty in the amount of 25 percent of the amounts then due at the time of the hearing (as a result of this order). One-half of the penalty shall be paid to claimant and one-half to her attorney in lieu of an attorney fee. ORS 656.262(10). Because the factual basis for an attorney fee under ORS 656.382(1) is the same as the basis for the penalty under ORS 656.262(10), claimant is not entitled to an additional attorney fee under ORS 656.382(1). Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Claimant is entitled to an assessed attorney fee for prevailing on the issue of the compensability of her psychological condition. 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 compensability of the psychological condition is $4,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved. However, we note that claimant is not entitled to an attorney fee for prevailing on the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 21, 1992 is reversed. The self-insured employer's "de facto" denial of a psychological condition is set aside, and the claim is remanded to the employer for processing according to law. The employer is assessed a penalty based on amounts of compensation due at the time of hearing as a result of this order, payable in equal shares to claiment and her attorney. The December 19, 1990 Determination Order is set aside as premature. Claimant's attorney is awarded $4,000 for services at hearing and on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
CARL F. JUDD, Claimant
WCB Case No. 92-11996
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Nichols' order that: (1) upheld the insurer's "de facto" denial of a cervical spondylosis condition; and (2) affirmed the Order on Reconsideration which awarded claimant 15 percent (48 degrees) unscheduled permanent disability. In its brief, claimant contends that, if the cervical spondylosis condition is compensable, any resulting impairment should be included in the calculation of claimant's unscheduled partial disability. On review, the issues are compensability and extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant's shoulder problem was initially diagnosed as tendinitis. (Ex. 1A).

The cervical CT scan revealed osteophytes at C5-6 and uncinate hypertrophy. (Ex. 8).

In March 1992, the insurer accepted claimant's right shoulder claim as a disabling right shoulder strain. (Ex. 13).

FINDINGS OF ULTIMATE FACT

Claimant's work activities for the employer were the major contributing cause of his cervical spondylosis condition. This condition was established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant contends that his cervical spondylosis condition is compensable. We agree.

An occupational disease is 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 employment and which required medical services or results in disability or death, including any series of traumatic events or occurrences. ORS 656.802(1)(c). The worker must prove that employment conditions were the major contributing cause of the disease or its worsening, and the existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

The parties do not dispute the diagnoses of cervical spondylosis by Drs. Peterson and Stevens which were supported by objective findings. Their sole disagreement concerns whether claimant's work exposure is the major contributing cause of that condition.

The issue of causation in this case 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).

As noted by Dr. Peterson, claimant worked for over 40 years as a pressman for the employer. His job consisted of loading the presses with paper and pulling and pushing knobs and equipment associated with the press. This involved frequent work at shoulder height and frequent reaching. After Dr. Peterson diagnosed cervical spondylosis, he concluded, without discussion or explanation, that it was not a result of claimant's employment.

In contrast, Dr. Stevens, claimant's attending physician, specifically disagreed with Dr. Peterson's opinion. Dr. Stevens explained that claimant has never had a known injury to his neck, such as accidents, falls, or landing on his head. He further stated that both the shoulder impingement condition and the cervical spondylosis condition were more likely than not related to claimant's repetitive overuse in his forty years' work as a pressman. Dr. Stevens concluded that claimant's long-term work exposure is the major contributing factor in his right shoulder impingement and, he suspected, in the cervical spondylopathy as well. (Exs. 7 and 9). Dr. Melgard also opined that claimant's longstanding work as a pressman contributed to his shoulder difficulty. (Ex. 10).

Although Dr. Stevens used the word "suspect," in the context in which it was used, we find it amounts to more than mere suspicion. Stevens had already firmly stated that he disagreed with Dr. Peterson's opinion that work was not the major cause of either of claimant's shoulder conditions and explained his basis for that disagreement in his chart note of October 18, 1991, as noted above. We therefore infer that Dr. Stevens believes that it is more probable than not that the major cause of claimant's cervical condition is his work activities.

In the absence of any explanation for Dr. Peterson's opinion that summarily rejected claimant's work as a possible cause of his condition, we give more weight to Dr. Stevens' opinion. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, the use of "magic words" is not required where, as here, the record as a whole satisfies claimant's burden of proof. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Consequently, we conclude that claimant has proved that his employment conditions are the major contributing cause of his cervical spondylosis. That condition is compensable.

Extent

Before a claim may be closed, claimant must be medically stationary from all conditions resulting from the compensable injury or occupational disease. ORS 656.268(1); Kociemba v. SAIF, 63 Or App 557 (1983); Mary Jay McKenzie, 44 Van Natta 2302 (1992).

Dr. Stevens referred claimant to Dr. Melgard, neurologist, for recommendations as to further treatment for claimant's cervical spondylosis condition. Melgard ruled out surgery and did not recommend further treatment. There is no evidence that, after considering Melgard's opinion, Dr. Stevens contemplated any further treatment of the cervical condition. We therefore conclude that claimant was medically stationary as to his cervical spondylosis condition, as well as his other shoulder condition, on April 29, 1992, the date Dr. Stevens declared him medically stationary. (Ex. 14). ORS 656.268(1); Kociemba v. SAIF, supra; Mary Jay McKenzie, supra. Thus, the claim was properly closed.

Based on claiment's timely hearing request from the Determination Order and Order on Reconsideration, we have authority to determine the extent of permanent disability resulting from his compensable condition, including the cervical spondylosis. See, e.g., Diane M. Shipler, 45 Van Natta 519, 520-21 (1993).

The parties stipulated to the non-impairment unscheduled disability factors as having been correctly decided on reconsideration. Because the parties do not dispute the value given for claimant's age, education and adaptability of (8), we adopt this value when we calculate claimant's permanent disability and discuss only the value for impairment.

Claimant contends that, because the only orthopedic examination of record is the IME of August 24, 1991, that examination should be used to determine the impairment due to claimant's cervical spine. We disagree.

Impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior relevant impairment findings. Relevant impairment findings include the findings of the attending physician at the time of claim closure or any findings with which he or she concurred, as well as the findings of the medical arbiter when one is appointed. Raymond L. Owen, 45 Van Natta 1528 (1993). Dr. Stevens did not concur with the independent examiner's findings. Accordingly, we consider only the impairment findings of the attending physician and the medical arbiter. Owen, supra.

After reviewing the evidence regarding the extent of claimant's impairment, we affirm and adopt the Referee's opinion on this issue with the following supplementation.

Temporary rules contained in WCD Admin. Order 93-052 apply to all ratings of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). The applicable standards, as amended by the temporary rules, are those in effect at the time of the Determination Order. WCD Admin Orders 6-1992 and 93-052 (Temp.). Because the temporary rules affect only non-impairment factors, which are not at issue here, they have no effect on the outcome of this case.

In addition to the Referee's reason for relying on the medical arbiter, we add the following. The range of motion or laxity in an injured joint must be compared to the contralateral joint, except when the contralateral joint has a history of injury or disease. OAR 436-35-007(15). Because the medical arbiter provided contralateral joint comparisons, and the attending physician did not, we find that the findings of the medical arbiter are most persuasive.

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 claimant's appellant briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order is dated December 21, 1992 is reversed in part and affirmed in part. The insurer's "de facto" denial of claimant's cervical spondylosis condition is set aside, and the claim 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. The remainder of the referee's order is affirmed.

In the Matter of the Compensation of
RAMON M. MARIN, Claimant
WCB Case No. 92-07796
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Daughtry's order that set aside its denial of claimant's injury claim for both legs, knees, and right ankle. On review, the issue is course and scope of employment.

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

SAIF cites Allbee v. SAIF, 45 Or App 1027 (1980), for the proposition that claimant was on a "personal mission" when he was injured in his employer's parking lot after work. We find Allbee, supra, distinguishable from the present case and, therefore, agree with the Referee's conclusions, with the following supplementation.

In Allbee, claimant drove from his home in Dayton to Newberg, where he bought a set of tire chains. He then drove to his employer's premises in Northeast Portland, arriving approximately at 1:00 in the afternoon. When he entered his office, he found it empty, as no other employees had shown up to work, due to snow and icy conditions. Claimant then left the office, intending to put chains on his tires. Claimant testified that he slipped and fell on the ice in the parking lot. The court found that it was more probable than not that claimant fell in the street; however, regardless of where he fell, the court found that claimant was on a personal mission when he left his office to put chains on his car. Allbee, supra.

In Boyd v. SAIF, 115 Or App 241 (1992), the claimant's injury occurred while she was climbing into her car to leave work after finishing her shift. The incident happened in a parking lot controlled by the employer. When the claimant started to get into her car, her knee twisted, she heard a popping sound, and experienced immediate pain. On these facts, the court found a work-connection sufficient to support the conclusion that the injury arose within the course and scope of the worker's employment. Thus, the claim was held to be compensable. The Boyd court distinguished the facts from those in Allbee, and found that in Allbee, the worker was on a personal mission when he fell on the ice in the employer's parking lot while putting tire chains on his car. Boyd, supra.

Here, we find the facts of the present case to be closer to Boyd than Allbee. Unlike the claimant in Allbee, claimant completed a full day of work and walked to the parking lot with the intent to leave work. However, he discovered that his car battery was dead, which prevented his departure from work until he could get a jump start. In other words, it was the dead car battery which necessitated claimant to find a way to start his car before he could complete his intended departure from work. In Allbee, on the other hand, the worker was not leaving the employer's premises after a day's work. Furthermore, the Allbee claimant was injured when he chose to first put tire chains on his car for his own personal benefit of security before leaving. Consequently, we find the case to be distinguishable.

Finally, we note that the Boyd court has stated that the fact that an injury occurs on employer-controlled premises while the employee is traveling to and from work makes the incident sufficiently work connected. Boyd, supra, 115 Or App at 244. Consequently, because claimant's injury occurred while he was attempting to leave work and in a parking lot controlled by the employer, we find that claimant has proven a work relationship sufficient to establish legal causation. See also William F. Gilmore, 45 Van Natta 410 (1993); Shirley D. Ward, 45 Van Natta 388 (1993).

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 course and scope issue is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 21, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an approved fee of $1,000, to be paid by the SAIF Corporation.

August 19, 1993 Cite as 45 Van Natta 1607 (1993)

In the Matter of the Compensation of
PHILL SANDERS, JR., Claimant
WCB Case No. 91-18448
ORDER ON REVIEW
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant, pro se, requests review of Referee Barber's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. With his brief, claimant submitted additional documents that were not admitted at hearing. We treat such submission as a motion for remand. On review, the issues are evidence, conflict of interest, 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

Preliminary Matter

Claimant has included documents with his brief that were not admitted at hearing. As stated above, we treat this action as a motion to remand to the Referee for further evidence taking.

Under ORS 656.295(5), we may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, claimant has submitted documents from his personnel file. There is no indication that such documents were not obtainable at hearing. Therefore, we conclude that claimant has not shown a compelling reason for remand and we deny his motion.

Evidence

Claimant objects to the admission of Exhibit A, which consists of claimant's personnel records, and Exhibit 1, a memorandum from Karen Hutchison, claimant's supervisor, to Clark Nelson, a manager. In particular, claimant asserts that Exhibit A was not disclosed to him or his attorney until the day of the hearing, contrary to OAR 438-07-015, and that some missing pages from Exhibit 1 were not submitted until after the hearing.

The record shows that claimant did not object to the admission of Exhibit A when it was submitted at hearing. (Tr. 83-84). Furthermore, there is no evidence that claimant objected to the post-hearing submission of some parts of Exhibit 1. Having failed to preserve his objections to the admission of these documents, claimant is precluded from raising his objections on review. See Marty L. Hornback, 44 Van Natta 975 (1992); Joseph B. Beaulieu, 40 Van Natta 1199, 1200 (1988).

Claimant did object at hearing to the admission of Exhibit 21, a report from the Equal Employment Opportunity Commission (EEOC). Specifically, claimant asserts that the report was not relevant to his claim for workers' compensation.

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 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).

Claimant filed a complaint with the EEOC, alleging that he had been harassed by Karen Hutchison on the basis of his race and sex. The EEOC issued a determination, based on its investigation, that claimant had not been subjected to illegal harassment based on his race or sex. (Ex. 21). Claimant, to some extent, also based his workers' compensation claim on the assertion that he experienced racial and sexual harassment. He told Dr. Glass, psychiatrist, who conducted an independent medical examination, about this belief, (Ex. 19-3), and testified at hearing that he was given the less desireable jobs because he is black, (Tr. 47).

Because claimant asserted racial and sexual harassment at the hearing, we find that the EEOC report was probative to a fact of consequence to the determination of compensability. Therefore, we conclude that the document was relevant and that the Referee did not abuse his discretion in admitting it.

Conflict of Interest

At hearing, the Referee informed the parties that he had attended the same high school as the employer's representative, Clark Nelson, 18 to 20 years earlier and had not had contact with him in the interim. (Tr. 153). Claimant contends that the Referee's prior relationship with Nelson caused a "conflict of interest."

Under OAR 438-06-095(1), "a referee may withdraw from a case whenever he or she considers himself or herself disqualified." Because the Referee had not had contact with Mr. Nelson in 18 to 20 years, we conclude that he did not abuse his discretion in failing to withdraw under OAR 438-06-095(1). Furthermore, claimant did not request removal of the Referee by filing an affidavit with the presiding referee, as required by OAR 438-06-095(2). On the contrary, claimant's attorney expressly agreed that the hearing could continue following the Referee's admission. Therefore, we conclude that claimant is precluded from asserting this objection on review.

Compensability

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer. ORS 656.802(3)(a)-(b).

Claimant has worked for the employer since 1979. In January 1991, the employer instituted a new production line called Bag-in-Box (BIB). Unlike existing production lines, which consisted of employees rotating among different positions in a line, employees assigned to BIB were trained to be a team; except for feeding the cartoner, there were no assigned positions, and workers were expected to respond wherever and whenever needed. Karen Hutchison supervised Bag-in-Box.

In May 1991, claimant began training for a temporary position in Bag-in-Box. As a temporary, claimant would fill in during the absences of permanent members. Claimant did well in the first two to three weeks of training. Thereafter, although fulfilling the technical aspects of the job, claimant's performance with regard to acting as a team member declined. In June 1991, Hutchison recommended that claimant be denied a temporary position in Bag-in-Box. On July 16, 1991, Hutchison informed claimant by letter that he had exhibited "critical deficiencies in the areas of teamwork and work group social skills." (Ex. 2-1). The letter also stated that claimant was not approved for a temporary position in BIB but offered "training in the areas of social skills and teamwork" if claimant wished to continue to be considered for the position. (Id.)

Claimant attended the social skills training and returned to the BIB line in an attempt to requalify for the temporary position. On August 27, 1991, claimant was informed that, due to continuing problems "in the areas of teamwork and work group social skills", (Ex. 5-2), claimant was not approved for the temporary BIB position. However, on September 3, 1991, claimant was informed that, although there continued to be concerns regarding claimant's ability to follow directions from supervisors, he was eligible to bid on BIB positions and that evaluations regarding the training in July and August would be removed from his personnel file. (Ex. 8).

In late October 1991, upon referral from his family physician, claimant began treating with Dr. Phillips, psychiatrist. Dr. Phillips diagnosed depression and released claimant from work for December 1991 "to reduce his job related stress." (Ex. 12). Claimant returned to work in January 1992, at times working in Bag-in-Box.

Although not entirely clear, it appears that claimant, for the most part, attributes his psychological condition to the employer's evaluation that claimant exhibited deficiencies in the areas of "social skills" and "teamwork" during the BIB training. For the reasons that follow, we find that the employer's evaluation of claimant's performance during BIB training was reasonable.

When Hutchison initially recommended in June 1991 that claimant not be assigned to BIB, she noted that claimant "isolate[d] himself to specific areas [on the line] where there was minimal effort needed to maintain the area" and "would choose not to take care of [areas that needed immediate attention], and would sometimes alert a team member of the problem instead." (Ex. 1-1). Hutchison also noted that she received complaints from team members about claimant's behavior, noting that claimant was "argumentative to [sic] any suggestions from the team." (Id. at 2).

In her July 1991 memorandum to claimant, Hutchison wrote that claimant was unable to "prioritize duties and independent responsibilities on the line", tended to "become argumentative, isolated from the group, [and was unable] to accept constructive criticism and direction from experienced team members and coordinators (especially women)." (Ex. 2). Hutchison reiterated these concerns in her August 1991 memorandum, stating that claimant continued to "not respond to the immediate needs of the lines in an appropriate manner", exhibited "argumentative behavior" to supervision, and failed to assist other team members. (Ex. 5).

Hutchison's evaluations of claimant's job performance were corroborated by testimony at hearing from permanent team members of BIB who were present during claimant's training period. We find that this testimony outweighs contrary evidence from co-workers testifying on behalf of claimant since most of these co-workers did not work on the BIB line and, if they were assigned to BIB, did not work the same shift as claimant. Therefore, we find that these co-workers were not as familiar with claimant's behavior during the BIB training period as the co-workers testifying on behalf of the employer.

Thus, we find that Hutchison's reports accurately described claimant's job performance during BIB training. Furthermore, in view of the importance of working as a team member on the BIB line, she was reasonable in stating that claimant exhibited "critical deficiencies in the areas of teamwork and work group social skills." Thus, we conclude that such evaluations are not considered in determining the compensability of claimant's psychological condition. See ORS 656.802(3)(b).

Claimant also appears to attribute his psychological condition in part to his assertion that he was harassed by Hutchison. In support of this contention, claimant cites to specific instances of confrontations between him and Hutchison that occurred before and during his training on BIB.

The record shows that, in August 1988, Hutchison spoke to claimant about not remaining on his assigned line and then, on a separate occasion, for failing to carry out a job assignment. (Ex. AA-10, AA-11, AA-12, AA-13). There also was evidence of at least one confrontation during claimant's BIB training when claimant balked at performing a job assignment. We conclude that, whether or not these events caused claimant's psychological condition, they were reasonable disciplinary or corrective actions by the employer.

First, the record clearly demonstrates that, throughout his work history with the employer, he has exhibited confrontational behavior. Claimant's personnel record consisted of numerous reports showing that sometimes he did not perform all job assignments, intimidated and criticized co-workers, and argued with supervision. As stated above, claimant exhibited this conduct during the BIB training. Under these circumstances, we find that the confrontations consisted of attempts by Hutchison to have claimant comply with job duties or assignments. Consequently, we conclude that her actions were reasonable disciplinary or corrective conduct. See ORS 656.802(3)(b).

Therefore, having found that employment conditions that allegedly underlied claimant's psychological condition were reasonable disciplinary, corrective or job performance evaluation actions by the employer, we conclude that claimant did not prove compensability. See ORS 656.802(3)(b).

ORDER

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

August 19, 1993 Cite as 45 Van Natta 1610 (1993)

In the Matter of the Compensation of
MICHAEL D. STONE, Claimant
WCB Case No. 92-04365
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Garaventa's order that: (1) upheld the insurer's partial denial of his low back condition; and (2) awarded no unscheduled permanent disability. On review, the issues are compensability and extent of unscheduled permanent disability.

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

Claimant contends that the opinion of Dr. Paluska, M.D., establishes that his compensable lumbar strain injury has combined with his preexisting degenerative disc disease, and the compensable injury remains the major contributing cause of his disability and need for treatment. We disagree.

Dr. Paluska opined that "(Claimant's) work injury, combined with preexisting degenerative disc disease, is the major cause for his ongoing need for treatment." We conclude that Dr. Paluska's opinion establishes only that claimant has two conditions, a compensable strain condition and a noncompensable disc disease condition, which are both responsible for his resultant condition and need for treatment. We do not read Dr. Paluska's opinion to mean that claimant's two conditions have medically "combined" with each other as required by the statute. Rather, Dr. Paluska has only used that term to indicate that, when the two conditions are considered together, both conditions have caused claimant's need for treatment. Accordingly, Dr. Paluska's opinion is not sufficient to establish that the compensable lumbar strain remains the major contributing cause of claimant's current disability and need for treatment.

ORDER

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

August 20, 1993 Cite as 45 Van Natta 1611 (1993)

In the Matter of the Compensation of
ANNA L. BRINKLEY, Claimant
WCB Case No. 92-10370
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Black's order that upheld the insurer's denial of claimant's hernia condition. On review, the issues are compensability and penalties and attorney fees.

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

On October 4, 1991, claimant complained to Dr. Holbert, gynecologist, of "problems with the left side of the incision with discomfort in that area and [claimant] is concerned that she may have hernia formation." Holbert found tenderness along the left side of the vertical midline incision, but on Valsalva maneuver he did not feel any distinct hernia. (Ex. 2A-1). In April 1992, Dr. Inouye, to whom claimant was referred for hernia surgery, noted that "[t]he bulge seems to be coming from the incision of a radical hysterectomy performed in January of 1991. At the time a suprapubic catheter and drainage tube was placed and she developed a postoperative infection in the wound." He diagnosed a ventral hernia through a previous incision for hysterectomy. (Ex. 3-1). At the time of surgery, he reported: "This patient had a radical hysterectomy for cancer in January of 1991 and subsequently developed an infection in her lower midline wound. She subsequently noticed a protrusion and bulge in this wound when she is upright and doing any lifting. The bulge and discomfort have become greater with time." (Ex. 4).

Although Dr. Kucera, gynecologist, who performed claimant's hysterectomy, identified several predisposing conditions, namely a prior hernia operation using mesh, smoking since age 15, and overweight, Dr. Williams stated that the cause, which would predispose claimant to an incisional hernia, was the large size of the surgical incision, drains which weakened the incision, and a post-operative infection. Based on this record, we agree with the Referee's finding that claimant had a continuing symptomatic condition in the incision and, therefore, that this condition was a preexisting condition and not a mere predisposition. See John E. Perkins, 44 Van Natta 1020 (1992). Consequently, we find that his application of ORS 656.005(7)(a)(B) was appropriate.

ORDER

The Referee's order dated November 2, 1992 is affirmed.

In the Matter of the Compensation of
SUZANNE HAFFNER, Claimant
Own Motion No. 93-0462M
OWN MOTION ORDER
Liberty Norhtwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for her compensable bilateral wrist injury. Claimant's aggravation rights expired on February 11, 1990. The insurer recommends that we reopen the claim and authorize the payment of temporary disability compensation.

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

On July 7, 1993, Dr. Golden, claimant's treating physician, recommended carpal tunnel surgery on the right side to relieve the worsening of the compensable condition. Surgery was authorized and performed on July 27, 1993. Thus, we conclude that claimant's compensable condition worsened requiring surgery on July 1993.

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).

We are persuaded that claimant's compensable injury has worsened requiring surgery. Furthermore, claimant is employed by the Eugene School District as a food service worker. Therefore, she is engaged in regular gainful employment and was in the workforce at the time of her disability.

Although the insurer agrees that claimant was in the work force at the time of her worsening, it also notes that claimant's surgery will occur during her summer vacation from her food service job. Assuming that, by this notation, the insurer is arguing that claimant is not entitled to temporary disability benefits, we make the following comments. Claimant need not prove an actual loss of wages to be entitled to temporary disability benefits. Claimant need only prove that, because of the worsening, she was less able to work in that she was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452 (1991), citing Smith V. SAIF, 302 Or 396, 401 (1986); Michael Pickett, 45 Van Natta 255 (1993).

Here, claimant has established that her compensable worsening resulted in her being less able to work to such an extent that she was temporarily incapacitated from regularly performing work at a gainful and suitable occupation. Thus, claimant is entitled to temporary disability benefits.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning July 29, 1993, the date she 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
DOUGLAS L. HOLTEN, Claimant
WCB Case No. 92-09621
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Davis' order that affirmed a Director's Review and Order assigning claimant to a vocational assistance provider. On review, the issue is vocational assistance.

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

A disagreement arose between claimant and the insurer regarding the assignment of claimant's vocational assistance provider. Specifically, claimant sought assignment with a particular provider. The insurer objected to the provider because its contractual relationship with the provider was ending. The insurer suggested three alternative providers, all of which were rejected by claimant. Consequently, the matter was referred to the Director for resolution. See ORS 656.340(11).

Pursuant to ORS 656.283, the Director found all three of the proposed vocational assistance providers to be acceptable, selected one of the providers, and ordered the insurer to assign claimant to that provider. See OAR 436-120-070(2); 436-120-210.

Claimant asserts that the Director's order should be modified because only the insurer's proposed providers were considered and that the Director's failure to consider all available providers was an abuse of discretion. See ORS 656.283(2)(d).

Under ORS 656.283(2), the Referee determines the historical facts relevant to the dispute and then, on the basis of that record, makes ultimate findings of fact to determine whether the Director's order is subject to modification for any of the specific reasons provided in ORS 656.283(2). Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992). The Board reviews the record made by the Referee but may make findings of ultimate fact different from those made by the Referee. Id.

We agree with the Referee's ultimate factual findings leading to his conclusion that there was no abuse of discretion by the Director in apparently limiting consideration of an appropriate vocational assistance provider to those proposed by the insurer. In that regard, we also note that, once resolution of such an issue is referred to the Director, the Director has sole discretion in making a selection. See ORS 656.340(11); OAR 436-120-070(2). Furthermore, the Director evaluated the proposed providers in light of certain criteria. See OAR 436-120-070(2). Consequently, we find no evidence that the Director's selection was arbitrary and capricious and, therefore, an abuse of discretion. See Colclasure v. Wash. County School Dist. No. 48-J, 117 Or App 132, n 2 (1992). Thus, we find no grounds to modify the Director's order. See ORS 656.283(2).

ORDER

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

In the Matter of the Compensation of
EDWARD J. NICKS, Claimant
WCB Case No. 92-07695
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myers' order that upheld the SAIF Corporation's partial denial of claimant's left carpal tunnel syndrome. On review, the issue is compensability.

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

On review, claimant's sole argument is that, because his vocational rehabilitation activities are the major contributing cause of his left carpal tunnel condition, the compensable injury remains the major contributing cause of the condition. We disagree.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Kephart v. Green River Lumber, 118 Or App 76 (1993), affirming our decision in that case. The court, citing Hicks v. Spectra Physics, 117 Or App 293 (1992), held that ORS 656.005(7)(a)(A) applies to injuries experienced during vocational rehabilitation, in that such injuries are not directly related to the industrial accident. Because such an injury is a consequence of the industrial injury, claimant must prove that the compensable injury is the major contributing cause of his consequential condition. We agree with the Referee that claimant has failed in his burden to so prove.

ORDER

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

In the Matter of the Compensation of
BARBARA L. ROUTH, Claimant
WCB Case No. 92-03462
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Schultz's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral hand condition. On review, the issue is compensability.

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

We agree with the Referee that Dr. Radecki provided the more convincing opinion wherein he stated that claimant's work activities were not the major contributing cause of her bilateral carpal tunnel syndrome (CTS). Dr. Radecki attributed claimant's condition to her age, sex, hobbies, bicycle riding, prior thyroid problems, slight obesity, menopause and, to a very limited degree, work activities. (Ex. 17). Claimant asserts that such factors as claimant's age, gender and weight merely predisposed her to CTS and, therefore, they should not be considered in determining compensability.

In Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992), the court distinguished between a susceptibility or predisposition to a disease and idiopathic factors that caused a disease independently of the claimant's activities. In particular, the court held that a claimant's susceptibility or predisposition to a disease is not considered in determining compensability. Id. at 569.

Although Dr. Radecki in a few instances referred to the factors cited above as "predisposing," he also stated that such factors "contributed" to the "idiopathic development" of claimant's CTS. (Exs. 13-3, 17). Dr. Radecki even quantified the level of contribution from each factor. (Ex. 17-2, 17-3). Based on this evidence, we find that Dr. Radecki's opinion is most reasonably interpreted as indicating that the factors caused claimant's CTS rather than predisposing her to the condition. Therefore, we reject claimant's assertion that such factors should not be considered when determining compensability.

ORDER

The Referee's order dated December 2, 1992 is affirmed.

In the Matter of the Compensation of
FARID M. AHMAD, Claimant
WCB Case No. 91-15710
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Davis' order that: (1) upheld the insurer's denial of his claim for a psychological condition; (2) declined to assess a penalty or attorney fee for the insurer's allegedly unreasonable denial of that condition; (3) concluded that claimant's claim for a low back condition was not prematurely closed; (4) affirmed an Order on Reconsideration which awarded 6 percent (19.2 degrees) unscheduled permanent disability for a low back injury; and (5) affirmed a Director's Review and Order that determined that claimant was not eligible for vocational assistance. On review, the issues are compensability, premature closure, extent of unscheduled permanent disability, vocational assistance, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant is 36 years of age and has completed 5 years of college. Claimant's highest specific vocational pursuit (SVP) level in the last ten years is 7 as a retail store manager (DOT # 185-167-047).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's psychological condition claim was not compensable, because claimant failed to prove that his compensable low back injury is the major contributing cause of that condition. We agree.

Claimant contends that his psychological condition developed as a consequence of his compensable low back injury. Accordingly, claimant has the burden to prove that the compensable injury is the major contributing cause of his psychological condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992). Because of the numerous possible causes of claimant's psychological condition, including the industrial injury and work related stressors, 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). The record contains four medical opinions that address causation.

Dr. Price, a consulting psychiatrist, saw claimant three times. She opined that claimant's compensable injury was the major contributing cause of claimant's psychological condition. Dr. Takacs, D.O., claimant's treating physician, concurred with that assessment, although she had initially opined that claimant's compensable injury was not the major stressor in his life. Dr. Maletzky, M.D., another consulting psychiatrist, saw claimant once and also opined that claimant's compensable injury was the cause of his psychological condition.

Dr. Parvaresh, M.D., an independent medical examiner, saw claimant once and opined that, if the compensable injury was limiting claimant's ability to work, "in the absence of any other known stressors in his life it would be reasonable to assume that his [psychological condition] is the outgrowth of that accident and its sequelae." (Ex 48). Subsequent to that report, Dr. Parvaresh attended the hearing. While there, Dr. Parvaresh learned that, prior to the industrial injury, claimant's career with the employer was in jeopardy due to his poor job performance. Because claimant's psychological well-being was tied to his position with the employer, Dr. Parvaresh opined that those non-injury related stressors were the major contributing cause of claimant's psychological condition. (Tr. 80).

When the experts disagree, we generally rely on those opinions that are the most well reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). It appears from the record that Dr. Parvaresh was the only reporting physician who was aware of claimant's job-performance problems. He thoroughly explained why those stressors were a greater contributor to claimant's psychological condition than the compensable injury. Consequently, we agree with the Referee that Dr. Parvaresh's opinion is the most well reasoned and based on the most accurate history.

Although we generally give greater weight to the opinion of a treating physician, we will not do so when there are persuasive reasons not to. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, Dr. Takacs only concurred in the assessment of a consulting psychiatrist, Dr. Price, whose opinion was not based on a complete history particularly with regard to the decline of claimant's managerial career prior to the injury. We find that such circumstances present a persuasive reason not to defer to Dr. Takacs' opinion.

Because we find Dr. Parvaresh's opinion to be the most persuasive, we conclude that claimant failed to establish that his compensable injury is the major contributing cause of his psychological condition. See Anna M. Braatz-Henry, 45 Van Natta 406 (1993).

Unreasonable Denial

We affirm and adopt the Referee's reasoning and conclusions of law on this issue.

Premature Closure

We affirm and adopt the Referee's reasoning and conclusions of law on this issue.

Extent of Unscheduled Permanent Disability

The Referee declined to include ratings for claimant's age, education and adaptability in calculating claimant's unscheduled disability, because claimant was capable of returning to his regular work. We modify claimant's award of unscheduled permanent disability based on the following reasoning.

Claimant became medically stationary on May 13, 1991, and his claim was closed by Notice of Closure on May 28, 1991. Because claimant became medically stationary after July 1, 1990 and the claim was closed before March 13, 1992, the rules in effect on the date of the Notice of Closure control. OAR 438-10-010(2); OAR 436-35-003(2); former OAR 436-35-003. Thus, the applicable "standards," as amended by the temporary rules, are those that became effective April 1, 1991. However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Determination Order. WCD Admin. Orders 2-1991, 7-1991 and 93-052.

The Referee found that claimant was entitled to a 6 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 (1). Therefore, we adopt this value when we calculate claimant's permanent disability and discuss only the value for adaptability.

To begin, we agree with the Referee that former OAR 436-35-310(1) does not contemplate a value for adaptability where, as here, claimant has returned to regular work. Therefore, under that rule claimant's adaptability factor would be zero. However, subsequent to the Referee's order, the Supreme Court has held that a claimant's age, education and adaptability factors must be considered even if a claimant has an adaptability factor of zero under the Director's "standards." See England v. Thunderbird, 313 Or 633 (1993)

In response to the Court's decision in England, supra, the Director amended OAR 436-35-280 through 436-35-310. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). OAR 436-35-280 now provides in relevant part:

> "The factors of age, OAR 436-35-290; education, OAR 436-35-300; and adaptability, OAR 436-35-310, shall be applied for losses indentified in ORS 656.214(5) and described in OAR 436-35-320 through 436-35-500."

In conjunction with this provision, OAR 436-35-290 through OAR 436-35-310 (concerning age, education, and adaptabilty) now allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work following a compensable injury. As noted above, these amended temporary rules apply to all ratings of disability made on or after June 17, 1993 and thus are applicable to the instant case. OAR 436-35-003(4). See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

OAR 436-35-310 governs adaptability. 436-35-310(2) provides for an adaptability value of 1 where, as here, the worker returns to the same job he held at the time of injury. Accordingly, claimant is entitled to an adaptabilty value of 1. OAR 436-35-310(2)(Temporary Rules, June 17, 1993, WCD Admin. Order 93-052).

OAR 436-35-280(4) provides that the value for age and education is added together. OAR 436-35-280(6) provides that the value for age and education are then multiplied by the adaptability value. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7). Applying these rules to the instant case, when the total value for claimant's age and education (1) is multiplied by the adaptability value (1), the total is 1. When this value is added to his value for impairment (6), the result is 7. Therefore, claimant's unscheduled permanent disability is 7 percent. The Referee's order shall be modified to increase claimant's award from 6 percent to 7 percent.

Vocational Services

We affirm and adopt the Referee's reasoning and conclusions of law on this issue, with the following supplementation. See John R. Coyle, 45 Van Natta 325, 327 (1993).

ORDER

The Referee's order dated July 27, 1992 is affirmed in part and modified in part. In addition to the Order on Reconsideration's award of 6 percent (19.20 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total of 7 percent (22.4 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the order is affirmed.

August 23, 1993 Cite as 45 Van Natta 1617 (1993)

In the Matter of the Compensation of
WESTON C. FOUCHER, Claimant
WCB Case No. 92-07561
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On review, the insurer contends that claimant has not carried his burden of proof, because he provided insufficient evidence from which to conclude that the onset of his back symptoms was related to his fall and, consequently, that the medical opinion based on claimant's unreliable history is unpersuasive. We disagree. Based on the record, we find claimant to be credible. Moreover, we find no indication that the doctor's opinion concerning causation is tainted by an inaccurate history.

In reaching these conclusions, we note that the Referee made no credibility finding. In the absence of an express credibility finding by the Referee, we have made the necessary credibility findings based on an objective evaluation of the documentary evidence and claimant's testimony, and not on demeanor. See Costal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Concerning the merits of the claim, what the insurer characterizes as a failure of proof, we instead find to be claimant's overabundance of caution and honesty in reporting his symptoms. Because claimant cannot remember exactly when he first experienced the onset of back pain, he has been unwilling to state for sure whether it was before or after the fall. Reviewing his testimony as a whole, we find that claimant did not have back pain before October 29, 1991. Therefore, we find that he has established medical causation. We base our reasoning on the following.

Claimant did not notice back pain severe enough to see a physician until after the October 1991 accident. According to his credible testimony, it developed gradually after the fall, until it became unbearable.

Dr. Franks, claimant's treating physician, is the only physician to express an opinion on causation. He examined claimant, took a complete and accurate history, and concluded that the fall was the type of traumatic occurrence that would cause and probably did cause claimant's disc herniation.

The insurer speculates that other off-the-job falls could have caused claimant's back condition. However, there is no evidence in the record of any non-work trauma that might have caused the herniation.

Although claimant at one time questioned whether his back symptoms might have arisen from driving the insured's delivery car, it is immaterial whether claimant believes driving or the fall caused his condition. His opinion on causation can be given little weight. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Wendy K. Sprinkle, 44 Van Natta 814 (1992). Claimant is not charged with knowing the etiology of his medical problem. That is a question for the experts. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

As noted, the only medical evidence on causation supports claimant's claim. It was Dr. Franks who suggested the causal relationship, which was appropriate as that relationship is a complex medical matter. See Uris v. Compensation Department, supra; Kassahn v. Publishers Paper Co., supra. Here, claimant essentially is adopting his doctor's expert opinion.

Considering the close temporal relationship between claimant's work injury and the onset of his low back pain, the lack of off-work traumatic events, claimant's credible testimony that he did not have back pain before October 29, 1991, as well as Dr. Franks' indisputed opinion that claimant's condition is work related, we conclude that claimant has established a causal nexus between his injury and his low back condition. Consequently, claimant has carried his burden of proving that the work injury was a material contributing cause of his low back condition.

Claimant is entitled to an assessed attorney fee for his attorney's services for finally prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review is $3,500. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 19, 1992 is reversed. The insurer's denial is set aside, and the claim is remanded to it for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed attorney fee of $3,500, payable by the insurer.

In the Matter of the Compensation of
DOUGLAS FREDINBURG, Claimant
WCB Case Nos. 92-05032 & 92-05033
ORDER ON RECONSIDERATION
Coons, et al, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Claimant has requested reconsideration of our June 17, 1993 Order on Review that reinstated the Department of Insurance and Finance's order declaring claimant to be a non-subject worker. Specifically, claimant contends that the Board lacked appellate jurisdiction over this matter. In order to fully consider the matter, we abated our prior order and granted the Department and Farmers Insurance an opportunity to respond. After receiving the parties' responses, as well as claimant's reply, we make the following conclusions.

Claimant requested a hearing concerning the Department's determination that claimant was not a subject worker of Dan Morris at the time of claimant's injury. A May 12, 1992 hearing was held before Referee Garaventa at which time claimant attempted to raise compensability issues concerning Farmer's denial and Morris' responsibility for the injury. Relying on OAR 438-06-038, the Referee determined that the only issue for resolution was the correctness of the Department's subjectivity determination. Final determination of the remaining issues was deferred.

On June 10, 1992, the Referee issued an Opinion and Order which set aside the Department's determination that claimant was not a subject worker of Dan Morris. Thereafter, the Department requested Board review. Claimant cross-requested review, contesting the Referee's refusal to resolve the compensability issue. On June 17, 1993, we found that claimant's employment was casual pursuant to ORS 656.027(3). Concluding that claimant was not a subject worker of Dan Morris at the time of claimant's injury, we reinstated the Department's determination that claimant was a non-subject worker. In light of our "subjectivity" conclusion, we declined to address the compensability arguments.

Claimant contends that the Referee's subjectivity determination is not a "matter concerning a claim" within the meaning of ORS 656.704. In light of such circumstances, claimant reasons that the parties must appeal the Referee's order directly to the Court of Appeals pursuant to ORS 183.480. We disagree.

The Board and the Director have each adopted rules applicable to the review of the Director's subjectivity determinations. See OAR 436-80-060(3) (WCD Admin. Order 8-1992) (temp. rule effective April 15, 1992); OAR 438-06-038 (WCB Admin. Order 2-1992) (temp. rule effective April 15, 1992, perm. rule effective October 12, 1992). When WCD's Compliance Section issues a subjectivity determination, the worker may request a hearing before a Board referee. OAR 436-80-060 (temp. rule).

These rules implemented an intra-agency agreement between the Board and WCD which contemplated a procedure whereby WCD would process all claims against alleged employers who do not have workers' compensation coverage. See WCB Admin. Order 2-1992. If, as a result of such processing, WCD determines that a worker is not a subject worker, WCD issues an order notifying the worker of his or her right to request a hearing on the determination before a Board referee. The agreement also states that the conduct of such hearings will be pursuant to ORS 656.283.

Here, the issue is who has appellate review authority of the Referee's decision arising from the subjectivity determination. In Spencer House Moving Company, 44 Van Natta 2522 (1992), we considered whether the Board has jurisdiction to review an appeal from a referee's order arising from a noncompliance proceeding. We held that when the only issue contested at a hearing concerning a Director's order finding an employer to be noncomplying is whether a claimant was a subject worker, appellate jurisdiction lies with the court. Although we recognized that such a proceeding could have a potentially significant impact on the future processing of a claim, we reasoned in Spencer House that the hearing did not also involve a "matter concerning a claim" because (in the absence of an employer's objection to the SAIF Corporation's acceptance of a claim on the employer's behalf or a claimant's objection to SAIF's denial of a claim) the worker's right to receive compensation or the amount thereof were not directly in issue. Relying on ORS 656.704(3), 656.740(4)(c), Ferland v. McMurtry Video Productions, 116 Or App 405 (1992), and Castle Homes, Inc. v. Whaite, 85 Or App 269 (1989), we concluded that we were without appellate authority to consider a Referee's order resulting from such a noncomplying employer proceeding.

Here, as in Spencer House, the issue for resolution before the Referee pertains to whether claimant was a subject worker. Nevertheless, this subjectivity issue does not arise within the context of an employer's appeal from a Director's Noncomplying Employer order. Rather, the subjectivity issue arises from claimant's request for hearing from a Director's decision finding claimant not to be a subject worker. In other words, the purpose of this subjectivity determination is not to decide whether the employer is noncomplying under ORS 656.740 (as in Ferland, Whaite, and Spencer House). Rather, the proceeding is designed to determine whether claimant was a subject worker who, as such, would have a right to receive compensation under the Workers' Compensation Law.

Inasmuch as the hearing regarding the subjectivity determination did not arise from a noncomplying employer order, the prerequisites for determination of appellate jurisdiction contained in ORS 656.740(4) are inapplicable; i.e, that the hearing regarding the noncompliance order must also involve a "matter concerning a claim." Instead, the sole inquiry for resolution of the jurisdictional question concerning this subjectivity determination is whether the hearing involved a "matter concerning a claim," which is defined as a matter "in which a worker's right to receive compensation, or the amount thereof, are directly in issue." See ORS 656.283(1); 656.704(3).[1]

Here, the Referee determined that claimant was a subject worker. Therefore, as a result of the Referee's determination, further processing of the claim would be forthcoming. Specifically, the Department would determine whether claimant's employer was noncomplying. See ORS 656.054; OAR 436-80-010; 436-80-060. On the other hand, had the Referee affirmed the Department's determination that claimant was not a subject worker, no further processing of the claim would occur. In other words, since claimant would be determined to not have been a subject worker, there will be no issuance of a noncomplying employer order under ORS 656.740. See OAR 436-80-010. Without such an order, the claim will not be referred to the SAIF Corporation under ORS 656.054 for acceptance or denial of the claim. See OAR 436-80-060(1).

Thus, in a hearing such as this one, regarding solely a Director's "nonsubjectivity" determination under OAR 436-80-060(3), a determination that claimant is not a subject worker is the functional equivalent of a conclusion that claimant is not entitled to receive compensation. Because claimant's right to receive compensation was directly in issue at hearing (regardless of the Referee's ultimate determination), the procedure for the conduct and review of that proceeding is as provided for a "matter concerning a claim." See ORS 656.283(1); 656.289(3); 656.295; 656.704(3).[2]

For the above reasons, we conclude that the Board had appellate jurisdiction over this matter. Accordingly, as supplemented herein, we adhere to and republish our June 17, 1993 order. The parties' right of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant relies on Franklin H. King, 41 Van Natta 1291 (1989), for the proposition that when a Referee's decision solely concerns subjectivity, appellate jurisdiction rests with the court. As with Spencer House, King involved a proceeding arising from a Director's noncomplying employer order. Inasmuch as the King ruling was controlled by ORS 656.740, its holding has no application to this case.

[2] Although OAR 438-06-038 limits the issues for litigation to solely the Department's subjectivity determination, claimant attempted to raise the issue of compensability at hearing. Moreover, he continued to advance his compensability arguments on Board review. For the reasons previously discussed, we have determined that we have appellate authority to review the Referee's subjectivity determination in this type of proceeding. Alternatively, claimant's arguments at hearing, as well as on review, regarding the compensability of his injury claim (an issue which if addressed would unquestionably have a direct effect on claimant's right to compensation) would vest appellate jurisdiction with this forum. See ORS 656.283(1) and (3); 656.295; 656.704(3).

In the Matter of the Compensation of
MELANIE C. MERRILL, Claimant
WCB Case Nos. 92-09600, 92-05080 & 91-08702
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Spangler's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a neck and bilateral arm injury; (2) found that claimant was not entitled to interim compensation; and (3) upheld the denials of SAIF and Hartford Insurance Company of claimant's upper back and shoulder claim. On review, the issues are aggravation and, if compensable, responsibility, and interim compensation. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In 1989, SAIF accepted a claim for cervical strain, bilateral wrist strain, and bilateral epicondylitis. (Ex. 3). Upon closure, claimant received an award of 8 percent unscheduled permanent disability. In 1990, Hartford accepted a claim for right shoulder strain and cervical/thoracic strain based on a September 1990 accident at a portrait studio where claimant worked. (Ex. 17). Following that incident, claimant continued to complain of neck pain, right shoulder pain, left shoulder pain, right arm pain, left arm pain, mid-back pain, and wrist pain. (Exs. 14, 15, 16-1, 16-2, 16-3, 16-4, 16-3A, 16-3B, 22).

In February 1992, claimant saw her treating physician, Dr. Mitchell, surgeon, with complaints of increased pain in her neck and upper back. (Ex. 16-5). Although since that time claimant continued to report ongoing pain in both hands and arms, the upper back, left shoulder, and neck, (Exs. 27-3, 29, 32A, 33), apparently her aggravation claim is limited to the neck and upper back. (See Ex. 23).

In order to establish a compensable aggravation, claimant first must prove causation. Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). In particular, because there is no evidence that claimant's symptoms were caused by a preexisting condition or constituted a consequential condition, claimant must show a material relationship between her prior compensable conditions and current symptoms. See ORS 656.005(7)(a). We agree with the Referee that the medical evidence failed to establish causation and we affirm and adopt that portion of his order. Consequently, we need not address whether claimant's condition has worsened or the issue of responsibility between SAIF and Hartford for claimant's neck and upper back pain. See Thomas L. Fitzpatrick, supra.

Interim Compensation

The Referee also found that a report from Dr. Mitchell dated February 11, 1992 contained prima facie evidence that claimant's condition had worsened and, therefore, constituted a claim for aggravation. However, the Referee found no evidence proving when SAIF received the report, thereby showing that SAIF's April 7, 1992 denial was untimely. Claimant challenges this conclusion, asserting that the record contains evidence that SAIF received the report more than 14 days before its denial. We agree.

A carrier is obligated to pay interim compensation on an aggravation claim beginning no later than 14 days after the carrier receives medical verification of the worker's inability to work due to the compensable condition. See ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984). Payment is to continue until a formal denial of the claim is issued. Id.

We agree with the Referee that the February 11, 1992 report constituted a claim for aggravation. In that report, Dr. Mitchell stated that claimant had a "flair up (sic) and aggravation of her cervical, thoracic pain and spasm" so severe that she had been unable to work and attributed this condition to her 1989 claim with SAIF. (Ex. 23). The report, therefore, contained medical verification of an inability to work due to the compensable condition with SAIF.

Furthermore, although there is no direct evidence proving when SAIF received the report, we find sufficient circumstantial evidence showing that SAIF not only received the report but that receipt was well before the April 7, 1992 denial. First, Dan Schmelling, a claims adjustor with SAIF, sent a letter to Managed Healthcare Northwest on February 27, 1992 to arrange an independent medical examination of claimant. (Ex. 27-2). The letter contained specific questions for the panel, including whether claimant's current symptoms were caused by her claim with Hartford. (Id.) This information indicates that SAIF was aware that, as of February 27, 1992, claimant had made a claim for additional medical treatment and that it was attempting to attribute the cause of claimant's symptoms to the claim with Hartford.

Moreover, the record contains only two reports from Dr. Mitchell to SAIF prior to February 27, 1992. One of the reports is dated December 9, 1991 and contains no reference to a worsened condition since it was written regarding an examination that occurred some months before the February 1992 examination which was the basis for Dr. Mitchell's opinion that claimant's condition had worsened. (See Ex. 22). The other report was the document dated February 11, 1992, which we have previously found constituted a claim for aggravation. It also was addressed to Dan Schmelling. This information shows that SAIF's knowledge of the aggravation claim was provided by the February 11, 1992 report.

Finally, SAIF offered no evidence contradicting the inference that it received the report before February 27, 1992. Consequently, although close, we conclude that the preponderance of the evidence proves that SAIF had received the February 11, 1992 report as of February 27, 1992 and, therefore, its April 7, 1992 denial was not timely. Thus, claimant is entitled to interim compensation for this period.

Claimant's attorney is not entitled to an assessed fee for the award of interim compensation since the issue concerned the amount of compensation rather than the cause of claimant's condition. See Short v. SAIF, 305 Or 541, 545 (1988); Gloria J. Shelton, 44 Van Natta 2232 (1992). However, claimant's attorney is entitled to a fee of 25 percent of the amount of interim compensation, not to exceed $3,800. See ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated October 30, 1992 is affirmed in part and reversed in part. That portion of the order finding that claimant is not entitled to interim compensation is reversed. Claimant is entitled to such compensation for the period of February 17, 1992 through the date of denial. Claimant's attorney is entitled to a fee of 25 percent of the amount of interim compensation, not to exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH D. NICHOLS, Claimant
WCB Case No. 92-09639
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order which: (1) declined to hold the record open for the submission of a medical report from claimant's treating chiropractor; and (2) upheld the insurer's partial denial of claimant's current low back condition. The insurer cross-requests review of that portion of the order that set aside its denial of claimant's claim for a medical report fee. On review, the issues are remand, compensability, and reimbursement for a medical report. We affirm.

FINDINGS OF FACT

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

On September 11, 1992, claimant's attorney sent a letter to claimant's treating chiropractor, Dr. Harris, seeking clarification of an earlier report. (See Exs. 15, 16).

At the hearing on October 13, 1992, claimant moved to leave the record open for admission of Dr. Harris' supplemental report, which claimant's attorney had not yet received. The insurer objected. Finding that claimant's attorney did not exercise due diligence in securing the report prior to hearing, the Referee sustained the insurer's objection and denied claimant's motion.

Claimant's attorney received Dr. Harris' supplemental report on October 13, 1992, shortly after the Referee closed the hearing record.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

Claimant contends that the Referee erred in refusing to admit Dr. Harris' supplemental report into evidence. Inasmuch as claimant did not offer that report at hearing, the Referee could not have abused her discretion by declining to admit it. Moreover, were we to construe claimant's argument as a motion to remand for the receipt of additional evidence, we would deny the motion.

We may remand a case to the Referee for the receipt of additional evidence if 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. Kienows Food Stores v. Lyster, 779 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 hearing. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Claimant requested Dr. Harris' supplemental report one month prior to hearing. He did not follow up on that request until one day prior to hearing. When he did follow up, Dr. Harris' response was virtually immediate. Under those circumstances, we conclude that, with the exercise of due diligence, Dr. Harris' report was obtainable at the time of hearing. Consequently, we decline to remand this matter for admission of Harris' report. See Bennie J. Mathena, 45 Van Natta 361, 364 (1993).

Compensability

The Referee upheld the insurer's partial denial of claimant's low back condition claim, because she concluded that claimant failed to prove that his industrial injury is the major contributing cause of his current disability and need for treatment. On review, claimant contends that his current degenerative disc disease, including the herniated disc at L3-4, is compensable. We disagree.

Claimant sustained a work injury on February 13, 1992, which the insurer accepted as a low back strain. (Exs. 1, 4). On February 25, 1992, he began treating with orthopedist Dr. Sirounian, who diagnosed chronic degenerative disc disease of the lumbar spine, with a herniated disc at the L3-4 level. (Ex. 4-2). The medical evidence establishes that claimant's degenerative disc disease preexisted the compensable injury. (See Exs. 2, 4, 7-2, 11A).

Claimant argues that the compensable injury worsened the preexisting degenerative disc disease, directly causing the herniated disc. Inasmuch as claimant argues that his compensable injury combined with his preexisting disease to cause or prolong his disability or need for treatment, he must sustain the burden of proving that the compensable injury is the major contributing cause of the resultant disability or need for treatment. See ORS 656.005(7)(a)(B); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993); Tektronix, Inc. v. Nazari, 117 Or App 409, 412 (1992), mod 120 Or App 590 (1993).

It is claimant's burden to prove the compensability of his condition. ORS 656.266. Because of the various possible causes of claimant's current low back condition, including his degenerative disc disease, we find 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).

The record contains reports by Dr. Sirounian, claimant's treating physician; Dr. Harris, claimant's treating chiropractor; and an independent medical examination report by orthopedist Dr. Dinneen and neurologist Dr. Snodgrass.

Drs. Dinneen and Snodgrass opined that claimant's compensable strain had resolved by May 1992. (Ex. 7-4). They further found that claimant had no disability resulting from the February 1992 incident and that any current impairment would be due to preexisting degenerative changes. (Id). We interpret their report as essentially finding no relationship between claimant's compensable injury and his degenerative disc disease.

Dr. Sirounian concurred with Drs. Dinneen and Snodgrass. (Ex. 9). In a subsequent report dated July 8, 1992, Dr. Sirounian explained that he agrees with the independent examiners that claimant has preexisting degenerative disc disease. (Ex. 11A-1). He further stated that the degenerative condition is chronic, has "persisted for some time," and that he cannot say whether the disease at the L3-4 level is old or new. (Id).

Dr. Sirounian also opined that claimant sustained a ligamentous strain which aggravated his preexisting condition. (Ex. 11A-2; see also Ex. 13). He further opined that the February 1992 injury "is the main contributing cause for his current disability and inability to return to his former employment." (Ex. 11A-2). However, in a subsequent report, Dr. Sirounian stated that in his July 8, 1992 examination he did not see any "signs of increased degeneration." (Ex. 13) (emphasis in original).

Dr. Sirounian's opinion is internally inconsistent. Although he opined that the compensable low back strain aggravated the preexisting degenerative condition, he also found no evidence of increased degeneration. We find his opinion unpersuasive.

Dr. Harris opined that claimant's February 1992 work injury resulted in a herniated disc. (Ex. 15). However, his opinion is conclusory and fails to address claimant's preexisting degenerative disc disease or its relationship to the herniated disc. Furthermore, Dr. Harris' opinion is controverted by the opinions of Drs. Dinneen, Snodgrass and Sirounian. Accordingly, we do not find Dr. Harris' opinion persuasive.

Inasmuch as the record contains no other medical evidence on the causation issue, we agree with the Referee that claimant failed to prove the compensability of his current low back condition.

Compensability of Medical Report

Claimant filed a claim for a $75 fee charged by Dr. Sirounian for writing a July 8, 1992 report to claimant's attorney. The insurer denied the claim. The Referee upheld the insurer's denial, concluding that the report constituted "compensation." We agree.

"Compensation" includes medical services provided for a compensable injury. ORS 656.005(8). In determining whether a medical report fee qualifies as a compensable medical service, we have drawn a distinction between a report generated as a part of treatment for a compensable injury and a report generated for the purpose of litigation. David M. Nelson, 42 Van Natta 2045 (1990). In Nelson, we stated:

> "A doctor's fee for writing a report is the responsibility of the carrier if the report is written in connection with compensable treatment. If the report, or the services upon which the report is based, is not for the purpose of treatment, but for the purpose of litigation, then the requester of the report/service must bear the cost of it." 42 Van Natta at 2047 (Cites omitted.)

We find that Dr. Sirounian's July 8, 1992 narrative report was not written for the purpose of litigation. Although requested by and addressed to claimant's attorney, the report was written prior to issuance of the insurer's July 14, 1992 denial and the filing of claimant's hearing request on July 23, 1992. Inasmuch as the compensability of claimant's current low back condition was not a ripe issue for litigation until issuance of the insurer's denial, the report could not have been generated for litigation purposes.

We find, instead, that the medical report was reasonable and necessary for determining whether a causal relationship exists between the current condition and the compensable injury. See Brooks v. D & R Timber, 55 Or App 688, 692 (1982); Cordy A. Brickey, 44 Van Natta 220 (1992). Accordingly, the medical report fee is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the medical report fee issue is $200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 9, 1992 is affirmed. Claimant's attorney is awarded $200 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
LINDA J. SMITH, Claimant
WCB Case Nos. 91-10738 & 91-17996
SECOND ORDER OF DISMISSAL
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

On December 4, 1992, we withdrew our November 12, 1992 and November 25, 1992 orders which had dismissed Argonaut Insurance Company's request for Board review (in accordance with our approval of a Disputed Claim Settlement (DCS) between claimant and Argonaut) and denied United Employers' request for reconsideration of that dismissal order. Although we did not share United Employers' concerns regarding the effect of the DCS on its interests, we took this action at the parties' request in order to retain jurisdiction to determine whether a mutually agreeable settlement could be achieved.

Since that abatement order, the Board's staff counsel has made periodic inquiries concerning the progress the parties are making in achieving a mutually agreeable settlement. (February 3, 1993, May 19, 1993, and June 17, 1993). The most recent letter from the Board's staff counsel granted a further extension within which to permit the parties to reach an agreement. If neither a settlement nor further written communication was forthcoming by August 1, 1993, the parties were notified that the Board would conclude that a settlement could not be achieved. Under such circumstances, the parties were advised that the Board would proceed with its reconsideration of its prior orders.

On July 29, 1993, United Employers' counsel asked claimant's counsel whether any progress had been made in determining whether a settlement could proceed. In the event that no prospect of resolution existed, United Employers' counsel suggested that the parties advise the Board to proceed with its reconsideration. Since the Board's receipt of a copy of that July 29, 1993 letter, no further response or other written communication from any party has been received.

In light of such circumstances, we conclude that no further settlement will be forthcoming. Consequently, in accordance with the written notice previously provided to the parties, we proceed with our reconsideration.

We adhere to the reasoning expressed in each of our prior orders (November 12, 1992, November 25, 1992, and December 4, 1992). Therefore, on reconsideration, as supplemented herein, we republish our November 12, 1992 and November 25, 1992 orders. 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
VICTOR L. STEWART, Claimant
WCB Case No. 92-07792
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Daughtry's order which dismissed his request for hearing for lack of jurisdiction over claimant's objection to the SAIF Corporation's "final determination" of his Inmate Injury Fund claim, which awarded no permanent disability. In his appellant's brief, claimant asks the Board to award scheduled permanent disability for the loss of use or function of his right thumb. In the alternative, claimant requests the Board to remand the case to the Hearings Division for a decision on the merits. On review, the issues are jurisdiction, remand, and extent of scheduled permanent disability. We reinstate claimant's hearing request and affirm SAIF's final determination.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant sustained a fracture of his right thumb in a July 1989 work injury while he was incarcerated. The Department of Justice, on behalf of the Inmate Injury Fund ("the Fund"), accepted the claim on March 20, 1990. (Ex. 3). Claimant was declared to be medically stationary as of December 6, 1990 by Dr. Becker, his treating physician. (Ex. 7). On January 10, 1991, the Department of Justice issued an "Acceptance and Interim Determination," awarding no permanent disability. (Ex. 6).

Claimant was released from prison on June 3, 1991. ORS 655.520(2) provides that, upon an inmate's release from confinement, the initial award shall be reaffirmed or modified, as appropriate, depending on the inmate's condition upon release. As required by ORS 656.520(2), SAIF, on behalf of the Fund, issued a "Final Determination" on December 12, 1991, again awarding no permanent disability. (Ex. 8).

Claimant objected to the Final Determination, seeking an award of scheduled permanent disability. He first sought relief from the Department, but both the Appellate Unit and Evaluation Section declined to consider claimant's request due to lack of jurisdiction. (See Exs. 9, 10, 12, B). Finally, claimant requested a hearing, raising extent of scheduled permanent disability.

The Referee held that, because claimant failed to exhaust his administrative remedies before requesting a hearing, the Department had jurisdiction over claimant's request. Therefore, the Referee dismissed claimant's hearing request. We disagree that the Referee lacked jurisdiction over claimant's hearing request.

ORS 655.525 provides that "[a]n inmate . . . may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304." Here, in response to the Fund's final determination of his claim without an award of permanent disability, claimant ultimately requested a hearing, objecting to the Fund's failure to award any permanent disability. Since claimant was seeking review of an action taken on his claim, he is entitled to be heard. ORS 655.525; see Antonio A. Gutierrez, 42 Van Natta 1650, 1651 (1990). Therefore, dismissal of his request for hearing was improper.

Remand

On review, claimant requested that we exercise our de novo review authority to determine the extent of his permanent disability. In the alternative, claimant requested remand to the Referee for a decision on the merits of his claim. SAIF, on behalf of the Fund, took no position on claimant's alternative request for remand to the Referee.

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, claimant declined the opportunity to present testimony at the hearing. (Tr. 2-3). In his appellant's brief, claimant asks the Board to award scheduled permanent disability based on the medical evidence already in the record. The record contains a closing examination by claimant's treating physician, on which claimant urges us to rely. (See Ex. 7). Under the circumstances of this case, we conclude that the record is sufficiently developed for our review. Therefore, claimant's alternative motion for remand is denied.

Extent of Scheduled Permanent Disability

Claimant objects to the Fund's "final determination" and seeks an award of scheduled permanent disability for the loss of use or function of his right thumb. As discussed above, we have jurisdiction to consider claimant's request. See ORS 655.525.

In determining the extent of claimant's permanent disability, we apply the disability standards adopted by the Director pursuant to ORS 656.726. See ORS 656.295(5). We apply those standards that were in effect on December 12, 1991, the date of claimant's "final determination." Former OAR 436-35-001 to 436-35-260 (WCD Admin. Order 2-1991, effective April 1, 1991); see OAR 436-35-003, OAR 438-10-010.[1]

Claimant relies on the medical reports of his treating physician, Dr. Becker. However, in his November 12, 1991 closing examination, Dr. Becker did not indicate that claimant has permanent impairment as a result of his right thumb fracture. Instead, he commented: "[F]racture does go into edge of joint - not directly into articular surface; impairment, if any, is 5% or less based on joint involvement." (Ex. 7) (emphasis added).

Claimant's injury is a Bennett's fracture of his metacarpocarpal joint. (Ex. 5). Impairment values are allowed for reduced range of motion of the carpometacarpal joint of the thumb. Former OAR 436-35-075. The medical records document no reduction in range of motion which can be rated under the standards. (See Exs. 3A, 4, 5, 7). Nor is there any medical evidence that claimant has a chronic condition as a result of which he is unable to repetitively use his hand/wrist. See former OAR 436-35-010(6). Therefore, we find that claimant has no permanent impairment.

Accordingly, we conclude that claimant is not entitled to permanent disability compensation under the standards. Therefore, we affirm the Fund's "final determination" which awarded claimant no permanent disability.

ORDER

The Referee's order dated September 25, 1992 is reversed. Claimant's hearing request is reinstated. The December 12, 1991 determination, awarding no permanent disability, is affirmed.

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[1] In applying the Director's standards, we recognize that the Referee and this Board are required to evaluate claimant's disability as of the date of issuance of the Reconsideration Order pursuant to ORS 656.268. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Nevertheless, the statutory scheme for review of determinations for claims under the Inmate Injury Fund does not envision claim closure pursuant to ORS 656.268. Rather, review of determination actions are to be in accordance with the procedures set forth in ORS 656.283 to ORS 656.304. ORS 656.525. In light of this statutory scheme and our mandate in applying the Director's standards, we conclude that the appropriate time to evaluate claimant's disability is as of the date of the Final Determination.

In the Matter of the Compensation of
ROBERT M. BREWER, Claimant
WCB Case No. 92-11462
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of Referee Black's order that set aside its denial of claimant's claim for a headache condition. In his brief, claimant contends he is entitled to a penalty for an unreasonable denial. On review, the issues are compensability and penalties.

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

The Referee analyzed claimant's headache condition as an industrial injury. On review, the employer contends that claimant's headaches should be analyzed as an occupational disease pursuant to ORS 656.802(1)(a) rather than as an injury. We disagree.

Occupational diseases are distinguished from accidental injuries in that the onset of the former is gradual over a long period of time, rather than within a relatively short, discrete period of time. Further, occupational diseases are not unexpected but recognized as an inherent risk of continued exposure to conditions of the particular employment. Valtinson v. SAIF, 56 Or App 184, 187-88 (1992); Nelda L. Gilbert, 44 Van Natta 2353 (1992).

Here, claimant worked painting pinstripes on buses for a two week period. Claimant was exposed to fumes from lacquer paint. After about a week, claimant noticed headaches which became increasingly worse. On July 8, 1992, claimant was sent home after half a day of work. He sought medical treatment at an emergency room for the headaches. He reported to the emergency room physician that he had had headaches for two days after exposure to paint fumes. Claimant also experienced vomiting. Based on these facts, we conclude that claimant's condition should be analyzed as an injury since its onset was unexpected and since it arose within a discrete, relatively short period of time.

In his brief, claimant contends he is entitled to penalties for an unreasonable denial. The penalty issue was raised by claimant at hearing, but was not addressed by the Referee's order. (Tr. 2). A penalty may be assessed when a carrier unreasonably denies a claim. ORS 656.262(10). The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim.

Here, at the time the denial issued, the employer had the emergency room physician's statement that the etiology of claimant's headaches was unclear. Based on these facts, we conclude that the employer had a legitimate doubt concerning its liability. Accordingly, penalties for an unreasonable denial are not warranted.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the 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 statement of services), the complexity of the issues, and the value of the interest involved. Claimant requested a fee of $1,125 for services on review; however, we note that the remainder of his brief was devoted to the penalty issue upon which he did not prevail on review.

ORDER

The Referee's order dated December 24, 1992 is affirmed. For services on review, claimant's attorney is awarded $900, payable by the employer.

In the Matter of the Compensation of
JOAN C. GILLANDER, Claimant
WCB Case No. 93-00657 & 93-03354
and, In the Matter of the Complying Status of
ED AND EVELYN PROCTOR, dba A DRIVING SERVICE, Employer
WCB Case No. 93-00977
ORDER OF DISMISSAL (REMANDING)
Nancy F. A. Chapman, Claimant Attorney
Eric S. Shilling, Attorney
Thomas Castle (Saif), Defense Attorney

Claimant requested Board review of Referee Galton's June 22, 1993 order which: (1) found that the Department had voluntarily withdrawn its proposed order finding Ed Proctor and Evelyn Proctor (Proctors), doing business as A Driving Service, to be noncomplying employers; (2) found that the SAIF Corporation had voluntarily withdrawn its denial of claimant's injury claim issued on behalf of the alleged noncomplying employer; and (3) found that claimant had voluntarily withdrawn her request for hearing of the Department's noncomplying employer order.

Prior to filing her appeal, claimant had requested reconsideration of the Referee's order. The day after claimant's request for review was filed, the Referee abated his order to consider claimant's motion. Stating that she wants the Referee to address her motion for reconsideration, claimant seeks dismissal of her request for Board review. We treat claimant's request as a motion for remand to the Referee. ORS 656.295(5). The motion is granted.

FINDINGS OF FACT

Claimant and the Proctors filed hearing requests concerning the following issues: (1) the Department's order finding the Proctors, doing business as A Driving Service, to be noncomplying employers; and (2) the SAIF Corporation's denial of claimant's injury claim issued on behalf of the Proctors. Another potential issue involved whether claimant was a subject worker for Thrifty Car Rental (dba Pacific Northwest Rental), who was insured by SAIF. (Claimant had requested a hearing regarding SAIF's denials on behalf of Thrifty). All of these requests were consolidated for hearing.

Prior to proceeding with the June 16, 1993 hearing, the parties reached the following agreements. Because claimant was alleging an employment relationship only with Thrifty, the Department would voluntarily withdraw its proposed order finding the Proctors to be noncomplying employers. In light of such circumstances, SAIF's denial (on behalf of the Proctors) would be null and void. Finally, claimant would withdraw her hearing requests from the Department's order, as well as SAIF's denial.

The Referee advised the parties that each of these matters would be dismissed in an order separate from the "SAIF/Thrifty" claim. (WCB Case Nos. 93-00657; 93-00977; 93-03354). The hearing proceeded concerning claimant's contention that she was employed by Thrifty (SAIF's insured). (WCB Case No. 92-03284). At the conclusion of that hearing, SAIF contended that the Proctors were claimant's employer. Furthermore, since the Department's noncompliance order had been rescinded, SAIF argued that ORS 656.029 (and SAIF/Thrifty's potential responsibility under that statute) was not applicable.

On June 22, 1993, the Referee issued an Order of Dismissal. (WCB Case Nos. 93-00657; 93-00977; 93-03354). Specifically, the Referee found that: (1) the Department had voluntarily withdrawn its proposed order finding the Proctors to be noncomplying employers; (2) SAIF had voluntarily withdrawn its denial of claimant's injury claim issued on behalf of the Proctors; and (3) claimant had voluntarily withdrawn her request for hearing of the Department's noncomplying employer order.

On July 6, 1993, the Board received claimant's July 1, 1993 request for Board review of the Referee's dismissal order. That same day, the Board received claimant's July 2, 1993 motion for reconsideration of the Referee's order.

On July 7, 1993, the Referee withdrew his dismissal order for reconsideration. On August 3, 1993, the Referee notified the parties that claimant's appeal had preceded his abatement order. Consequently, claimant was requested to advise the Referee whether she wished to continue with her appeal. On August 6, 1993, claimant sought dismissal of her request for Board review to permit the Referee to proceed with consideration of her motion.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Upon the filing of a request for Board review, jurisdiction over the order vests with the Board. See Ramey S. Johnson, 40 Van Natta 370 (1988).

Here, the Referee abated his June 22, 1993 order on July 7, 1993. However, claimant's request for Board review of that June 22, 1993 order was filed on July 6, 1993, when the Board received claimant's request. See OAR 438-05-046(1)(b). Inasmuch as the Referee's July 7, 1993 order was issued without authority, it is a nullity. Thus, authority over this case rests with the Board.

In light of the circumstances surrounding claimant's request, we treat her motion as one for remand to the Referee for further development. See ORS 656.295(5). We may remand to the Referee if the record has been improperly, incompletely or otherwise insufficiently developed. Id. Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

It is our general practice to defer consideration of remand motions until we conduct our review of the merits of the case. We follow such a practice because normally a record has already been developed and it is necessary to review that record in light of "extra-record" information.

In contrast to the usual situation, this case involves the dismissal of several hearing requests prior to the introduction of evidence or the presentation of testimony. Moreover, these requests had previously been consolidated for hearing with another request which did proceed to hearing. Finally, an allegation has been made that arguments raised following that hearing call into question the pre-hearing understandings which prompted a party's voluntary withdrawal of some of her hearing requests.

Consequently, we conclude that the present record is not properly, completely, or sufficiently developed for us to resolve the issues raised by claimant's appeal. Therefore, we hold that remand is warranted. ORS 656.295(5).

Accordingly, this case is returned to Referee Galton for further action consistent with this order. In other words, consideration of claimant's motion for reconsideration and its effect on the issues raised in these consolidated hearing requests.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOROTHY E. McCALL, Claimant
WCB Case No. 91-16935
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Menashe's order which: (1) found that claimant is not permanently and totally disabled; and (2) declined to direct the insurer to pay claimant's scheduled permanent disability award at the rate of $305 per degree. In her appellant's brief, claimant also requests the Board to authorize reimbursement for her costs which were incurred in taking the deposition of one of claimant's witnesses. On review, the issues are permanent and total disability, rate of scheduled permanent disability, and reimbursement of costs.

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

Claimant requests reimbursement for her costs incurred in taking the deposition of one of her witnesses, vocational expert Mr. Tindall. Claimant explains that Mr. Tindall was to testify on the second hearing day, but that hearing session ended before Mr. Tindall's testimony could be taken. Since the parties had difficulty scheduling another hearing date, claimant agreed to have Mr. Tindall's testimony taken by deposition, as suggested by the Referee. Under these circumstances, claimant contends that the costs of the deposition should be paid for by the Board as part of the hearing.

Claimant cites no authority, nor are we aware of any authority, which permits us to authorize reimbursement for her deposition costs. Furthermore, claimant agreed to have the deposition taken, rather than continue the hearing to a mutually suitable date. Considering such circumstances, claimant's request for reimbursement of deposition costs is denied.

ORDER

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

August 24, 1993 Cite as 45 Van Natta 1631 (1993)

In the Matter of the Compensation of
KENNETH W. METZKER, Claimant
WCB Case Nos. 92-06974 & 92-06973
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Spangler's order that: (1) declined to increase claimant's rate of temporary disability; (2) declined to address claimant's entitlement to temporary partial disability after June 2, 1992 for lack of jurisdiction; (3) declined to assess penalties and attorney fees for an allegedly unreasonable refusal to pay temporary disability benefits; and (4) declined to assess penalties and attorney fees for an allegedly unreasonable calculation of claimant's rate of temporary disability. In its brief, the self-insured employer asks that in the event we find jurisdiction over the temporary partial disability issue, we remand for the taking of additional evidence. On review, the issues are rate of temporary disability, jurisdiction, entitlement to temporary partial disability, remand, and penalties and attorney fees. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

After being released to light duty by Dr. Versteeg, claimant returned to modified work in June 1992. At that time, claimant was working 13 hours a week.

CONCLUSIONS OF LAW AND OPINION

Rate of temporary disability

The issue before the Referee was whether claimant was paid the correct rate of temporary total disability for the August 2, 1991 and February 11, 1992 compensable right hip claims. He found the employer did not incorrectly calculate claimant's temporary total disability rate. We agree and adopt that portion of the Referee's "Conclusions of Law and Opinion" as supplemented.

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. Because claimant was paid on an hourly basis with varying hours, he was paid on other than a daily or weekly basis. Therefore, we find the employer correctly based claimant's temporary total disability rate on the weekly wage calculated pursuant to OAR 436-60-025(5)(a).

Temporary partial disability

Jurisdiction

The Referee declined to address the question of entitlement to temporary partial disability after June 2, 1992 for lack of jurisdiction. The Referee reasoned that questions of entitlement must first be decided by the Evaluation Section, as well as the Appellate Review Unit, before such an issue can be decided by the Hearings Division. We disagree.

Under ORS 656.268(5), the Hearings Division lacks initial jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. However, a Referee has original jurisdiction over disputes concerning an injured workers' procedural entitlement to temporary disability because that issue is ripe prior to claim closure. Here, claimant is objecting to the employer's unilateral termination of temporary disability while the February 1992 claim was in open status. In effect, claimant is raising an issue regarding the employer's "pre-closure" conduct. Therefore, we conclude the Referee had jurisdiction, limited to claimant's procedural entitlement to temporary disability. See Michael J. Drake, 45 Van Natta 1117 (1993); Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992).

Remand

The employer, in its brief, moves for remand to the Hearings Division, in the event we find jurisdiction. The employer argues the case was insufficiently developed in regard to evidence needed to establish claimant's entitlement to temporary partial disability past June 1992. Inasmuch, as we have concluded that we have jurisdiction to proceed in this matter, we consider the employer's request.

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).

We find the issue was before the Referee and litigated by the parties. The parties had ample opportunity to present their cases. If the employer was surprised by new evidence the remedy was to request a continuance. No showing has been made on this record of good cause or any other compelling reason justifying remand. Nor has it been shown that material evidence was not obtainable with due diligence at the time of the hearing. The motion is, therefore, denied.

Merits

On February 11, 1992, claimant injured his right hip and his claim was accepted as disabling. In April 1992, claimant had right hip surgery. Eventually, claimant's attending physician, Dr. Versteeg, released claimant to light duty. Claimant returned to modified work in June 1992. The record reflects the employer paid claimant temporary total disability from February 11, 1992 until May 18, 1992. (Exs. 30, 32).

Pursuant to ORS 656.268(3), temporary disability shall continue until whichever of the following events occurs first: (a) the worker returns to regular or modified employment; (b) the attending physician gives the worker a written release to return to regular employment, or (c) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker, and the worker fails to begin such employment. See Soledad Flores, 43 Van Natta 2504 (1991).

Therefore, on claimant's return to modified employment the employer was authorized to terminate temporary total disability. ORS 656.268(3)(a). However, the employer was obligated to begin paying temporary partial disability in accordance with OAR 436-60-030(1). OAR 436-60-030(2) provides that if claimant's wages in modified employment were equal to or greater than his wages at the time of injury, his temporary partial disability rate would be zero. See Safeway v. Owsley, 91 Or App 475 (1988).

In late 1991 or early 1992 claimant's hours were reduced from 32 to 40 hours a week to approximately 13 hours a week. (Tr. 33). Thus, at the time of injury claimant's regular work consisted of 13 hours a week. Claimant testified that when he returned to work following his surgery he was again working 13 hours a week. (Tr. 18-19). This evidence indicates that claimant returned to modified work with no reduction of wages. There is no evidence to the contrary. Therefore, we conclude that claimant's temporary partial disability rate is zero. Based on this record, we find claimant has failed to carry his burden in proving greater entitlement to temporary disability.

Penalties and attorney fees

Claimant seeks entitlement to penalties and attorney fees for unreasonable claims processing on two separate grounds: (1) the calculation of claimant's rate of temporary disability; and (2) the refusal to pay temporary partial disability after claimant returned to modified work in June 1992. In light of our discussion above we find no unreasonable claims processing by the employer. Accordingly, we conclude there is no basis for either a penalty or an assessed attorney fee. See ORS 656.262(10); 656.382(1).

ORDER

The Referee's order dated September 17, 1992 is affirmed.

August 24, 1993 Cite as 45 Van Natta 1633 (1993)

In the Matter of the Compensation of
PRUITT WATSON, Claimant
WCB Case No. 92-04422
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Barber's order which: (1) denied claimant's motion to set aside a disputed claim settlement; and (2) upheld the self-insured employer's "back-up" denial of claimant's neck, shoulder, and back conditions. On review, the issue is validity of a disputed claim settlement and, if the disputed claim settlement is set aside, compensability. We reverse.

FINDINGS OF FACT

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

On August 18, 1991, claimant slipped and fell at work, injuring his neck, left shoulder and low back. (Exs. 2-122, 2-107).

Dr. Novick, chiropractor, examined claimant on August 21, 1991 and diagnosed cervical and lumbar strains, brachial neuralgia, and left shoulder contusion/strain. He noted that claimant was injured in June 1991 as a bus passenger in an accident, in which the "[l]eft shoulder was primary area of injury, exacerbated in 8/18/91 work injury." (Ex. 2-107). The employer, through its claims processing agent, received this report on August 22, 1991. (Id).

On October 16, 1991, Dr. Geist, orthopedist, conducted an independent medical examination. (Ex. 2-58). The employer received this report on October 25, 1991. (Id). Dr. Geist noted claimant's history of a low back injury sustained at work in New Orleans in 1985, as well as the June 1991 bus injury. (Ex. 2-58 to -59). He concluded that the major contributing cause of claimant's present condition was the August 18, 1991 work injury, noting that claimant had recovered from the June 1991 bus injury. (Ex. 2-65).

On November 11, 1991, the employer accepted the claim "for cervical sprain/strain, lumbar strain/sprain and contusion with left arm pain and left leg pain." (Ex. 2-116).

On January 3, 1992, the employer scheduled a closing examination with Dr. Grimm, neurologist, in which claimant's current left knee condition was to be evaluated. (Ex. 2-112). Dr. Grimm examined claimant on January 15, 1992 and February 25, 1992. (Ex. 2-9). The employer received Dr. Grimm's report on March 4, 1992. (Id).

On January 15, 1992, claimant, through counsel, initiated settlement negotiations with the employer proposing to resolve the claim by claim disposition agreement. On February 6, 1992, claimant terminated his attorney's services. (Ex. 2-110). However, settlement negotiations between claimant and the claims manager continued, and on February 27, 1992, the claims manager proposed a disputed claim settlement (DCS). Claimant accepted the offer.

Pursuant to settlement discussions, on March 4, 1992, the employer issued a "back-up" denial in connection with the proposed DCS. (Ex. 2-7). The denial recited that a claim for neck, shoulder and back injuries arising out of an August 18, 1991 work injury had previously been accepted in good faith, but that "through our continued investigation, we have uncovered a prior claim for the same condition occurring in New Orleans in 1985 and another claim for injuries sustained in a bus accident." Based on this "new information," the employer revoked its previous acceptance and issued a denial of claimant's entire claim. (Id).

The DCS recites the employer's assertion that "there is insufficient evidence to establish that claimant's work activity with the employer was the major cause of his neck, left shoulder and low back conditions. The employer contends that all of claimant's present problems are attributable to the 1985 injury." (Ex. 2-3).

The DCS was approved by a referee on March 6, 1992. Claimant received the sum of $11,000 upon approval of the settlement. (Ex. E-1). Claimant subsequently filed both a motion to set aside the DCS and a timely hearing request from the employer's "back-up" denial.

CONCLUSIONS OF LAW AND OPINION

Validity of Disputed Claim Settlement

The Referee declined to set aside the DCS, finding there were no extraordinary circumstances to justify setting it aside. Claimant contends that the DCS should be set aside because there was no bona fide dispute regarding the compensability of his claim. The employer's sole contention on review is that claimant is bound by the DCS in the absence of extraordinary circumstances to justify setting it aside. We disagree, and set aside both the DCS and the "back-up" denial.

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Roberts v. Willamette Industries, 82 Or App 188, rev den 302 Or 461 (1986). Settlements are to be encouraged within the limits of the statute; once approved, they should be set aside only if they clearly violate the statute. Kasper v. SAIF, 93 Or App 246, 250 (1988). In determining whether a settlement violates the statute, we exercise de novo review authority. See, e.g., Daryl G. Richmond, 38 Van Natta 220 (1986) (on reconsideration), aff'd Richmond v. SAIF, 85 Or App 444 (1987); Roberts v. Willamette Industries, supra. We regard setting aside an approved settlement to be an extraordinary remedy to be granted sparingly in the most extreme circumstances. Tom B.Talmage, 42 Van Natta 1519 (1990); Mary Lou Claypool, 34 Van Natta 943, 946 (1982).

Here, we find that the DCS clearly violates ORS 656.289(4) because there was no bona fide dispute concerning the compensability of claimant's injury claim. Consequently, it must be set aside.

Settlement discussions began following acceptance of claimant's claim. Initially, claimant was represented by counsel. Preliminary negotiations between claimant's counsel and the employer focused on a claim disposition agreement. However, differences could not be resolved.

Shortly thereafter, claimant discharged his attorney and decided to proceed on his own without benefit of counsel. Claimant and the claims manager reached an agreement wherein the employer would issue a "back-up" denial denying the claim followed by a disputed claim settlement. (Ex. D-4; see also Tr. 7). In accordance with the agreement, a "back-up" denial issued on the basis that it "uncovered a prior claim for the same [accepted] condition occurring in New Orleans in 1985 and another claim for injuries sustained in a bus accident." (Ex. 2-7). The parties then entered into the DCS.

The evidence indicates that the decision to enter into a disputed claim settlement, as opposed to a claim disposition agreement, was premised not on the merits of the case, but solely on financial and practical considerations. According to the claims manager's affidavit:

> "Of particular importance was the fact that [claimant] wished to obtain his money as soon as possible because he wanted to leave the state immediately. We determined that a Disputed Claim Settlement was more appropriate in this regard than a Claim Disposition agreement because there was no 30 day waiting period. [See ORS 656.236(1)(c).] Because of some previous, undisclosed medical problems and injuries, it was determined that a back-up denial could be issued and that a Disputed Claim Settlement could be entered into." (Ex. D-3).

Based on the medical record and the claims manager's affidavit, we find there was no bona fide dispute concerning compensability when the parties entered the DCS. Contrary to the terms of the "back-up" denial, the employer knew about claimant's 1985 back injury and bus injury, as well as their relationship to his August 1991 injury, at the time of its acceptance. The first medical report following the August 1991 work injury noted that claimant was injured in a bus accident in June 1991, injuring primarily his left shoulder. The same report noted that the left shoulder injury was exacerbated by the August 1991 work injury. (Ex. 2-107). A subsequent independent medical examination by Dr. Geist, which the employer received prior to its acceptance, contained claimant's medical history, including the 1985 low back injury in New Orleans and the June 1991 bus injury. (Ex. 2-58 to 59, 2-65).

Thus, information regarding the prior injuries did not constitute "later obtained evidence" within the meaning of ORS 656.262(6). See CNA Ins. Co. v. Magnuson, 119 Or App 282, 286 (1993). Absent such evidence, there was no statutory authorization for the "back-up" denial; it was an invalid attempt to revoke the prior acceptance. Because claim acceptance was not validly revoked, there was no bona fide dispute concerning compensability to resolve by DCS. Based on this clear violation of ORS 656.289(4), and the fact that claimant entered into the agreement without the benefit of counsel, and the apparent attempted circumvention of the spirit of ORS 656.236(1),[1] we find that these circumstances are extraordinary and warrant setting aside the March 4, 1992 DCS. See Kasper v. SAIF, supra.

Validity of "Back-Up" Denial

As we stated above, we do not find that the employer's back-up denial was based on new evidence; that is, "something other than the evidence that the insurer had at the time of its initial acceptance." ORS 656.262(6); CNA Ins. Co. v. Magnuson, supra. A "back-up" denial which is not based on later obtained evidence is not permissible under the statute and must be set aside. See Rose Mills, 45 Van Natta 1215, 1217 (1993); Ralph E. Murphy, 45 Van Natta 725 (1993). Indeed, the employer does not attempt to defend its denial on the merits. Accordingly, the denial is set aside.

Compensability

Since we set aside the employer's "back-up" denial on procedural grounds, we do not address the compensability issue. The employer's November 1991 claim acceptance remains in effect.

Offset

Since we have set aside the March 6, 1992 Disputed Claim Settlement, and since the settlement proceeds have already been paid, we may authorize an offset for the amount paid by the employer against future permanent disability benefits in the same claim. See Steve Maywood, 44 Van Natta 1199 (1992), aff'd mem 119 Or App 517 (1993). The employer requested authorization for an offset at the hearing, in the amount of $11,250, the full settlement amount. (Tr. 2-3). Claimant admits he received the settlement proceeds in the amount of $11,000, while the remaining $250 was paid to claimant's former attorney in satisfaction of his lien. (Tr. 17; Ex. 2-3, 2-6). Although not paid directly to claimant, the attorney fee portion of the settlement is properly considered a benefit to claimant. See Steiner v. E.I. Bartells Co., 114 Or App 22 (1992); Buck E. Johnson, 45 Van Natta 244 (1993). Accordingly, we authorize an offset in the amount of $11,250 against future awards of permanent disability on this claim.

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[1] ORS 656.236(1) prohibits the release of medical benefits on an accepted claim and requires a 30 day "waiting period" for Board approval. The claims manager's affidavit persuades us that the DCS was designed to avoid these CDA requirements.

Attorney Fee

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 $3,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 8, 1992 is reversed. The employer's March 4, 1992 "back-up" denial and the parties' March 6, 1992 Disputed Claim Settlement are set aside. The claim is remanded to the employer for further processing according to law. The employer's request for authorization of an offset in the amount of $11,250 against future awards of permanent disability is approved. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the employer.

In the Matter of the Compensation of
EDWIN WOODWORTH, Claimant
WCB Case No. 92-02969
ORDER ON REVIEW
W. D. Bates, Jr., Claimant Attorney
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee McWilliams' order that set aside its denial of claimant's injury claim for a right inguinal hernia. On review, the issue is compensability.

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

Applying a material contributing cause standard, the Referee found that claimant had established the compensability of his right inguinal hernia. On review, the insurer contends that claimant has preexisting conditions and must meet the major contributing cause standard in order to establish compensability. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). Specifically, the insurer contends that Dr. Innes' opinion supports the conclusion that claimant had a preexisting hernia or preexisting emphysema prior to the work incident. We disagree.

Dr. Innes speculated that claimant had a preexisting hernia or a tendency to develop a hernia. However, he characterized his opinion as an assumption and conceded that there was no way of knowing that a hernia was present prior to the pulling incident. (Ex. 16-25). There is no other medical evidence in the record which would support a finding that claimant had a preexisting hernia. Based on the record, we are unable to find that claimant had a preexisting hernia condition.

Dr. Innes explained that claimant's barrel chest and past history of smoking gave him the impression that claimant had some degree of emphysema. Dr. Innes indicated that a history of smoking or emphysema would be significant as a causative factor in the hernia because of the repeated coughing that condition would cause. However, although he clearly suspected that claimant had emphysema, Innes stated that he did not actually observe any of the signs or symptoms of emphysema on examination. At hearing, claimant testified that he had never been diagnosed with emphysema and did not have any trouble with his lungs, such as difficulty breathing or coughing. In addition, claimant had not smoked for eight years. On this record, we are unable to conclude that claimant has a preexisting condition as contemplated by ORS 656.005(7)(a)(B).

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 issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 15, 1992 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

In the Matter of the Compensation of
ESTHER M. ANDERSON, Claimant
Own Motion No. 93-0245M
OWN MOTION ORDER OF ABATEMENT
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our July 30, 1993 Own Motion Order on Reconsideration in the above-captioned case.

Claimant has submitted an affidavit regarding her willingness to return to work, and a statement from her former employer attesting to claimant's desire to return to work up to the time of her surgery. The employer states that claimant's condition physically prevents her from being able to do the job because of extensive walking, since the business is located on the second floor of the building.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case No. 91-18171
SECOND ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 29, 1993 Order on Reconsideration which held that SAIF has the burden of proving by clear and convincing evidence that claimant's claim is not compensable, notwithstanding its revocation of claim acceptance within the 90 day claim processing period. SAIF argues that our decision is inconsistent with our prior decisions in Tony N. Bard, 45 Van Natta 1225 (1993), and Anthony G. Ford, 44 Van Natta 240 (1992). We disagree.

The Bard and Ford cases involved allegations of fraud being committed by workers to obtain compensation. We decided (in Bard and Ford) that ORS 656.262(6) does not apply in cases where the acceptance was induced by fraud, misrepresentation or other illegal conduct.

The present case does not involve any allegation of fraud being committed by the injured worker. Rather, SAIF revoked its acceptance on the basis of "new evidence" that the claim is not compensable. We concluded (in our original order) that the language of ORS 656.262(6) is not ambiguous and that according to its plain terms, it applied to SAIF's "back-up" denial. We continue to so hold.

Accordingly, we withdraw our July 29, 1993 order. On reconsideration, as supplemented herein, we adhere to and republish our July 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
LUELLA M. BEST, Claimant
WCB Case Nos. 92-12794 & 92-14573
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

EBI Companies, on behalf of Siltec, requests review of those portions of Referee Garaventa's order that: (1) set aside its denial of claimant's new injury claim for a cervical and left shoulder strain condition; (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of the same employer, of claimant's aggravation claim for the same condition; and (3) awarded an assessed attorney fee, payable by EBI. On review, the issues are responsibility, aggravation and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In this case, neither insurer contends that claimant's current neck and left shoulder condition is not compensable. The Referee stated that Liberty concedes that claimant's current condition is compensable, (O&O p. 3; see Tr. 4-5), and Liberty does not contest that statement on review. Moreover, because Liberty's denial of claimant's aggravation claim is based on the premise that the compensable condition has not worsened, Liberty has not denied medical services under ORS 656.245.

EBI argues that claimant did not suffer a new injury, but only a continuation of the condition which Liberty Northwest accepted and that Liberty, therefore, remains responsible for claimant's current problems. Liberty argues that claimant did suffer a new injury during EBI's coverage and responsibility thus shifts to EBI or, alternatively, that claimant's compensable condition did not worsen such that her accepted claim with Liberty should be reopened.

As a preliminary matter, we acknowledge EBI's argument that to shift responsibility to EBI, Liberty must prove that the June 16, 1992 incident, while EBI was on the risk, caused a worsening of her underlying condition. In this regard, EBI cites Teresa L. Walker, 41 Van Natta 2283 (1989) and Peggy Holmes, 45 Van Natta 272 (1993). However, the Walker and Holmes holdings have been applied only in single employer/insurer cases where neither compensability nor responsibility is at issue; i.e., where the sole question is whether a claim is properly processed as an aggravation or a "new injury." Because this is a responsibility dispute, we apply the following reasoning.

Responsibility

Under ORS 656.308(1), when an accepted injury is followed by an increase in disability during employment with a later employer/insurer, responsibility rests with the original employer/insurer 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, Liberty Northwest, the last employer/insurer with whom claimant had a compensable cervical and left shoulder injury, remains presumptively responsible. In order to avoid responsibility, Liberty Northwest has the burden of establishing that claimant sustained a new compensable injury involving the same condition during EBI's coverage. Gerald K. Mael, 44 Van Natta 1481, 1482 (1992).

In order to prove a "new compensable injury," Liberty Northwest must show that the claimed June 1992 incident was a material contributing cause of claimant's disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). A mere symptomatic exacerbation of the accepted condition is not a "new injury." See Michael L. Whitney, 45 Van Natta 446 (1993). In addition, 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).

The Referee found, based on the opinion of Dr. Conduff, that claimant suffered a new injury while EBI was on the risk. We disagree, for the following reasons.

On August 11, 1992 (after the claimed June 1992 aggravation or new injury), claimant stated that her left shoulder problems had been "ongoing" since the initial injury claim was closed in December 1990 and that these problems have "affected [her] 24 hours a day." (Ex. 31-4). Claimant's statement suggests that the June 1992 incident may have only increased her symptoms from the 1989 compensable injury. If that is true, responsibility would not shift to EBI. See Leland G. Townsend, 45 Van Natta 1074 (1993); 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 1992 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 rev den 300 Or 546 (1986). The medical evidence relevant to the "new injury" question is provided primarily by Drs. Conduff and Kulus.

We find that Conduff's opinion lacks persuasive force in this regard. Conduff first saw claimant on June 22, 1992, after the June 16 incident. Because Conduff did not examine claimant until after the claimed new injury, he is unable to compare her condition, before and after that date, on a firsthand basis. Moreover, Conduff's belief that before June 16, 1992, claimant was "substantially asymptomatic from her 1989 injury," is contrary to claimant's assertion that her problems had been ongoing on a "24-hour" basis (Compare Exs. 31-4, 38-1). Under these circumstances, we are unable to find that Conduff's opinion regarding claimant's current condition is based on an accurate history. Consequently, Conduff's conclusion that the June 16, 1992 incident caused claimant's subsequent need for treatment is not persuasive and we decline to rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Kulus, on the other hand, examined and treated claimant between December 27, 1989 and May 14, 1992, and again on June 16 and 17, 1992. (Ex. 2). According to Kulus' June 16 chart note,

claimant "reinjured her left neck and shoulder at work today." (Ex. 2-8). On August 12, 1992, Kulus stated that he "last saw [claimant] on June 18, 1992 for an acute exacerbation of this condition." (Ex. 32). Considering Kulus' description of the June 1992 incident, in light of claimant's own assertions that her problems were "ongoing" since 1989 "24 hours a day," we conclude that claimant's current problems are nothing more than a symptomatic exacerbation of her accepted condition, as opposed to being the result of an actual independent compensable injury during the subsequent work exposure. (See Exs. 20, 29C, 30A). Therefore, we conclude that claimant's June 16, 1992 incident was not a "new injury" and responsibility remains with Liberty. Inasmuch as EBI's denial is reinstated and upheld, we also reverse the $2,000 assessed attorney fee payable by EBI.

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).

Here, even assuming that claimant's compensable shoulder and neck condition worsened, resulting in diminished earning capacity, we conclude that claimant has not carried her additional burden under ORS 656.273(8), which states:

> "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."

The record in this case reveals long-standing expectations that claimant's neck and shoulder problems would continue and that her work activities would cause exacerbations. (See Exs. 7, 13, 14, 15-2, 17, 18). Although Drs. Kulus and Brooks opined that claimant was medically stationary prior to initial claim closure, they clearly anticipated that claimant would have residual symptoms and that she would continue to need pain medication and job restrictions. Dr. Brooks informed claimant that "she may need to learn to live with some degree of discomfort and to modify some of her activities because of this." (Ex. 14). Under these circumstances, we conclude that the December 21, 1990 Determination Order contemplated future periods of increased symptoms accompanied by diminished earning capacity. Thus, claimant must show that her recent exacerbation exceeded the diminished earning capacity contemplated by her 6 percent unscheduled permanent disability award. On this record, we are unable to find that claimant has carried this burden. Accordingly, we agree with the Referee that Liberty's denial should be affirmed.

We note particularly that Liberty has not denied claimant's claims for medical services for her neck and left shoulder conditions. Therefore, Liberty remains responsible for medical treatment related to claimant's condition under ORS 656.245.

ORDER

The Referee's order dated January 11, 1993 is reversed in part and affirmed in part. That portion of the order that set aside EBI Companies' denial is reversed. The denial is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
EDWARD K. CAMPANELLI, Claimant
WCB Case No. 92-10772
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Neal's order which affirmed an Order on Reconsideration that awarded claimant 17 percent (54.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant, age 25, graduated from high school in 1984. He was in the Air Force from 1985 to 1987, where he served as an ICBM technician refurbishing missile sites. (Ex. 11A).

In 1987 and the early part of 1988, he worked as a car salesman. (Ex. 11A).

He worked at the employer from May 1988 to the present. (Ex. 11A).

Drs. Cohen and Klein released claimant to work with a 30 pound lifting restriction. They also restricted claimant from prolonged stooping and repetitive lifting or twisting. (Exs. 8, 10 and 18).

FINDINGS OF ULTIMATE FACT

The highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination is his job at injury. This job is Warehouse Worker (DOT # 922.687-058), which is classified as medium strength. The SVP is 2.

Claimant's residual functional capacity is light work.

Claimant has sustained a 19 percent loss of earning capacity as a result of his low back injury.

CONCLUSIONS OF LAW AND OPINION

The sole issue at hearing and on review is the adaptability factor. The Referee concluded that claimant went from a medium job at the time of injury to a residual functional capacity of medium/light. We modify.

The temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. OAR 436-35-003(4) (WCD Admin. Order 93-052) (Temp.); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993). In determining the extent of permanent disability, the adaptability factor is a comparison of the highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination as compared to the worker's maximum residual capacity at the time of determination. OAR 436-35-310(1). For a job to qualify, the worker must meet the requirements as outlined in OAR 436-35-300(3). OAR 436-35-310(1)(a). If a worker does not meet these requirements, or if a worker's highest prior strength has been reduced as a result of an injury that is not an accepted Oregon workers' compensation claim, the prior strength is based on the worker's job at the time of injury. OAR 436-35-310(1)(b) and (c). The requirements listed in OAR 436-35-200(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the Specific Vocational Preparation (SVP) category assigned by the DOT. See OAR 436-35-300(3).

Claimant worked for two years as an ICBM technician refurbishing missile sites and for less than a year as an automobile salesman. There is no evidence that claimant had successfully performed a job with a greater strength demand during the previous 10 years than the job he held at the time of injury, Warehouse Worker (DOT # 922.687-058), which is assigned the strength category of medium. Claimant does not contend that the duties of this job differed from those described in the DOT, with the exception of the strength demands, which he contends were heavy.

After reviewing the testimony and the record, we conclude that claimant's job at injury was correctly identified as Warehouse Worker (DOT # 922.687-058). Accordingly, we conclude that claimant's job at injury required the physical capacity to perform medium work.

Claimant further contends that his residual functional capacity (RFC) is in the light work category. We agree. The Referee correctly found that claimant was released for work with a 30 pound lifting restriction and that he had limitations on prolonged stooping, repetitive lifting or twisting. For all workers, the adaptability value is calculated according to OAR 436-35-310(2) and (3). For workers determined by the rules to have the RFC to do more than the requirements of one category, but not the full range of requirements for the next higher category, the classification established between the two categories shall be used. OAR 436-35-310(2). For workers determined by the rules to have a RFC established between two categories and also have restrictions, the next lower classification shall be used. OAR 436-35-310(3). Claimant's 30 pound lifting restriction falls between medium and light. See OAR 436-35-310(2). In addition, claimant's physicians restricted him from frequently stooping or twisting. Accordingly, his RFC is classified as light. OAR 436-35-310(3). Applying the chart provided in OAR 436-35-310(2), the comparison of claimant's strength of medium as a Warehouse Worker to his RFC of light is 3. See OAR 436-35-310(2).

We now assemble the factors relating to unscheduled disability according to the method set forth in OAR 436-35-280. Claimant's impairment is (7). Claimant's age of under 40 is (0). Claimant's formal education is (0). The SVP assigned to his job is 2, for a value of (4). The values for formal education and skills are added for a value of (4). OAR 436-35-300(5). Claimant's age (0) plus education (4) is (4). OAR 436-35-280(4). The result times the adaptability factor of (3) is (12). OAR 436-35-280(6). That result plus the impairment value of (7) is (19). Therefore, claimant is entitled to 19 percent unscheduled permanent disability. OAR 436-35-280(7).

ORDER

The Referee's order dated November 17, 1992 is modified. In addition to the 17 percent (54.4 degrees) unscheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, giving him a total award to date of 19 percent (60.8 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded shall not exceed $3,800.

In the Matter of the Compensation of
DONALD R. DODGIN, Claimant
WCB Case No. 91-13730
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Westerband, Gunn, and Neidig.

Claimant requests review of that portion of Referee Spangler's order that found that the Hearings Division lacks jurisdiction to reclassify his claim as disabling. Should we conclude that the Hearings Division had jurisdiction to reclassify his claim, claimant contends that: (1) the Referee erred in refusing to admit a medical report; (2) he is entitled to temporary total disability benefits; and (3) a penalty and/or related attorney fee should be assessed against the SAIF Corporation for its allegedly unreasonable claim processing. In its brief, SAIF contends that the Referee erred in directing it to report claimant's claim to the Director for a determination under ORS 656.268. On review, the issues are jurisdiction, claims processing, evidence, and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, a landscaper, sustained a laceration to his left wrist off-the-job on October 28, 1989. The laceration was treated and sutured, and claimant returned to work. On November 1, 1989, claimant fell at work, causing one of the sutures to loosen. The suture was repaired, and he returned to work.

On November 10, 1989, claimant reopened the laceration while working and sought treatment. The laceration was resutured, but claimant was unable to return to work.

Claimant began treating with Dr. Balkanovich and, on November 29, 1989, underwent surgery to remove an ulcer and repair skin damage. Claimant filed a claim the next day. Dr. Balkanovich released claimant for regular work a few weeks after surgery.

SAIF denied the claim, and claimant requested a hearing. A prior referee dismissed the hearing request; however, the Board vacated the dismissal order and remanded the case to the referee for a hearing. While the case was pending, the parties entered into an August 2, 1991 Stipulation and Order, in which SAIF agreed to rescind its denial and accept claimant's left wrist injury claim.

On August 12, 1991, SAIF issued a Notice of Claim Acceptance which advised claimant that his left wrist injury claim had been accepted and classified as nondisabling. On September 19, 1991, claimant's attorney wrote the Department of Insurance and Finance (DIF) to request that the claim be reclassified as disabling. (Ex. 14). On October 18, 1991, DIF responded that, because the reclassification request was made more than one year after the date of injury, DIF could not take action on the request. DIF advised that the request should be processed as an aggravation claim. (Ex. 15).

CONCLUSIONS OF LAW AND OPINION

Evidence

We first address the Referee's evidentiary ruling. The Referee declined to admit Exhibit 5A, a note in which claimant's doctor releases claimant for work. The note is dated December 12, 1989, and is marked with a date stamp indicating that claimant's attorney received the note on September 11, 1991. However, claimant did not provide SAIF with a copy of the document until January 3, 1992, the date of hearing. The Referee found that the document was not timely disclosed and that there was not good cause for the untimely disclosure. On review, claimant argues that the Referee erred in declining to admit the exhibit. We disagree.

We agree with the Referee's finding that the exhibit was not timely disclosed to SAIF in accordance with the Board rules. See OAR 438-07-015(3), (4); OAR 438-07-018(1), (2). Nevertheless, the Referee has discretion to admit untimely disclosed documents, based on a determination of whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party. OAR 438-07-018(4). We review the Referee's evidentiary ruling for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

The Referee found that material prejudice had resulted from the timing of the disclosure. We agree. Claimant's doctor's authorization of time loss is directly relevant to the issue of claimant's disabling status and, because SAIF was not aware of the exhibit, its disclosure at hearing seriously impaired SAIF's ability to prepare its defense. That is enough to prove material prejudice.

We also agree with the Referee's finding that claimant did not prove good cause for the untimely disclosure. The only reasons submitted for the untimely disclosure are inadvertence and claimant's attorney's belief that SAIF already had a copy of the document. Neither reason establishes good cause for the delay. Accordingly, we do not find that the Referee abused his discretion in refusing to admit Exhibit 5A.

Classification - Jurisdiction

The Referee refused to consider claimant's request to reclassify his claim as disabling, finding that the request must first be made to the Director of DIF, not the Hearings Division. The Referee ordered SAIF to report the reclassification request to the Director for a determination. On review, claimant contends that the Referee had jurisdiction over this matter and should have reclassified his claim as disabling. SAIF contends that the Director does not have jurisdiction to consider claimant's reclassification request and that claimant's claim must be made as an aggravation claim. After reviewing relevant case law and the statutory scheme for reclassification requests, we conclude that we have jurisdiction over claimant's request for reclassification.

We begin with the recent Court of Appeals' decision in Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993). Reviewing the statutory scheme in ORS 656.262(6) and ORS 656.268,[1] the court concluded that a claimant has one year from the date of injury in which to seek reconsideration by the Department of Insurance and Finance (DIF) of an insurer's decision to reclassify his claim from disabling to nondisabling. The court held that, if an insurer 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 the insurer fails to do so, then it must process the disabling claim to closure. Id. at 281.

This case is factually distinguishable from Degrauw because, whereas the claimant in Degrauw was challenging the insurer's reclassification of the claim from disabling to nondisabling, this claimant is challenging SAIF's initial classification of his claim as nondisabling. Nevertheless, we have previously applied the reasoning in Degrauw to the initial classification of a claim.

In Charles B. Tyler, 45 Van Natta 972 (1993), the claimant's injury claim had been accepted and classified as nondisabling almost eight months after the date of injury. More than a year after the date of injury, the claimant requested reclassification of the claim as disabling. Relying on Degrauw, we concluded that the claimant had sufficient time to challenge his claim classification within one year from the date of injury. We held that the claimant's reclassification request was untimely and, therefore, he must make the claim as an aggravation claim pursuant to ORS 656.273. See ORS 656.277(1), (2).[2]

Here, as in Tyler, claimant did not request reclassification of his claim as disabling within one year after his November 10, 1989 injury. Unlike Tyler, however, claimant's injury claim was not accepted until more than a year after the date of injury. At the time of claim acceptance in August 1991, SAIF classified the claim as nondisabling. Because the claim was classified more than a year after the date of injury, claimant was precluded, through no fault of his own, from seeking reconsideration by DIF of the nondisabling classification.[3] See Degrauw v. Columbia Knit, Inc., supra.

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[1] ORS 656.262(6) provides, in part:

"The notice of acceptance shall:

"(a) Specify what conditions are compensable.

"(b) Advise the claimant whether the claim is considered disabling or nondisabling.

"(c) Inform the claimant of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon pursuant to ORS 656.268 within one year of the date of injury." (Emphasis added.)

[2] ORS 656.277 provides, in part:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of 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] We recognize that, in occupational disease cases, we have interpreted the "date of injury" as the date of claim acceptance for classification purposes. E.g., Robert E. Wolford, 45 Van Natta 435 (1993). We did so because of the uncertainty in determining a precise "date of injury" in an occupational disease claim. We found that, if the "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), it would be impossible for the claimant to challenge the nondisabling classification. Like the Degrauw court, we found that such an interpretation would be inconsistent with the statutory scheme. See Charles B. Tyler, supra. We decline to apply that analysis to injury claims, however, because of the relative certainty with which the date of the injury can be established.

SAIF argues on review that claimant is foreclosed from seeking reclassification because he did not raise that issue when his claim had been denied as nondisabling. We disagree. While SAIF is correct that it listed claimant's injury as nondisabling on the same 801 form by which it denied the claim, (see Ex. 5), that "classification" did not trigger claimant's statutory right to seek reclassification. In fact, an insurer is not required to advise a claimant of his right to object to a nondisabling classification until issuance of the notice of claim acceptance. ORS 656.262(6)(c). Consistent with that statutory scheme, we have held that a claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling. Thomas L. Runft, 43 Van Natta 69 (1991).

The classification of a claim is important because it determines the duration of a claimant's aggravation rights. Aggravation rights run from the date of injury for nondisabling claims, whereas those rights run from the date of the first claim closure for disabling claims. ORS 656.273(4). With that in mind, we do not believe it is consistent with the statutory scheme to preclude a claimant from challenging an insurer's nondisabling classification in those cases where the injury claim is first classified more than a year after the date of injury. Rather, the statutory scheme provides that a claimant has a right to object to a nondisabling classification. We conclude, therefore, that the claimant should have a meaningful opportunity to exercise that right.

For these reasons, we reject SAIF's contention that claimant must make his reclassification request as an aggravation claim. An aggravation is established by proof that a claimant has a worsened condition, i.e., a change in condition which renders the claimant more disabled. ORS 656.273(1); Smith v. SAIF, 302 Or 396, 399 (1986). It would be virtually impossible for a claimant whose injury was, in fact, disabling from the outset to establish a change in condition. Thus, if his claim was classified as nondisabling more than a year after the date of injury, the claimant would be effectively denied an opportunity to object to the classification. Such a result is not consistent with the statutory scheme.

Rather, we believe that, inasmuch as an objection to a nondisabling classification is a matter "concerning a claim," ORS 656.283(1) allows claimant the opportunity to make that objection. That is, claimant may object to an initial claim classification by requesting a hearing, as he did in this case. However, we emphasize that our holding is limited to circumstances where the claimant is precluded, through no fault of his own, from seeking reclassification by DIF of an injury claim because the claim was initially classified more than one year after the date of injury. Because the Referee declined to exercise jurisdiction of claimant's reclassification request, we reverse.

Reclassification - Merits

Although the Referee declined to reach the merits of claimant's reclassification request, the parties presented their evidence pertaining to that issue. Because we find that the record has been sufficiently developed for our review, see ORS 656.295(5), we proceed to the merits of the reclassification request.

Claimant testified that he left work on November 10, 1989, when he tore the sutures from his wrist, and did not return to work until several weeks after surgery had been performed on November 28, 1989. That testimony is uncontroverted and supported by the medical record. Because we find that claimant was temporarily disabled as a result of the accepted injury, we conclude that his claim should be reclassified as disabling. See ORS 656.005(7)(c).

Penalties and Attorney Fees

Although we were persuaded by claimant's testimony that he was temporarily disabled from work, his testimony regarding what, if any, notice he gave the employer regarding his temporary disability is confused and contradictory. Claimant initially testified that Dr. Balkanovich gave him a written release from work, then later testified that he "somewhat" recalled receiving the written release. (Tr. 26). He also testified that he did not give the written release to the employer; that he did not recall whether he did so; and, finally, that he showed the release to the employer. (Tr. 27-28). When his attorney showed him a written release from work dated December 12, 1989, claimant stated that it was the release that he showed the employer before his surgery. However, when he was reminded that the surgery occurred before the date of the release, in November 1989, he all but conceded that his memory of those events was uncertain. (Tr. 28-29).

Given claimant's testimony, and the lack of any documentary evidence establishing when the employer or SAIF received notice or knowledge that claimant was disabled as a result of the compensable injury, we do not find that claimant has sustained his burden of proving an unreasonable resistance to compensation. Accordingly, there is no basis for assessing a penalty or related attorney fee against SAIF. See ORS 656.262(10), 656.382(1).

ORDER

The Referee's order dated January 13, 1992, is reversed in part and affirmed in part. That portion of the order that directed the SAIF Corporation to report claimant's claim to the Director is reversed. SAIF is directed to reclassify the claim as disabling and to process it 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 remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
WILLIAM J. EMERY, Claimant
WCB Case Nos. 92-10927 & 92-06427
ORDER OF ABATEMENT
Susan Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Liberty Northwest Insurance Corporation moves to abate and reconsider those portions of our July 29, 1993 Order on Review that: (1) directed that the Referee's assessed attorney fee award be paid by Liberty Northwest, rather than Kemper Insurance Company; and (2) awarded claimant an assessed attorney fee, payable by Liberty Northwest, for claimant's counsel's services on Board review. In order to allow sufficient time to consider the motion, the above-noted Board order is withdrawn.

Claimant and Kemper are 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
ANTHONY FOSTER, Claimant
WCB Case No. 92-06071
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral upper extremity conditions; and (2) declined to assess penalties based on SAIF's allegedly unreasonable denial and its allegedly unreasonable failure to pay interim compensation. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Stipulation of the Parties," with the following exception and supplementation.

We do not adopt the Referee's finding that claimant used a pneumatic grinder at home. Instead, we find that claimant used a "drummel [sic]" grinder, about the size of a razor, at home and pneumatic tools at work, including a grinder weighing about 1-1/2 pounds. (See Tr. 11-12, 24, 28, 44). The tools used at work, particularly a pneumatic hammer, vibrated claimant's upper extremities causing upper extremity pain and numbness. The tools claimant used at home did not vibrate like the tools he used at work. (Tr. 44-45, 47).

FINDINGS OF ULTIMATE FACT

Claimant's work activities for the employer involved repetitive traumatic use of his upper extremities. These work activities were the major contributing cause of claimant's disability and need for medical services for his upper extremity conditions and/or their worsening. The existence of claimant's upper extremity conditions is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Credibility

In this case, the Referee found, based on demeanor, that claimant appeared to be a credible witness. Despite this favorable demeanor based credibility finding, the Referee rejected claimant's specific testimony, because he perceived a conflict between that testimony and the documentary evidence. Thus, we find the Referee's decision not to rely on claimant's testimony was primarily based on inconsistencies in the record. When a Referee's finding is based on substantive discrepancies in the record, we are equally capable of assessing a witness' credibility, based on an objective evaluation of the evidence. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

The Referee concluded that claimant's reporting is not reliable, for two reasons. First, the Referee found claimant's testimony concerning the onset of symptoms to be inconsistent with Dr. Warren's history. Warren's November 4, 1991 chart note documents claimant's history that his hands "fell asleep" before he began working for the employer in 1991. (Ex. 2-5). On the other hand, at hearing, claimant denied having any hand or arm symptoms before this job. (Tr. 35, 51). Considering the extent and disabling nature of claimant's post-June 1991 symptoms (which led to five surgeries), and the absence of evidence of prior treatment for anything similar, we are inclined to believe that claimant previously experienced nothing similar to his 1991 problems. More importantly, assuming claimant did have prior hand symptoms, there is no proof that Warren's history was inaccurate or incomplete in this regard. Rather, it is clear that Warren did have claimant's history and nonetheless related claimant's 1991 problems to his 1991 work exposure, specifically to the exposure beginning in June 1991.

Moreover, claimant's comment that "sensation in his left hand is better than it has been for years [post-surgery]" does not convince us that Warren's history was materially inaccurate. (See Ex. 8). Thus, although we agree that there is some inconsistency between claimant's testimony and one chart note, we conclude that this discrepancy does not infect Dr. Warren's conclusions or impact the outcome of the case.

The Referee's second reason for finding claimant unreliable is based on a conclusion that claimant did not delay filing this claim for fear of losing his job. However, because we accept claimant's explanation for delaying claim filing, (see Tr. 41, 57), and conclude that claimant's reporting to Warren was materially reliable, we find no persuasive reason to disbelieve claimant.

Compensability

Claimant bears the burden of proving that his work activities were the major cause of his upper extremity conditions or their worsening. ORS 656.802(2).

The Referee held that claimant failed to carry his burden, because he found the opinion of Dr. Radecki, independent examiner, more persuasive than the opinion of Dr. Warren, treating physician. In reaching this result, the Referee reasoned that Warren's failure to distinguish between preexisting and post-work exposure symptoms, as well as claimant's unreliable reporting, render Warren's conclusions unpersuasive. In addition, the Referee inferred that claimant's right arm and forearm were not stressed by his work, because they were not treated until November 1991 and claimant stopped working in August 1991. We disagree.

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). In this case, we find no such reasons not to defer to Dr. Warren's opinion.

First, we note that Warren did distinguish between claimant's preexisting symptoms and those associated with his work exposure. Specifically, Warren relied on claimant's uncontroverted reporting that his trouble with his arms and forearms "really got worse" when he began using a pneumatic hand hammer at work. (See Exs. 29-17, 29-31; see also Ex. 29-8). In addition, we note that Warren distinguished claimant's right ulnar nerve subluxation condition, which Warren believed preexisted the work exposure, from the other upper extremity conditions, which he believed did not. (Ex. 26-2).

Second, even if all claimant's conditions preexisted his work exposure, we understand Warren's opinion to indicate that claimant's work activities would nonetheless be the major contributing cause of the conditions' worsening. Thus, in our view, Warren's opinion supports a conclusion that claimant's work caused the conditions or their worsening. See ORS 656.802(2).

Third, we decline to infer that claimant's right arm problems are not work-related simply because they were not treated until after claimant stopped working. In this regard, we note that Warren recorded claimant's right sided complaints and explained why these problems increased over time, even after he stopped working. (See Exs. 2-5, 8, 29-21-22). Considering Warren's unrebutted explanation, Dr. Radecki's skepticism in this regard is not persuasive. (See Ex. 22-4). In addition, we are unpersuaded by Radecki's opinion concerning the importance of arguably inconsistent history to Warren. As we have stated, Warren was appraised of the identified inconsistency and it did not affect his opinion. (See Ex. 29-37). In addition, although claimant did not discuss the extent and duration of his off-work activities with Warren, the doctor was eventually informed in this regard and the additional information did not affect his opinion. (See Ex. 29-23-25; 29-36-37).

Under these circumstances, finding no persuasive reason to discount Warren's opinion, we rely on it. On this basis, we conclude that claimant has carried his burden and his claim is compensable.

Penalties and Attorney Fees

We adopt the Referee's opinion regarding the penalty issues.

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 $10,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's 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 November 4, 1992 is affirmed in part and reversed in part. That portion of the order that upheld the SAIF Corporation's denial of claimant's claim for bilateral upper extremity conditions is reversed. The denial is set aside and the claim is remanded to SAIF for further processing according to law. The remainder of the order is affirmed. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an attorney fee of $10,000, to be paid by SAIF.

In the Matter of the Compensation of
DOTTY C. FOWLER, Claimant
WCB Case No. 92-03437
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Foss, Whitty, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of that portion of Referee Myers' order which set aside its partial denial of claimant's current low back condition and request for surgery. Claimant cross-requests review of that portion of the Referee's order which upheld the insurer's denial of an aggravation claim for her low back condition. In its appellate brief, the insurer moves to consolidate this case with an earlier related case pending review before the Board. On review, the issues are compensability, aggravation and motion for consolidation. We deny the motion for consolidation, and we affirm in part and reverse in part.

FINDINGS OF FACT

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

On May 24, 1993, the Board issued its Order on Review of Referee Brown's order in WCB case number 91-15570. The Board reversed Referee Brown's order and held, inter alia, that the insurer's failure to challenge the Determination Order and Order on Reconsideration awards of permanent disability did not constitute acceptance of claimant's low back condition. Dotty C. Fowler, 45 Van Natta 951 (1993).

CONCLUSIONS OF LAW AND OPINION

Motion to Consolidate

Prior to reaching the merits of the insurer's motion to consolidate, we issued our order in the earlier case with which the insurer sought consolidation. See Dotty C. Fowler, supra. Nevertheless, we take administrative notice of our prior decision and have considered it in reviewing the present case. Accordingly, the insurer's motion to consolidate is denied.

Law of the Case

Referee Myers found that, based on the earlier order of Referee Brown and interim order of Referee Livesley, the law of the case established that claimant's low back condition was part of her accepted claim. However, subsequently, we reversed Referee Brown's order, finding that the insurer's failure to challenge awards of permanent disability did not constitute acceptance of the low back condition. Dotty C. Fowler, supra; see also Cecilia A. Wahl, on recon 44 Van Natta 2505 (1992) (payment of permanent disability award does not constitute acceptance of the condition).

Here, the insurer specifically accepted only a left trapezius strain resulting from the February 13, 1989 work injury. (Ex. 4). Since the insurer did not specifically accept claimant's low back condition, it is not part of the accepted claim. See Johnson v. Spectra Physics, 303 Or 49 (1987). Accordingly, we reverse Referee Myers' order insofar as it set aside the insurer's partial denial of compensability of claimant's current low back condition.

We turn now to the issue of whether claimant's aggravation claim is compensable.

Aggravation Claim

A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be compensable. We determine first whether the worker's current condition is compensable; that is, whether the current condition is compensably related to the original work injury. If we find that the current condition is compensable, we then determine whether the compensable condition has worsened since the last arrangement of compensation. ORS 656.273(1); see also Gray v. SAIF, 121 Or App 217 (1993); Marie M. Sax, 44 Van Natta 2152 (1992).

Here, the insurer denied both the causation and worsening components of claimant's aggravation claim. (See Exs. 32, 34). Accordingly, it is claimant's burden to first prove the compensability of her current condition.

Claimant contends that her low back condition was directly caused by the February 1989 lifting incident at work. Therefore, in order to establish compensability of her low back condition, claimant must establish, by medical evidence supported by objective findings, that the work injury was a material contributing cause of her condition. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant's current low back condition was diagnosed as a recurrent disc at the L5-S1 level, for which Dr. Jany, her treating physician, sought surgery authorization in February 1992. (Ex. 30). Thus, the issue in this case is whether the original work injury is a material contributing cause of claimant's recurrent L5-S1 disc.

Claimant's original injury occurred on February 13, 1989 as a result of a lifting incident at work, which the insurer accepted as a left trapezius strain. (Exs. 2, 4). Claimant initially treated with Dr. Hoogeveen on February 16, 1989, who excused claimant from work with diagnoses of cephalgia and cervical and left shoulder strains. (Exs. 3, 3A).

The first documentation of claimant's back pain is in Dr. Hoogeveen's March 24, 1989 chart note, where he refers to an undated incident in which claimant twisted her left ankle and back trying to keep herself from falling. (Ex. 4A-2). Dr. Hoogeveen noted that claimant had "twisted her back slightly which gave her kind of a setback for 2 days," and which resulted in hip and left-sided back pain with "tenderness over the left SI joint [and] left trochanteric region." (Id). Claimant remained off work. (Id).

Claimant's back pain continued, and on April 21, 1989, Dr. Hoogeveen referred her to Dr. Jones for an orthopedic consultation. (Ex. 4A-4). In his May 24, 1989 examination, Dr. Jones noted that claimant's lumbar spine x-rays showed normal disc heights. (Ex. 4B-2).

Dr. Bernstein, neurologist, saw claimant in consultation on September 11, 1989. (Ex. 5B). On November 29, 1989, Dr. Bernstein ordered a lumbar spine MRI, which revealed a large L5-S1 disc herniation. (Ex. 6). On January 17, 1990, Dr. Jones performed surgery for the herniated L5-S1 disc. (See Exs. 8, 9, 10). As noted above, the insurer has never specifically accepted claimant's low back condition.

Claimant continued to experience low back pain, but Dr. Jones felt her condition was medically stationary in February 1991, and her claim was closed. (See Exs. 10A, 14, 17). In August 1991, Dr. Jany, an orthopedist in the same clinic as Dr. Jones, assumed claimant's treatment. (Ex. 19-1).

Claimant continued to have back pain. In February 1992, claimant reported weakness in her left leg and back spasms several weeks previously. Dr. Jany ordered an MRI in order to rule out a recurrent L5-S1 disc herniation. (Ex. 28). The February 17, 1992 MRI revealed an L5-S1 disc herniation, and Dr. Jany requested surgery authorization for the recurrent disc. (Exs. 29, 30).

After our review of the record, we find that claimant's back pain first appeared more than one month after her work injury, following an apparently unrelated back twisting incident; initial lumbar x-rays were normal; the herniated disc first appeared over nine months after the work injury; and the recurrent disc occurred two years after the initial work injury, apparently without any precipitating

incident. Given these factors, we find that the causation issue is a complex medical question, resolution of which turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Drs. Barth, neurologist, and Baker, orthopedist, performed an independent medical examination on December 6, 1990, following claimant's lumbar laminectomy in January 1990. They opined:

> "[H]er back complaints and lumbar laminectomy were not the direct result of the industrial incident of February 13, 1989, when she strained her left upper trapezius muscle. This appeared to have been a separate incident, which was not work related, and which occurred on March 24, 1989, when she twisted her left ankle and tried to keep from falling."

Ex. 11-6). Neither Dr. Barth nor Dr. Baker offered an opinion regarding causation of claimant's February 1992 recurrent disc herniation.

There are two medical opinions which link claimant's low back condition to the original work injury of February 1989. However, we do not find either opinion persuasive.

Dr. Bernstein opined, in response to claimant's attorney's letter, that "the need for her laminectomy and diskectomy at the L5-S1 level does relate directly to her injury of 2/12/89." (Ex. 33A). However, it is unclear from the context of claimant's attorney's request and the doctor's response whether Dr. Bernstein's opinion addressed the initial 1990 surgery or the proposed recurrent disc surgery. (See Exs. 33C, 33A). Moreover, we do not find a bare, one-sentence conclusion persuasive in linking claimant's current back condition to a work injury which occurred three years previously, particularly when claimant's back symptoms began one month later following a separate incident, and the herniated disc first appeared nine months later.

Dr. Jany also responded to claimant's attorney's letter. He opined that the major cause of claimant's low back injury, which resulted in surgery by Dr. Jones at the L5-S1 level, was the lifting incident at work in February 1989. He added that the lifting incident "has been very consistently the source of her problems all along." (Ex. 36). We find that Dr. Jany's opinion concerns the causation of claimant's initial need for surgery, but does not address her current condition or need for surgery. Thus, we do not find his opinion helpful in addressing causation of claimant's current low back condition.

Moreover, although Dr. Jany states that the February 1989 work incident has been consistently the source of claimant's low back problems all along, he does not address the contrary opinion of independent examiners Barth and Baker. (See Ex. 11-6). Nor does Dr. Jany explain his opinion in light of Dr. Hoogeveen's March 24, 1989 chart note, which documents the first appearance of claimant's back pain, apparently following an unrelated back-twisting incident. Under these circumstances, we do not find Dr. Jany's conclusory, one-sentence opinion persuasive in establishing the compensability of claimant's current low back condition.

There are no other medical opinions which specifically address the causation of claimant's current low back condition. On the record before us, we are unable to find that claimant's original disc herniation and surgery, or her recurrent disc and need for surgery, are work-related. Accordingly, because it is claimant's burden to prove the compensability of her current condition, and because we find the evidence insufficient to carry claimant's burden, we conclude that claimant's current low back condition is not compensable.

Having found claimant's current condition not compensable, we need not address whether her current condition has worsened. See Gray v. SAIF, supra. Accordingly, we affirm that portion of the Referee's order which upheld the insurer's denial of claimant's aggravation claim.

ORDER

The Referee's order dated August 12, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's denial of claimant's current low back condition and awarded a $2,000 attorney fee is reversed. The insurer's denial of claimant's current low back condition is reinstated and upheld. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JAMES E. GORE, Claimant
WCB Case No. 91-16593
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Black's order that set aside its denial of claimant's aggravation claim. In addition, the employer seeks remand for admission of post-hearing evidence. On review, the issues are remand and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

The Referee declined to reopen the record for receipt of additional evidence, namely an additional report by Dr. Nagel dated July 21, 1992 and the stress x-rays and x-ray reports referred to in that report. On review, the employer moves for remand, alleging that the hearing record is incompletely or otherwise insufficiently developed according to statute. ORS 656.295(5). Specifically, the employer contends that the record is insufficiently developed because Dr. Nagel, claimant's attending orthopedic surgeon, indicated that he should have performed those x-rays prior to hearing to establish whether instability is present in claimant's right ankle. We disagree that this constitutes an insufficiently developed record.

We may remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). 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 6421, 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). Evidence which is not in existence at the time of hearing is "unavailable" but may still be "obtainable." Compton, supra, at 648.

Here, both sides had ample opportunity to obtain and present evidence relative to the issue of whether claimant's right ankle condition worsened, and whether that worsening was related to the accepted condition. The record is sufficiently developed. Furthermore, evidence is not newly discovered merely because it was generated after the hearing. The employer, who had obtained a medical examination of claimant prior to hearing, could have obtained stress x-rays as well. The employer failed to show why it was not able to do so. We accordingly deny the insurer's request for remand and proceed with our review.

Aggravation

We affirm and adopt the Referee's order with the exception of the last two sentences of the last paragraph on page 6. Claimant's prior accepted injuries are not "preexisting conditions" within meaning of ORS 656.005(7)(a)(B). See SAIF v. Drews, 117 Or App 596, 599 (1993).

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the remand and compensability issues is $1,790, 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 statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 3, 1992, as reconsidered January 4, 1993, is affirmed. Claimant's attorney is awarded $1,790 for services on Board review, to be paid by the self-insured employer.

August 26, 1993 Cite as 45 Van Natta 1653 (1993)

In the Matter of the Compensation of
BOB E. GROTZ, Deceased, Claimant
WCB Case No. 92-06846
Order on Review
Welch, Bruun & Green, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The beneficiaries of the deceased claimant request review of Referee Neal's order that upheld the SAIF Corporation's denial of claimant's injury claim. In its brief, SAIF moves to strike portions of claimant's reply brief. On review, the issues are motion to strike and compensability. We deny the motion to strike and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to strike

SAIF moves to strike portions of claimant's reply brief relating to his request for an attorney fee. However, because we agree with the Referee's conclusion that claimant has not proven compensability, the attorney fee issue is moot. Consequently, the motion to strike is denied.

Compensability

We adopt the Referee's "Opinion" and offer the following additional analysis regarding the sufficiency of the relationship between claimant's employment and his fatal injury. See Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985).

Whether the activity at the time of injury was for the benefit to the employer

We agree with the Referee that the deceased claimant was probably returning a New Holland skidder, which he had borrowed for personal use at his home, when he was killed at the employer's Boardman plant on March 22, 1992. In reaching this conclusion, we acknowledge that there is testimony by the decedent's widow and brother, suggesting that the decedent intended to do some work for the benefit of the employer on that Sunday. In this regard, claimant's widow testified that the decedent stated that he would be away from home for about an hour and a half or two hours, because he needed to move some grass seed at the plant. She stated that she planned to accompany her husband with their child, but decided not to, because the decedent explained that he was staying longer at the plant than she had expected, for the purpose of moving seed. Even assuming that the widow (and brother) accurately reported the decedent's intent, we would not conclude that the beneficiaries have thus established that the decedent was performing work "for the benefit of the employer" when he was killed. See Mellis, 74 Or App at 574.

As the Referee noted, the decedent had no work duties or responsibilities at the Boardman plant. Moving seed was not part of claimant's regular work. Although the New Holland skidder was used by others at the plant to put raw seed into a feeder for processing, neither seed nor processing

equipment was ready for use on Monday, the next business day. Moreover, even if claimant believed that he needed to move seed for reasons other than processing (e.g., delivery to customers) he probably would have used a forklift, rather than the skidder. In this regard, we note undisputed testimony indicating that a forklift was the proper tool for moving bagged seed, the forklift was working, and claimant had access to its keys. (Tr. 132-33; 137-38; 143; 160-61).

Finally, because the decedent was apparently killed while replacing the bucket which had been on the skidder when he borrowed it, we find that he had not finished restoring the equipment to the condition it was in when he borrowed it. Consequently, on this evidence, we conclude that claimant's activity was more likely completion of his personal mission than work for the benefit of the employer.

Whether the activity was contemplated by employer and employee

There is evidence that the decedent had a great deal of leeway in performing his work. For example, although he usually worked 40 hours per week, Monday through Friday, he was authorized to work nights and weekends when necessary. Consequently, working on this Sunday may have been contemplated by the employer.

On the other hand, the decedent did not request permission to borrow the skidder before he took it home for his personal use. Moreover, there is no reliable evidence indicating that the employer needed grass seed moved or that it planned to process seed anytime soon after Sunday March 22, 1992. Consequently, even assuming that the decedent intended to move grass seed and was preparing to do so, we do not find that his activities --borrowing and returning the skidder and/or moving grass seed-- were contemplated by the employer.

Whether the activity was an ordinary risk of, and incidental to, the particular employment

The decedent's job was to contract for the growing and selling of grass seed. There is no evidence that his work involved using a skidder for anything, including moving seed. Consequently, we do not find that his use of the skidder, including his activity at the time of his death, was an ordinary risk of his particular employment or that it was likely incidental to that employment.

Whether the employee was paid for the activity

Because the decedent was paid by salary and was authorized to work on weekends, he could have been paid for work performed on Sunday, March 22, 1992. However, we find no evidence that he was actually paid for working that day.

Whether the activity was on the employer's premises

It is undisputed that the accident occurred on the employer's premises.

Whether the activity was directed or acquiesced in by the employer

There is no contention that the decedent's activity was directed by the employer.

Because the decedent had never borrowed the skidder before, there is no pattern from which we might deduce that the employer acquiesced on this occasion. It is true that Dave Matteson, a co-equal employee, knew that the decedent borrowed it on March 20, 1992. However, because there is no evidence that Matteson was authorized to grant the decedent permission to use the machine, we cannot say that the employer thus acquiesced in the borrowing or any other use of that equipment.

Whether the employee was on a personal mission

We have found, supra, that the beneficiaries have not proven that the decedent was engaged in anything other than a personal mission --returning the borrowed skidder-- when he was killed.

Conclusion

Upon considering the facts and arguments in light of the seven "Mellis factors" listed above, we conclude that the beneficiaries have not proven that the decedent's activities were for the benefit of the employer; were contemplated by the employer; or that they were acquiesced in by the employer. Although the accident happened on the employer's premises, we cannot say whether the decedent was paid for his activities at the time of the accident. Moreover, we find it likely that claimant was on a personal mission at the time of his injury and that no aspect of the decedent's employment placed him at risk. In sum, we find that the relationship between the decedent's injury and his employment was not sufficient to establish compensability.

ORDER

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

August 26, 1993 Cite as 45 Van Natta 1655 (1993)

In the Matter of the Compensation of
JOSLIN A. McINTOSH, Claimant
WCB Case No. 91-12955
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Galton's order that: (1) affirmed an Order on Reconsideration that awarded 13 percent (19.5 degrees) scheduled permanent disability for loss of use or function of the left leg (hip); and (2) declined to modify the approved attorney fee granted by the Order on Reconsideration. On review, the issues are extent of scheduled disability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the January 15, 1992 "Interim Order of Remand" and incorporated in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent disability

The Referee affirmed the Order on Reconsideration which granted claimant 13 percent scheduled permanent disability for loss of use of her left leg (hip). We agree.

At the outset, claimant requests that this matter be remanded to the Director for promulgation of a temporary rule pursuant to ORS 656.726(3)(f)(C). In Gary D. Gallino, 44 Van Natta 2506 (1992), we held that neither the Hearings Division nor the Board have authority to remand an Order on Reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C). Thus, as in Gallino, we decline to remand this case to the Director for the adoption of a temporary rule.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require the application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 436-35-003(1); WCD Admin. Order 2-1991.

Claimant contends that she is entitled to an increased award of scheduled permanent disability based on Dr. Woolpert's March 20, 1991 examination. (Ex. 4A). However, Dr. Woolpert indicated that

claimant was not medically stationary at the time of the examination. In fact, claimant was not determined to be medically stationary until July 19, 1991. Inasmuch as claimant was not medically stationary at the time of Dr. Woolpert's examination, the report is not persuasive evidence concerning the extent of claimant's permanent disability. See Gettman v. SAIF, 289 Or 609 (1989); Jesus Mejia, 44 Van Natta 32 (1992). Accordingly, we do not rely on Dr. Woolpert's report.

The only other medical evidence in the record concerning the extent of claimant's permanent disability comes from Dr. Peterson. The only evidence of permanent disability in Dr. Peterson's report consists of findings of a decreased range of hip motion. Peterson reported that claimant retained 95 degrees of flexion; 10 degrees of extension; and 0 degrees of internal rotation in the left hip. Dr. Rabie, claimant's attending physician, concurred with Dr. Peterson's findings.

Relying on Dr. Peterson's findings, claimant is entitled to 1 percent for loss of flexion; 2 percent for loss of extension; and 10 percent for loss of internal rotation. See OAR 46-35-007(16); OAR 436-35-220(5),(6), (10). These impairment values are added for a total of 13 percent impairment. OAR 436-35-220(12). Accordingly, claimant's award of scheduled permanent disability is 13 percent.

Attorney Fees

We adopt the Referee's conclusions and reasoning concerning the attorney fee issue. See Kenneth V. Hambrick, 43 Van Natta 1636 (1991).

ORDER

The Referee's order dated October 7, 1992 is affirmed.

August 26, 1993 Cite as 45 Van Natta 1656 (1993)

In the Matter of the Compensation of
JOHNNA N. REDFORD-FERNAAYS, Claimant
WCB Case No. 91-18263
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myers' order that: (1) found that claimant's aggravation claim for her low back condition was not prematurely closed; and (2) declined to award additional scheduled and unscheduled permanent disability. On review, the issues are premature closure, extent of scheduled permanent disability, and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1984 while working for the employer (EBI's insured) as a certified nurse's aide. As a result of the compensable injury, claimant underwent a bilateral L4-5 hemi-laminectomy and diskectomy and a right L5-S1 decompressive hemi-laminectomy. The claim was initially closed by a October 1985 Determination Order that awarded claimant 25 percent unscheduled permanent disability. Claimant's award was increased to 35 percent by a December 1985 stipulation.

Claimant returned to work as a rest stop attendant and later as a housekeeper in a nursing home. In 1990, she was working as a "bath attendant" in a nursing home. In May 1990, claimant slipped while assisting a patient who was in a bathtub. She felt an immediate onset of back pain and right leg numbness. Claimant sought treatment on May 17, 1990 from Dr. Hazel.

Claimant filed an aggravation claim against EBI and a "new injury" claim against SAIF, the carrier for the nursing home. By Opinion and Order dated January 16, 1990, an earlier referee found that EBI remained responsible for claimant's low back condition and ordered EBI to accept claimant's aggravation claim.

Following the May 1990 slipping incident, claimant returned to light duty work at the nursing home. She continued to treat with Dr. Hazel. On August 4, 1990, Dr. Hazel reported that claimant was medically stationary, but noted that she continued to have periodic back discomfort. In an 828 form dated February 1, 1991, Dr. Hazel noted that he had last examined claimant on September 11, 1990 and listed that date as her medically stationary date.

Claimant's claim was closed by an April 12, 1991 Determination Order which awarded only temporary disability benefits. The Determination Order listed August 4, 1990 as claimant's medically stationary date.

Claimant did not see Dr. Hazel between September 11, 1990 and April 29, 1991. During that time period, claimant experienced increasing low back pain and began to have difficulty walking due to leg numbness. On April 30, 1991, claimant returned to Dr. Hazel with complaints of increased low back pain. Dr. Hazel recommended that claimant use a chair brace and consider a L4-5-S1 arthrodesis surgery. Thereafter, Dr. Hazel requested authorization for the surgical procedure which was ultimately granted.

Claimant requested reconsideration of the April 12, 1991 Determination Order. On November 16, 1991, claimant underwent an examination by an medical arbiter. The Order on Reconsideration issued on December 19, 1991 and affirmed the Determination Order in its entirety.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant's claim was not prematurely closed by the April 12, 1991 Determination Order. We disagree.

In order to establish that the April 1991 Determination Order prematurely closed her claim, claimant must demonstrate that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

At the outset, we note that the relevant inquiry is not whether claimant was medically stationary on August 4, 1990. Rather, it is whether claimant was medically stationary on April 12, 1991, the date of claim closure. See Scheuning, supra.

Although Dr. Hazel initially found claimant medically stationary on August 4, 1990, he subsequently reported that she was medically stationary on September 11, 1990. (Ex. 95). Dr. Hazel did not examine claimant again until April 30, 1991, 18 days after claim closure. At that time, Hazel noted that claimant's low back symptoms had increased since September 1990 and recommended treatment in the form of a chair brace. Dr. Hazel also reported that a further surgical procedure should be considered. Eventually, Dr. Hazel requested authorization to perform an L4-5 intertranverse process arthrodesis which was approved by the Medical Director.

In conjunction with Dr. Hazel's report, claimant testified that following her return to modified work in the fall of 1990, her low back pain became increasingly worse. She also testified that the numbness in her leg increased. Claimant finally returned to Dr. Hazel in late April 1991 because her back pain had gotten to the point that she could not concentrate on her job duties.

While claimant may have been medically stationary on August 4, 1990, we conclude that the record as a whole establishes that she was not medically stationary on April 12, 1991, the date of claim closure. Claimant suffered from increased low back pain both prior to and after closure. Furthermore, the treatment proposed by Dr. Hazel was not palliative in nature but rather was designed to improve claimant's back condition and ongoing complaints. Moreover, there was no change in claimant's condition following claim closure. Finally, surgery was requested and authorized in order to further improve claimant's condition. Under these circumstances, we find that the April 12, 1991 Determination Order prematurely closed claimant's claim. See Aguiar v. J. R. Simplot Co., 87 Or App 475, 479 (1987).

Inasmuch as we have found claimant's claim prematurely closed, we do not reach the issue of the extent of claimant's permanent disability.

ORDER

The Referee's order dated March 5, 1992 is reversed. The April 12, 1991 Determination Order and December 19, 1992 Order on Reconsideration are set aside as premature and the claim is remanded to the insurer for processing according to law. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

August 26, 1993 Cite as 45 Van Natta 1658 (1993)

In the Matter of the Compensation
JOHNNA N. REDFORD-FERNAAYS, Claimant
WCB Case No. 91-0574M
OWN MOTION ORDER OF DISMISSAL
Peter O. Hansen, Claimant Attorney
Beers, et al., Defense Attorney

The insurer submitted claimant's claim for an alleged worsening of her April 4, 1984 industrial injury. Claimant's aggravation rights expired on October 15, 1990.

On July 23, 1991, Dr. Hazel, treating orthopedist, requested authorization for a proposed L4-5 transverse process arthrodesis. On October 10, 1991, the insurer requested Director's review of the reasonableness and necessity of this proposed surgery pursuant to ORS 656.327 and OAR 436-10-046. On November 14, 1991, the Board postponed action regarding the own motion request pending resolution of the Director's review.

On January 14, 1992, the Medical Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute in which he concluded that the proposed surgery was appropriate for claimant's current condition. However, in the meantime, claimant had requested a hearing on a December 19, 1991 Order on Reconsideration issued by the Appellate Review Unit of the Workers' Compensation Division. (WCB Case No. 91-18263). One of the issues claimant raised in her hearing request was premature closure. Finding that, if claimant prevailed on the premature closure issue, her claim would not be within our own motion jurisdiction, we continued to postpone action on the own motion request pending resolution of the premature closure issue.

On March 5, 1992, Referee Myers issued an Opinion and Order in which he concluded that claimant's claim was not prematurely closed. Claimant requested Board review of Referee Myers' order. By an order issued on today's date, the Board reversed the Referee's decision, found that claimant's claim had been prematurely closed, and remanded the claim to the insurer for processing according to law.

We have own motion jurisdiction of claimant's claim only if her aggravation rights under ORS 656.273 have expired. Here, claimant's claim was last reopened prior to the expiration of her aggravation rights, and that claim was found to have been prematurely closed. Therefore, claimant's claim remains in open status pursuant to a reopening under ORS 656.273. Accordingly, we have no own motion jurisdiction over claimant's claim, and we dismiss claimant's request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID J. ROWLEY, Claimant
WCB Case No. 90-20805
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Schultz' order that: (1) set aside its denial of claimant's aggravation claim; and (2) directed it to reclassify the claim as disabling. On review, the issues are reclassification and aggravation. We vacate in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial of claimant's aggravation claim, based on medical evidence suggesting that claimant is permanently precluded from operating a chain saw due to his compensable bilateral trigger finger conditions. In addition, the Referee directed SAIF to reclassify the claim (which it accepted as nondisabling) as a disabling injury and process it to closure. We disagree.

First, claimant was compensably injured on October 15, 1988. By Notice of Acceptance dated February 3, 1989, SAIF accepted and classified the claim as nondisabling. Claimant did not challenge this classification nor did he allege that his claim had become disabling until September 16, 1992, more than one year after the date of injury. Claimant does not allege that he failed to receive notice of the nondisabling classification within one year from the date of injury. See, e.g., DeGrauw v. Columbia Knit, Inc., 118 Or App 277, 281 (1993) (held that employer is precluded from reclassifying claim as nondisabling more than one year after date of injury). Despite having sufficient time to challenge the nondisabling classification within one year from the date of injury, claimant failed to do so and, therefore, must make his claim as a claim for aggravation. See ORS 656.277(2); Charles B. Tyler, 45 Van Natta 972 (1993). We conclude the Referee erred in directing SAIF to reclassify the claim as disabling.

Second, although claimant timely made an aggravation claim under ORS 656.273(3), we do not find that he proved that claim under ORS 656.273(1). Specifically, claimant has not established that his compensable trigger finger conditions have worsened since his claim was accepted and classified as nondisabling. See ORS 656.273; see also Karen S. McKillop, 44 Van Natta 2473, 2475 n. 2 (1992)(The status of the claim was established at acceptance). In reaching this conclusion, we acknowledge that Dr. Schwartz, who treated claimant on three occasions between November 1988 and April 1991, checked a box indicating concurrence with a statement that claimant was "more disabled now due to a worsening of the accepted condition than at closure of the previous claim[.]" (Ex. 9). However, Schwartz also recorded claimant's 1990 history of "continuing problems with both hands" and claimant's feeling that his "symptoms are a continuing of the difficulty that started when he was running a chain saw." (Ex. 5-1). Claimant testified that his condition had been "pretty much" the same since early 1989. (Tr. 15, 18).

Under these circumstances, we are not persuaded that Schwartz' unexplained check-the-box opinion establishes that claimant's post-acceptance condition was worse than when the initial injury claim was accepted and classified as nondisabling. Rather, the record strongly suggests that claimant's condition did not worsen since 1988. (See Exs. 15, 28).

Apart from the unexplained opinion of Dr. Schwartz, the evidence of an alleged worsening comes from Dr. Long who examined claimant on February 7, 1991. In a September 15, 1992 report (Ex. 28), Dr. Long essentially opined that the classification of the injury as nondisabling was erroneous at the outset and certainly at the time of acceptance in 1989.[1] Dr. Long reasoned that if (as was the case) claimant was not able to return to work as a timber faller in 1989, "then clearly permanent disability should have been recognized," and since permanent disability had not been acknowledged by SAIF, claimant's condition must have worsened since the acceptance.

[1] Dr. Long erroneously refers to the acceptance in 1989 as a claim closure.

The ultimate conclusion of Dr. Long that there must have been a worsening since the acceptance, does not follow logically from Dr. Long's premise. The evidence strongly suggests that the initial classification of the injury as nondisabling was erroneous, since claimant was at least temporarily, if not permanently, disabled from work at the time of claim acceptance in 1989. Specifically, he did not return to work as a timber faller on the advice of Dr. Schwartz. Nonetheless, an aggravation claim under ORS 656.273 is not established by evidence that the classification of the injury as nondisabling was erroneous at the outset. Since claimant did not timely challenge the initial classification of his claim as nondisabling, claimant must establish now that his condition worsened after the acceptance. Claimant has failed to establish a worsening of his condition. Consequently, SAIF's denial must be upheld.

ORDER

The Referee's order dated October 2, 1992 is vacated in part and reversed in part. That portion of the order that directed the SAIF Corporation to reclassify the claim as disabling and process it to closure is vacated. The remainder of the order is reversed. SAIF's denial is reinstated and upheld.

In the Matter of the Compensation of
ILENE F. CHILSON-BOWERS, Claimant
WCB Case Nos. 92-05902 & 92-05415
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Davis' order that: (1) set aside its denial of claimant's "new injury" claim for a neck condition; and (2) upheld the SAIF Corporation's Disclaimer of Responsibility and denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant never completely recovered from the 1990 neck injury accepted by SAIF. Her condition remained symptomatic up to and through February 13, 1992.

Claimant's symptoms in February 1992 involved the same body part and same condition as did her original injury in April 1990.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that claimant had sustained a new compensable injury at Liberty's insured. Consequently, the Referee found that SAIF had established that responsibility for claimant's neck condition shifted to Liberty.

On review, Liberty contends that claimant's neck condition in February 1992 was an aggravation of her 1990 injury at SAIF's insured rather than a new injury. We agree.

In order to shift responsibility under ORS 656.308(1), SAIF as the last insurer against which claimant had a compensable neck injury, must establish, by medical evidence supported by objective findings, that claimant's subsequent work exposure was a material contributing cause of her disability or need for treatment. Ricardo Vasquez, 43 Van Natta 1678 (1991); see SAIF v. Drews, 117 Or App 596 (1993). The question of whether the work activity was a material contributing cause of the disability and need for treatment is a question of medical causation. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976).

SAIF accepted claimant's April 10, 1990 injury claim for a neck strain. In May 1991, Dr. Hayes, claimant's treating physician, declared her medically stationary and released her to perform only sedentary work. Claimant was having discomfort with even minimal exertion. The claim was closed by a June 1991 Notice of Closure with an award of 44 percent permanent partial disability. Following claim closure, claimant continued to be treated on a regular basis for recurrent headaches and chronic neck pain associated with limitation of motion and muscle spasm.

Claimant began working for Liberty's insured on February 11, 1992. By noon of the first day, after moving thin sheets of plywood back and forth on a waist-high table, claimant experienced pain in her neck, upper back, and shoulders. She worked all that day and the next, but not thereafter. On February 17, 1992, claimant returned to Dr. Hayes. He noted tenderness, muscle spasm, and limitation of motion, but no neurological deficits, and diagnosed a new neck strain superimposed on a chronic neck strain. Dr. Hayes prescribed medication and physical therapy and recommended that claimant remain off work.

On March 13, 1992, Dr. Hayes requested that SAIF reopen claimant's claim because of an exacerbation of her previous neck injury. He advised SAIF that claimant's neck pain was in the same location as her previous injury and had the characteristics of her previous injury. On April 2, 1992, Dr. Hayes completed an 827 form for Liberty. His diagnosis was cervical strain, exacerbation of a preexisting condition. Finally, on April 28, 1992, Dr. Hayes advised Liberty that work for its insured caused a worsening of claimant's condition and was the major cause of the exacerbation of claimant's condition.

We find Dr. Hayes' opinion to be contradictory and inconsistent over time. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Consequently, it is unpersuasive and we do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

Instead, we rely on the well-reasoned opinion of independent orthopedic surgeon Dr. Coletti. Dr. Coletti, who examined claimant on June 10, 1992, opined that claimant experienced a waxing of symptoms in February 1992. Dr. Coletti reasoned that claimant had a chronic pain condition as a result of the April 1990 neck injury, and that the February 1992 incident represented only a symptomatic increase of her chronic condition. He felt there had been no separate injurious event at Liberty's insured. Although Dr. Coletti noted that the February 1992 work activity caused claimant pain and to seek treatment, he explained that it was predictable that activity would cause symptoms, while rest would improve her symptoms.

Based on Dr. Coletti's opinion, we conclude that the February 1992 incident was merely another symptomatic exacerbation of claimant's 1990 injury and not an actual, independent injury. See Ricardo Vasquez, supra. Accordingly, we find that the February 1992 incident at Liberty's insured was not a material contributing cause of claimant's current neck condition. SAIF has not established that claimant sustained a "new compensable injury" in February 1992. Therefore, responsibility remains with SAIF.

Given our conclusion that responsibility for claimant's neck condition does not shift to Liberty, SAIF, rather than Liberty, is responsible for the assessed attorney fee awarded by the Referee.

Attorney Fees on Board Review

Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, ORS 656.295(6), compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod on recon, 119 Or App 447 (1993); Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Liberty's appeal to the Board placed claimant's award at risk. Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review, payable by Liberty. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $150. 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 30, 1992 is affirmed in part and reversed in part. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The SAIF Corporation's Disclaimer of Responsibility and denial is set aside, and the claim remanded to SAIF for processing in accordance with law. The Referee's $2,000 assessed attorney fee award shall be paid by SAIF, rather than Liberty. For services on Board review, claimant's counsel is awarded a $150 fee, payable by Liberty. The remainder of the order is affirmed.

August 27, 1993 Cite as 45 Van Natta 1662 (1993)

In the Matter of the Compensation of
ALAN J. DAVIS, Claimant
WCB Case No. 91-02485
ORDER ON REVIEW (REMANDING)
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant, pro se, requests review of Referee Spangler's order dismissing his request for hearing. On review, the issue is the propriety of the order of dismissal. We remand.

FINDINGS OF FACT

Claimant has a compensable 1977 back injury claim. In January 1991, the self-insured employer denied responsibility for claimant's medical treatment. Claimant, pro se, requested a hearing and retained counsel. A postponement was granted in order to allow claimant's attorney to prepare for hearing. After claimant's counsel withdrew, a second postponement was allowed.

In November 1991, claimant requested a third postponement, asserting that he had filed a claim with the Veterans' Administration (VA) regarding his compensable back injury and Post Traumatic Stress Disorder (PTSD) and that the VA would resolve the issue of whether his current need for treatment was due to his back injury. The request was allowed.

In June 1992, the case was set for an August 1992 hearing. A fourth postponement was allowed in order to allow claimant to receive the VA's decision regarding his claim in that forum. On September 18, 1992, an interim order issued directing claimant to provide the employer's counsel with requested tax documents and the VA decision or indicate that the information did not exist. A fifth postponement was allowed in order to provide the employer's attorney an opportunity to review the requested tax documents, which were disclosed by claimant the day before hearing.

At the October 8, 1992 hearing before Referee Spangler, claimant requested a sixth postponement because the VA still had not issued its decision regarding his claim for disability but had informed claimant that it expected to render its decision within 90 days of September 21, 1992. The Referee denied the motion on the basis that claimant had not shown "extraordinary circumstances" required by OAR 438-06-081. After this ruling, claimant indicated that he had not subpoenaed his witnesses and could not go forward with his case. Consequently, he requested a dismissal, which was granted by the Referee.

CONCLUSIONS OF LAW AND OPINION

OAR 438-06-081 provides that a "scheduled hearing shall not be postponed except by order of a referee upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." Furthermore, "extraordinary circumstances" does not include "incomplete case preparation, unless the referee finds that completion of the record could not be accomplished with due diligence." OAR 438-06-011(4).

In this case, claimant asserts that the VA decision is of critical importance to his workers' compensation claim and that he could not adequately prepare his case in its absence. The prior postponements which have been granted in this case support claimant's assertion. Moreover, based on the VA letter, it would appear that the decision was imminent. In light of such circumstances, we find that the record could not be completed with due diligence. Therefore, we conclude that there were "extraordinary circumstances" beyond the control of claimant, thereby warranting a postponement. See OAR 438-06-081. Having found that claimant was entitled to a postponement, we reinstate his request for hearing.

We may remand a case to the Referee if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, because the VA decision was not available at the time of hearing, we find that remand is appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Therefore, we remand to the Referee with instructions to schedule a hearing in the ordinary course of business. At that hearing, the parties shall have the opportunity to present evidence regarding the issues raised by claimant's hearing request.

Accordingly, the Referee's order dated October 9, 1992 is vacated. This matter is remanded to Referee Spangler for further proceedings consistent with this order. Following these further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DUANE R. DICKEY, Claimant
WCB Case No. 92-08798
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Neal's order that: (1) found that the self-insured employer had properly processed his low back claim as an aggravation, rather than a new occupational disease; and (2) affirmed an August 24, 1992 Order on Reconsideration that awarded no unscheduled permanent disability for his low back condition. In its brief, the employer contends that the Referee did not address the issue of its entitlement to an offset. On review, the issues are claims processing, extent of unscheduled permanent disability and offset. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claims processing

The Referee concluded that the employer had properly processed claimant's low back claim as an aggravation, rather than a new injury. On review, claimant argues that his claim should be processed as a new occupational disease, rather than an aggravation of his low back condition.

Subsequent to the Referee's order, we issued our decision in Peggy Holmes, 45 Van Natta 278 (1993). In Holmes, we noted that under the law in effect prior to the 1990 legislative changes, we had held that, where the issue is whether a claimant suffered an aggravation or new injury for the same carrier, the test for determining how the claim should be processed is the same test applied in subsequent employer situations. See Teresa L. Walker, 41 Van Natta 2283 (1989). In other words, prior to the 1990 changes, we had determined that a claimant did not establish entitlement to compensation for a new injury -- as opposed to an aggravation -- unless she proved that her subsequent injury or work exposure independently contributed to a worsening of her prior underlying condition. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986); Teresa L. Walker, supra.

In Holmes, we concluded that for purposes of consistency, we would continue to conform the test for distinguishing new injuries from aggravations, in cases involving the same employer/insurer, with current responsibility law. Peggy Holmes, supra; ORS 656.801(1). Consequently, we concluded that a worker sustains a new injury only if the later injury is a material contributing cause of the claimed disability and/or need for treatment. See Ricardo Vasquez, 43 Van Natta 1678 (1991). Similarly, a worker sustains a new occupational disease only if his later work exposure is the major contributing cause of his current condition. See Donald C. Moon, 43 Van Natta 2595 n.1 (1991). In the present case, therefore, claimant is required to show that his work exposure after the accepted low back strain was the major contributing cause of his current low back condition.

Claimant argues that the opinion of Dr. Jura, his treating physician since October 1991, establishes a new occupational disease. On May 31, 1992, Dr. Jura reported that claimant had not sustained a new injury in March 1992, but he had treated him for "more back pain in the very same area injured on 8-9-91." Dr. Jura concluded that claimant's exacerbation "proves the injury reported on 8-9-91 to be quite valid..."

On August 31, 1992, Dr. Jura reported that on or about December 12, 1991, the change in claimant's job "back to his original injurious job did cause a material worsening of his previous back condition." Dr. Jura further stated that claimant's employment after that date was the major contributing cause of his back symptoms and disability and his need for treatment on and after March 17, 1992.

In an October 9, 1992 deposition, Dr. Jura stated that claimant's complaints on March 17, 1992 were the same kind of low back pain symptoms that he had complained about since October 1991, and that the symptoms had reappeared. Dr. Jura further stated that the initial cause of claimant's continuing lumbar strain was his August 9, 1991 injury with the employer, and the lumbar strain had not resolved itself from October 1991 through at least March 1992.

We find that, when taken as a whole, Dr. Jura's opinion supports a conclusion that it is more likely than not that claimant's current problems are a continuation of his prior 1991 injury-related condition. See Peggy Holmes, supra. We are unable to find persuasive medical evidence that establishes that claimant's work exposure after the accepted low back strain is the major contributing cause of his current condition. Under the circumstances, we agree with the Referee's conclusion that the employer properly processed this matter as an aggravation claim, rather than as a new occupational disease.

Extent of unscheduled permanent disability

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

Offset

Both parties have stipulated that, if it is determined that the employer properly processed claimant's claim as an aggravation, the employer is entitled to offset its claimed overpaid temporary disability benefits in the amount of $1,060.44 against future awards of permanent disability. We agree that the employer has established its entitlement to an offset. The Referee's order is modified accordingly.

ORDER

The Referee's order dated December 8, 1992 is modified in part and affirmed in part. The self-insured employer is authorized to offset overpaid temporary disability benefits in the amount of $1,060.44 against future awards, if any, of permanent disability. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
KIMBERLY L. LOCKARD, Claimant
WCB Case No. 92-07201
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

The SAIF Corporation requests review of that portion of Referee Daughtry's order that awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability for her mid and upper back condition, whereas a Determination Order and Order on Reconsideration awarded no permanent disability. In her respondent's brief, claimant contends that: (1) she has established an entitlement to an award of 29 percent (92.8 degrees) unscheduled permanent disability; and (2) if her award is increased to 29 percent, a penalty pursuant to ORS 656.268(4)(g) should be assessed. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's first two full paragraphs in the Findings of Fact section.

CONCLUSIONS OF LAW AND OPINION

The Referee relied upon the report of a medical arbiter and concluded that claimant had permanent impairment in the thoracic and cervical areas. He therefore awarded claimant 19 percent unscheduled permanent disability. We disagree.

A First Medical Report stated that, as a result of her March 23, 1991 injury, claimant was experiencing pain in the neck, mid and low back. The report stated that claimant was unable to lift and take care of her child.

On June 10, 1991, claimant was examined at BBV Medical Services. The independent medical exam (IME) report diagnosed "vague strain to the spine, by history." The doctors believed that claimant was probably medically stationary, but a physical capacities evaluation was suggested to determine claimant's lifting capacities. The BBV doctors reported that claimant had multiple inconsistencies in her exam, suggesting that "psychological factors are responsible for her limitations in ranges of motion" and the physicians found no physical factors that would indicate limitation in range of motion due to structural damage. The IME's stated that, in their opinion, claimant had no permanent impairment.

On August 12, 1991, claimant's treating doctor, Dr. Goldberg, M.D., recommended a physical capacity evaluation, and suggested that claimant be returned to work as soon as possible, "with sheltering at first."

A physical capacities evaluation was performed at Salem Hospital on August 16, 1991. The report, authored by Robert Love, OTR, indicated that claimant could intermittently lift from 0 - 10 pounds from 0" to 38".

On September 17, 1991, Mr. Love wrote to SAIF and reported that he had compared claimant's August 1991 evaluation with a surveillance video tape taken on August 12 and August 15, 1991. Mr. Love found inconsistencies between the amount claimant lifted during the evaluation and the amount of weight she lifted while being taped. He also noted inconsistencies in the distance the weight was carried, claimant's ability to work at floor and overhead levels, and her complaints of pain and lightheadedness demonstrated during the evaluation, but not exhibited on the video tape.

Mr. Love concluded that, after viewing the video tape, he believed that claimant's performance was affected by subjective perceptions. He recommended a return to work "under modified conditions at the 30 to 40 pound range."

On October 16, 1991, Dr. Goldberg reported that claimant was medically stationary, with no further treatment required. Based upon the file review, he agreed that claimant had returned to pre-injury status and her work capacities were "at least in the medium range and that was the pre-injury work capacity."

On November 15, 1991, Dr. Strum, IME, reported that he had reviewed the surveillance video tape and found a significant discrepancy in what claimant described as her ongoing functional level versus what was demonstrated during her exam. He observed good mobility on the tape, while claimant had stated "marked functional disability in terms of not being able to carry out daily activities."

On February 7, 1992, Dr. Goldberg agreed with both the physical capacities evaluation and the independent medical exam reports.

On May 2, 1992, claimant was examined by a medical arbiter, Dr. Mayhall, M.D. Dr. Mayhall reviewed claimant's records and diagnosed cervical and thoracic sprain, by history. He found lost range of motion in the lumbar, cervical and thoracic regions. However, Dr. Mayhall noted that it was difficult to know whether claimant's decrease in lumbar range of motion was due to "her injury, her body habitus or her pregnancy." He concluded that he was unable to find a permanent medical condition arising out of the injury that would stop claimant from repetitive use of the body. Dr. Mayhall noted that claimant's physical capacities evaluation indicated her capabilities and "there are reports in the record of unobserved activities which are greater than the claimant herself apparently feels she can do."

Under the circumstances, we conclude that claimant has failed to establish that her lost range of motion is due to the compensable injury. Neither the treating doctor nor the medical arbiter found permanent lost range of motion attributable to the injury, and both doctors noted the inconsistencies documented throughout the record.

Finally, although claimant argues that the child she was lifting in the surveillance tape only weighed 18 pounds, as opposed to 25 to 30 pounds, we do not find this fact dispositive. First, claimant demonstrated the ability to only lift up to 10 pounds in her physical capacities exam, which is still less than the 18 pound child that was lifted in the video tape. Moreover, other discrepancies were noted by Mr. Love, such as claimant's actual ability to carry and work at various levels. As noted previously, claimant's treating doctor concurred in the report generated by Mr. Love.

Accordingly, we reverse the Referee on the issue of extent of disability.

ORDER

The Referee's order dated August 24, 1992 is reversed. The May 21, 1992 Order on Reconsideration which awarded no permanent disability is reinstated. The-out-of compensation attorney fee award is also reversed.

August 27, 1993 Cite as 45 Van Natta 1666 (1993)

In the Matter of the Compensation of
JEFFREY V. SNODGRASS, Claimant
WCB Case No. 92-07072
ORDER ON REVIEW
Foss, Whitty, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Black's order that: (1) upheld the SAIF Corporation's denial of his left clavicle injury claim; and (2) declined to assess a penalty and penalty-related attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.
We reverse.

We clarify that the Referee admitted Exhibits 0 through 17, 6A, and 7A into evidence.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant had sustained a left sternoclavicular joint injury. However, finding that there were no objective findings of injury, the Referee concluded that claimant had not established the compensability of his injury claim.

In order to establish a compensable injury, claimant must prove, by medical evidence supported by objective findings, that his work activities were a material contributing cause of disability or a need for medical treatment. ORS 656.005(7)(a)(A). Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In determining that claimant had sustained an injury to his left clavicle, the Referee specifically found claimant's description of the accident credible. Following our de novo review of the record, we agree with his assessment. However, we disagree with the Referee's conclusion that there are no objective findings of injury as required by ORS 656.005(7)(a)(A).

"Objective findings" in support of medical evidence are defined to include, but are not limited to, "ranges of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). A physician's report that he or she has examined claimant and determined that he suffers from a disability or physical condition that requires medical services satisfies this requirement. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

Here, based on claimant's reporting to him of the mechanics of injury and his physical examination of claimant which revealed tenderness over the left clavicle, Dr. Tilley diagnosed possible subluxing sternoclavicular joint, restricted claimant to light duty work and advised him to consult an orthopedist. Thereafter, claimant returned to Dr. Adams, his treating orthopedist. Dr. Adams diagnosed a subluxation of the left sternoclavicular joint, placed claimant in a clavicle splint and advised him to remain off work. These reports are sufficient to satisfy the definition of "objective findings" under ORS 656.005(7)(a) and Suzanne Robertson, supra.

Consequently, we find claimant has established by objective medical evidence that his injury was a materially contributing cause of his left clavicle disability and need for medical treatment.

Penalty/Attorney Fee

Claimant contends that because SAIF failed to investigate his claim before denying it, the denial was unreasonable and he is entitled to a penalty and related attorney fee. We agree that the denial was unreasonable.

If SAIF's denial was based upon a legitimate doubt, in light of the information available to it at the time of the denial, the denial is not deemed unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). However, a reasonable doubt does not exist where a decision is made quickly without independent investigation. Patrick J. Casey, 45 Van Natta 1536 (1993); Philip A. Parker, 45 Van Natta 728 (1993); Kenneth A. Foster, 44 Van Natta 148, aff'd mem, SAIF v. Foster, 117 Or App 543 (1992).

Here, at the time of its denial on May 20, 1992, SAIF was in receipt of claimant's 801 form dated May 7, 1992. On the form, claimant indicated that he had injured his left shoulder and upper chest on May 1, 1992, when a wrench he was using to adjust the brakes on the truck trailer slipped, throwing him to the ground. In the employer's section of the form, the insured noted that the injury was unwitnessed, and requested that SAIF "investigate immediately." SAIF received claimant's claim on May 13, 1992.

In addition, SAIF received a May 5, 1992 emergency room note and Form 827 completed by Dr. Tilley prior to the issuance of its denial. Dr. Tilley indicated that claimant had dislocated his left collar bone on May 1, 1992 while trying to adjust brakes on the truck. Dr. Tilley noted tenderness of the left clavicle, diagnosed a possible subluxing sternoclavicular joint, restricted claimant to light duty work and advised him to consult an orthopedist. In addition, SAIF had in its possession a chart note from Dr. Adams dated May 6, 1992. Although this report is not in the record, we note that on that same day, Dr. Adams authored a work release which claimant delivered to the insured that afternoon.

However, despite these medical reports and the insured's request that SAIF conduct an investigation, SAIF denied the claim seven days after receiving it, based on "insufficient evidence." In doing so, SAIF did not take claimant's statement or schedule an independent examination. SAIF indicates that it denied the claim because it interpreted Dr. Tilley's emergency room note to mean that he found nothing wrong with claimant; it did not believe claimant could continue to drive if he had sustained an injury; and the insured had expressed doubts that such an injury could occur while adjusting brakes. SAIF's speculation notwithstanding, we are persuaded that the evidence available to SAIF prior to the denial should have prompted it either to investigate further or accept the claim based on Dr. Tilley's reports.

Under these circumstances, we find that SAIF had no legitimate doubt as to its liability for the claim. See Philip A. Parker, supra at 729. 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. ORS 656.262(10).

Moreover, claimant's attorney is entitled to an assessed 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 fee for claimant's counsel's services at hearing and on review concerning this issue is $3,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's briefs), the complexity of the issue and the value of the interest involved.

Finally, inasmuch as penalties and attorney fees are not considered compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for services at hearing or on review concerning these issues. State of Oregon v. Hendershott, 108 Or App 584 (1991); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated December 9, 1992 is reversed. The SAIF Corporation's denial is set aside, and the claim is remanded to it for processing according to law. SAIF is assessed a penalty in the amount of 25 percent of all compensation due at the time of the hearing, to be paid in equal shares to claimant and his attorney. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded an assessed attorney fee of $3,200, payable by SAIF.

In the Matter of the Compensation of
NATHAN A. STEPHENS, Claimant
WCB Case No. 90-22010
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Neal's order that set aside its denials of claimant's occupational disease claims for bilateral carpal tunnel syndrome (CTS) and bilateral ulnar neuropathies. Claimant cross-requests review of that portion of the order that awarded his attorney an assessed fee of $3,000. In addition, claimant asks this Board to find his left elbow osteoarthritis occupational disease claim compensable. On review, the issues are compensability and attorney fees.

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

Compensability of Left Elbow Osteoarthritis

The insurer expressly denied the compensability of claimant's multiple left arm "complaints" in its November 1990 denial. Claimant raised the issue of that denial in his December 1990 Request for Hearing. Moreover, at hearing, claimant identified the issues as compensability of his bilateral CTS,

bilateral ulnar neuropathies and left elbow osteoarthritis. The insurer objected to claimant raising the issue of compensability as to his left elbow osteoarthritis. The Referee ruled that it was "best to try all this at once," and granted the insurer's motion to leave the record open for a report from its expert concerning the left elbow osteoarthritis issue. (Tr. 14-15). The Referee found claimant's bilateral CTS and bilateral ulnar neuropathies compensable and set aside those denials. Inadvertently, however, she did not address the merits of claimant's left elbow claim.

OAR 438-06-031 allows for the raising of issues throughout the course of a hearing, provided the evidence supports the issue raised. The Referee may also continue the hearing upon motion of an adverse party if that party is surprised and prejudiced by the additional issue. Id. Here, the Referee left the record open to cure the "surprise" asserted by the insurer. Under these circumstances, we find that the Referee had the authority to address the compensability of claimant's left elbow claim. Because we conclude that this issue was properly before the Referee and fully litigated, we consider it on review.

To establish that this condition is compensable, claimant must prove that his work exposure included a series of traumatic events which were the major cause of the onset or worsening of his left elbow osteoarthritis, requiring medical services or resulting in disability. ORS 656.802(1)(c). Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991).

Claimant is left-hand dominant. He operated a spray paint gun with his left arm, scraped metal parts alternately with his left and right hands, and operated a grinder with both hands. Claimant testified that he sustained no injuries to his left elbow, except for occasionally bumping into the metal parts he painted at work. Dr. Balkovich, claimant's treating hand surgeon, is the only physician to offer an opinion on causation. As did the Referee, we find his opinion to be persuasive. Dr. Balkovich performed a thorough examination, and unequivocally opined that claimant's bilateral CTS, bilateral ulnar neuropathies and left elbow osteoarthritis are work-related. When he was deposed, Dr. Balkovich explained that claimant's upper extremity conditions, including his left elbow osteoarthritis, arose from heavy use of the upper extremities on the job. In reaching his conclusion, Dr. Balkovich had an accurate understanding of the extent of claimant's off-work activities. Although Dr. Balkovich agreed that claimant's wood-cutting activities "could" contribute to his condition, he opined that eighteen years of heavy hand use "overshadows" those off-work activities.

On this record, we find that claimant also has proven that his work activities were the major contributing cause of his left elbow osteoarthritis.

Attorney Fees

The Referee awarded claimant's counsel an assessed fee of $3,000 for services rendered in prevailing over the insurer's denials. Claimant contends that the award is inadequate and should be increased.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that $3,000 adequately and reasonably compensates claimant's counsel for services at hearing regarding the bilateral CTS and ulnar neuropathy denials. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issues and the value of the interest involved.

However, claimant's attorney also is entitled to a reasonable assessed fee for services at hearing and on review concerning the left elbow osteoarthritis compensability issue. ORS 656.386. After considering the same factors set forth in OAR 438-15-010(4) and considering the time devoted to this issue (as represented by the hearing record and claimant's brief), we find that a reasonable fee for claimant's counsel's services at hearing and on review is $1,500, to be paid by the insurer.

Additionally, claimant's attorney is entitled to a reasonable assessed fee for services on review for defending against the insurer's appeal concerning the bilateral CTS and ulnar neuropathy issues. ORS 656.382(2). After considering the same factors set forth in OAR 438-15-010(4) and considering the time devoted to these issues (as represented by claimant's respondent's brief), we find that a reasonable fee for claimant's counsel's services on review is $1,000, to be paid by the insurer. The remainder of the referee's Order is affirmed.

Finally, inasmuch as attorney fees 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 attorney fee issue. State of Oregon v. Hendershott, 108 Or App 584 (1991); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 5, 1992 is affirmed as modified. The insurer's denial of claimant's left elbow osteoarthritis condition is also set aside. The claim is remanded to the insurer for processing in accordance with the law. For services at hearing and on review concerning the left elbow osteoarthritis issue, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by the insurer. For services on review concerning the bilateral CTS and ulnar neuropathy issues, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer. The remainder of the Referee's Order is affirmed.

In the Matter of the Compensation of
PATRICK D. WHITNEY, Claimant
WCB Case No. 90-18705
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Neal's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition; and (2) affirmed that portion of a Determination Order insofar as it awarded no scheduled permanent disability for the loss of use or function of his hips. SAIF cross-requests review of that portion of the Referee's order which increased claimant's award for a back injury from 5 percent (16 degrees), as awarded by a Determination Order, to 10 percent (32 degrees). On review, the issues are aggravation and extent of permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except that we correct that portion stating that claimant received 10 percent unscheduled permanent disability from a September 21, 1990 Determination Order. Claimant was awarded 5 percent unscheduled permanent disability by the said order.

CONCLUSIONS OF LAW AND OPINION

Aggravation and Extent of Scheduled Permanent Disability

We affirm and adopt those portions of the Referee's order concerning these issues.

Extent of Unscheduled Permanent Disability

Claimant has a compensable 1981 low back injury claim. He eventually was awarded a total of 20 percent unscheduled permanent disability for this claim. In March 1990, claimant again injured his low back. SAIF accepted a low back strain. A September 1990 Determination Order awarded 5 percent unscheduled permanent disability.

The Referee found that claimant was entitled to an award of 10 percent permanent disability under the standards. Pursuant to ORS 656.222, however, the Referee found that claimant's prior award of 20 percent permanent disability had to be considered. The Referee then concluded that claimant was entitled to an additional 5 percent for a total award of 10 percent unscheduled permanent disability. Although agreeing that the prior disability award should be taken into account in determining claimant's present permanent disability, SAIF asserts that claimant's current disability does not warrant a greater award than that provided by the Determination Order.

We first note that ORS 656.222 is not applicable to this case since it is limited to subsequent awards of scheduled permanent disability. See City of Portland v. Duckett, 104 Or App 318 (1990). However, under ORS 656.214(5), if a claimant suffers from disability due to preexisting injuries and has received unscheduled permanent disability for such disability, the prior disability award is considered in arriving at the appropriate permanent disability for the current injury. See Mary A. Vogelaar, 42 Van Natta 2846, 2848 (1990). This determination requires a two-step process. First, we determine the current extent of disability under the standards. We then compare this value with the prior award of unscheduled permanent disability to determine if the current award reflects any preexisting disability for which the claimant received benefits. If preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id. Therefore, we proceed with our determination of claimant's current unscheduled permanent disability award under the standards.

With regard to the factors of age, education and adaptability, claimant was entitled to no value under the former relevant administrative rules inasmuch as claimant had returned to his usual and customary work. See former OAR 436-35-290(2)(a); 436-35-300(2)(a); 436-35-310(2)(a) (WCD Admin. Order 6-1988). However, the Supreme Court declared these administrative rules invalid. England v. Thunderbird, 315 Or 633, 639 (1993).

In response to the decision in England, the Director adopted temporary rules amending OAR 436-35-280 through 436-35-310 to allow a value for age, education, and adaptability, subject to certain criteria, where a worker has returned to his regular work following a compensable injury. Inasmuch as these temporary rules apply to all ratings of disability made on or after June 17, 1993, they are applicable to this case. See OAR 436-35-003(4) (WCD Admin. Order 93-052). Therefore, we proceed to determine the appropriate values for age, education and adaptability.

Because claimant was not yet 40 years old at the time of determination, he is not entitled to a value for age. OAR 436-35-290.

With regard to education, because claimant had a high school diploma at the time of determination, no value is allowed. OAR 436-35-300(2)(a). The occupation assigned the highest SVP met by claimant based on the jobs he performed during the ten years preceding the time of determination is as a machinist. OAR 436-35-300(3) (Ex. 28). This occupation is assigned an SVP of 7, entitling claimant to a value of 1. DOT 600.280-022; OAR 436-35-300(3)(e). Therefore, claimant is entitled to a value of 1 for the education factor. OAR 436-35-300(5).

Adaptability is based on the highest strength rating of the occupations performed by claimant during the ten years preceding the time of determination as compared to claimant's maximum residual capacity at the time of determination. OAR 436-35-310(1). Here, claimant's highest prior strength rating is medium. DOT 600.280-022. Because claimant's treating physician released claimant to regular work with a 20-pound lifting restriction, claimant's RFC at the time of determination was light. Former OAR 436-35-270(3)(c). Therefore, claimant is entitled to a factor of 3 for adaptability. OAR 436-35-310(2).

With regard to impairment, we agree with the Referee that claimant is entitled to 10 percent and we adopt that portion of her order.

We now assemble the factors to determine claimant's permanent disability. Adding the age and education values results in a value of 1. OAR 436-35-280(4). That value is then multiplied by the adaptability factor of 3, resulting in a value of 3. See OAR 436-35-280(6). The impairment value of 10 percent is then added to the value of 3, resulting in an award of 13 percent unscheduled permanent disability under the standards.

Consideration of Prior Award

We now consider whether the award under the standards reflects any preexisting disability for which claimant previously received permanent disability. After reviewing the record, we conclude that claimant's current disability does not exceed the 20 percent value previously awarded to him.

We base this conclusion on evidence that, at the time that claimant was awarded 20 percent unscheduled permanent disability by an August 1985 Referee's order, claimant was employed as a salesperson for a parts store. That job essentially required the same duties and knowledge as his present occupation. An April 1985 report from an independent medical examination does show that claimant exhibited better range of motion in comparison to Dr. Gritzka's February 1991 report. However, Dr. Gritzka explained that the disparity could be the result of differences in measuring techniques rather than greater impairment. (Ex. 53A-22). Thus, we find insufficient evidence showing that claimant demonstrated greater impairment before his March 1990 injury.

Basically, we find that the only difference in claimant's earning capacity is a lifting restriction of 20 pounds. However, in view of the evidence showing that claimant is capable of performing the same job duties and has not proven greater impairment, we conclude that the restriction is insufficient to show that claimant has a greater loss of earning capacity than that compensated by the previous award of 20 percent. Consequently, because SAIF asserts only that claimant should not be awarded a greater amount than that provided by the September 1990 Determination Order, we affirm Determination Order's award of 5 percent unscheduled permanent disability.

ORDER

The Referee's order dated April 3, 1992 is affirmed in part and reversed in part. In lieu of the Referee's increased unscheduled permanent disability award, the Determination Order award of 5 percent (16 degrees) is reinstated and affirmed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
STEVE F. HILDEN, Applicant
WCB Case No. CV-93002
CRIME VICTIM ORDER
Diane Brissenden, Assistant Attorney General

Steve F. Hilden, hereafter referred to as applicant, has requested Board review of the Department of Justice's December 17, 1992 Order on Reconsideration. By its order, the Department affirmed a November 6, 1992 order which denied applicant benefits for failure to meet the provisions of ORS 147.015(1) and 147.105(5).

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of the record. The Department mailed a copy of its record to applicant on April 7, 1993. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record and the parties' written arguments. OAR 438-82-030(2).

ISSUE

Whether applicant is entitled to benefits under ORS Chapter 147.

FINDINGS OF FACT

On July 20, 1991, applicant sustained an injury to the third finger of his right hand. He was treated at Mid-Columbia Medical Center for a fracture dislocation of his right long finger for which he underwent surgery.

According to the police report, applicant was at a tavern when he was approached by an unknown male (hereinafter "suspect") who began harrassing applicant. Thereafter, applicant went to the restroom and the suspect followed him into the restroom and attempted to instigate a fight. Applicant and the suspect argued, at which time the suspect grabbed applicant's hand, squeezed it, and broke applicant's finger.

In his February 7, 1992 application for crime victims' compensation, applicant indicated that he was approached by the suspect in the restroom of the tavern. The suspect made "provocative statements" to applicant. Applicant advised the suspect that he wished to have no involvement with the suspect and left the restroom. The suspect followed applicant from the restroom and challenged him to a "finger wrestling" contest. Applicant declined. Suspect then grabbed applicant's right middle finger and broke it by twisting and forcing the finger down towards the floor. Suspect was then told to leave the tavern, at which time applicant transported himself to the hospital.

In his application, applicant also reported that there were two witnesses to the incident, James Gocitto and Mike Voodre. The Department contacted "George", the owner of the tavern, who informed the Department that James Gocitto no longer worked at the tavern. However, the owner indicated that he was at the tavern the night of the incident. The owner reported that applicant and the suspect exchanged words at the bar. Thereafter, applicant went into the bathroom, offered to shake the suspect's hand and the suspect squeezed applicant's hand and broke it. The Department also contacted Mike Voodre who indicated that he did not remember much about the incident except what applicant told him after it happened. Voodre was not in the restroom at the time of the incident.

The hospital admitting report of July 21, 1991, states that applicant "was in a finger wrestling match tonight and suffered a displaced interarticular closed fracture of the base of the proximal phalanx of the right long finger."

On November 7, 1992, the Department issued its order which denied applicant's claim on the basis that due to conflicting statements, applicant did not meet the eligibility criteria set forth in ORS 147.015(1) and (5). Claimant requested reconsideration of the Department's order. On December 17, 1992, the Department issued its Order on Reconsideration which declined to reverse the original order. On February 16, 1993, the Board received claimant's request for review of the Department's order.

CONCLUSIONS OF LAW AND OPINION

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

Pursuant to ORS 147.015(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 accordingly. ORS 147.125(1)(c).

"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 437-76-010(8). It is applicant's burden to establish that the injury was not substantially attributable to his actions or that his actions did not substantially provoke the wrongful act. Maria Cardenas, 42 Van Natta 562 (1990); Marc D. Mardis, 39 Van Natta 633 (1987).

Here, applicant's statement to the police indicates that the suspect harrassed him in the tavern and then followed him into the restroom. Thereafter, the suspect attempted to instigate a fight at which time applicant and the suspect argued and then the suspect grabbed applicant's hand squeezing it and breaking applicant's finger. However, in applicant's statement to the Department, he described the suspect as making "provocative statements" in the restroom, following him back to his seat and then challenging applicant to "finger wrestle." Applicant declined to "finger wrestle" whereupon the suspect grabbed applicant's finger and broke it by twisting it and forcing it down towards the floor.

The incident is also described in the hospital admitting report which describes applicant's injury as the result of a "finger wrestling match." The report does not indicate that this history came from any other individual than applicant. Finally, the owner of the tavern described the incident somewhat differently, reporting that applicant and the suspect exchanged words followed by the suspect squeezing applicant's hand causing the injury.

In applicant's written argument he indicated that he was not in a "finger wrestling match" as reported in the hospital admission report. Applicant also indicated that the police report was not correct. He stated that the suspect did not harass him prior to his going to the restroom, but that the suspect first approached him in the restroom. He further stated that the incident did not take place in the restroom. Rather, the suspect followed him back to his table in the tavern and the incident took place at applicant's table. Applicant also indicated that his hand was not squeezed, rather his finger was twisted. In addition, applicant reported that the tavern owner did not witness the incident because the owner was upstairs at the time of the incident. Finally, in his statement to the Department, applicant indicated that James Gocitto and Mike Voodre did witness the event. However, there is no statement from Gocitto in the record and Voodre indicated he did not remember the incident except for what applicant told him after it had happened.

As noted above, the incident is described in several different ways, with applicant's level of involvement changing in each account. In addition, the method by which the injury occurred and the location it occurred is also not consistent. Finally, the witnesses cited in applicant's claim for benefits (James Gocitto and Mike Voodre) did not provide support for his version of the incident.

In light of this conflicting evidence, we consider the hospital admitting report to be particularly helpful in resolving this issue. We reach such a conclusion because the physician treating applicant was not concerned with assigning blame for the incident. Moreover, the information came directly from applicant, not second or third hand as the police report from the ensuing investigation. The hospital admitting report unequivocally states that applicant was involved in a "finger wrestling" match.

It is applicant's burden to establish his entitlement to benefits. In light of the differences in the statements regarding applicant's role in the incident as well as the statements concerning how the incident occurred, we are unable to conclude that applicant's injury was not substantially attributable to his own actions or conduct. Consequently, applicant has not established his entitlement to benefits.

In conclusion, we recognize the physical and emotional trauma that this incident has caused applicant. Yet, to recover benefits as a victim of a crime under the Act, the Leglislature has mandated that several specific prerequisites must by satisfied. One of those requirements is that applicant's injury was not substantially attributable to his own actions or conduct. For the reasons detailed above, the record does not support such a conclusion. Inasmuch as applicant's claim does not satisfy all of the statutory requirements for receiving benefits under the Act, he is not entitled to benefits.

ORDER

The November 6, 1992 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered December 17, 1992, is affirmed.

August 31, 1993 Cite as 45 Van Natta 1675 (1993)

In the Matter of the Compensation of
THOMAS L. BARNETT, Claimant
Own Motion No. 93-0215M
OWN MOTION ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 6, 1993 Own Motion Order. In that order we denied reopening claimant's claim for own motion relief on the ground that he had not proved that he was in the work force at the time of his worsening. Claimant has submitted an affidavit in support of his contention that he remained in the work force at the time of his worsening.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The SAIF Corporation is requested to file a response to the motion within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDY G. HARBO, Claimant
WCB Case No. 90-18082
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The self-insured employer requests review of that portion of Referee Mongrain's order which set aside its "back-up" denial of claimant's left shoulder and right ankle injury claim. In its brief, the employer argues that the Referee erred in requiring it to prove by clear and convincing evidence that claimant's claim is not compensable. On review, the issues are the propriety of the "back-up" denial and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate fact, except for the second finding of ultimate fact. We also add the following findings of fact.

On August 9, 1990, the employer accepted claimant's claim for left shoulder and right ankle injuries allegedly occurring on August 2, 1990. On September 10, 1990, the employer closed the claim and denied current treatment and disability as unrelated to the compensable injury. On April 25, 1991, the employer denied responsibility for claimant's left shoulder condition on the basis that it was related to claimant's 1985 accepted injury with another employer. Finally, on May 15, 1991, the day of hearing, the employer denied that claimant sustained any compensable left shoulder and right ankle injury on or about August 2, 1990. The employer asserted that if a compensable injury had occurred, the claimant's condition had reverted to pre-injury status prior to September 10, 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant is not credible and concluded that it was improbable that claimant fell on his left shoulder or otherwise injured it on August 2, 1990. However, applying ORS 656.262(6), he concluded that the employer failed to prove by clear and convincing evidence that claimant's left shoulder and right ankle claims are not compensable. In addition, he concluded that the employer's September 10, 1990 denial of claimant's current right ankle condition was invalid and premature, on the basis that there was no ankle-related claim for medical services and/or disability benefits at that time.

On review, the employer contends that ORS 656.262(6) does not apply to "back-up" denials based on fraud, misrepresentation or illegal activity. We agree.

Subsequent to the Referee's order, we held in Tony N. Bard, 45 Van Natta 1225 (1993), that a carrier that can prove that it was induced to accept a claim through fraud, misrepresentation or other illegal conduct can revoke its acceptance at any time, thereby requiring a claimant to prove the compensability of the claim. We concluded that, in cases where claim acceptance was induced by fraud, misrepresentation or illegal activity, ORS 656.262(6) does not apply, and the carrier is not required to prove by clear and convincing evidence that the claim is not compensable. Id.

The carrier bears the burden of proving fraud, misrepresentation or other illegal activity, in order for the "back-up" denial to be effective. See Bauman v. SAIF, 295 Or 788 (1983). In order to justify a "back-up" denial, the misrepresentation must have been sufficiently material that the carrier's decision to accept the claim could reasonably have been affected. Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987); SAIF v. Abbott, 103 Or App 49, 52-53 (1990).

Based on this record, we find that claimant intentionally misrepresented the circumstances of his unwitnessed injury. On the 801 claim form, claimant wrote that he injured his left shoulder and right ankle when he stepped off a platform after a railing broke. (Ex. 6, Tr. 24-27). Claimant testified that he was given first aid by his foreman, which consisted of placing an ice pack on his shoulder and ankle. (Tr. 27 and 28).

In contrast, the employer reported that claimant had injured his right ankle because of unsafe footing when he stepped from the platform to the ground. (Exs. 6 and 6A-1). The foreman, Mr. Edwards, testified that claimant told him he stepped off the platform and his ankle was "hurting really bad." (Tr. 129 and 130). Edwards got an ice pack and put it on claimant's ankle. (Tr. 131). Edwards testified that claimant did not mention anything about his shoulder at that time and that Edwards only heard mention of the shoulder from the office help several days later. (Tr. 130 and 137). Edwards also testified that some bolts had come loose on a bar between the platform and the chipper, causing the bar to wobble. (Ex. 6A, Tr. 135 and 136).

Claimant initially sought treatment from Dr. Kleeman. Unlike the circumstances surrounding the injury as reported on the 801 form, claimant reported to Kleeman that he toppled backward, landing on his left shoulder and getting his right ankle tangled in the scaffolding. Claimant complained of pain in the AC joint area of the left shoulder and in the right medial ankle. Kleeman's examination of the ankle revealed some tenderness over the medial malleolus, and no fracture or dislocation, although, he opined, there may have been a small avulsion fracture in the medial malleolus. Examination of the shoulder revealed slight tenderness over the AC joint. (Ex. 7).

On August 21, 1990, Dr. Wenner, orthopedist, examined claimant. In contrast to his earlier reports, claimant reported to Dr. Wenner that he fell four feet, stopping the fall by grabbing a rail with his left arm. He reported that he felt a jerk and pop in the left shoulder, with increasing pain since that time. (Ex. 8).

Based on the consistent reports and testimony of the employer we find that claimant misrepresented the circumstances of his injury. We also find that claimant failed to disclose previous left shoulder injuries.

The record shows that on November 15, 1988, claimant saw Dr. Chamberlain, orthopedist, for treatment of left shoulder pain. Chamberlain noted that claimant had "dislocated" his left shoulder twice, the first time in 1987, when he was lifting furniture, the second on or about November 1, 1988, when he fell at a stadium and had his left shoulder "relocated" by paramedics. Chamberlain also noted that claimant had experienced pain in the shoulder prior to the 1987 furniture-lifting incident. (Ex. 3).

In January 1989, claimant reported to Dr. Young, orthopedic surgeon, that at the time of the 1985 compensable injury and afterward, he had increasing pain in the left shoulder, worsened by any heavy or overhead use. An arthrogram and x-ray demonstrated significant degenerative change at the AC joint. Young recommended excision of the left distal clavicle and shoulder decompression. (Ex. 5A).

Subsequent to the filing of his August 2, 1990 claim, however, claimant did not report previous left shoulder injuries or conditions to Drs. Kleeman and Wenner. (Exs. 7, 8).

These reports persuade us that claimant had a preexisting left shoulder condition for which he sought treatment in 1988 and 1989 and which he failed to disclose to the employer and the doctors treating him for the current injury.

We agree with the Referee that claimant is not credible,[1] and find that the employer has met its burden of proving that claimant intentionally misrepresented facts in order to induce the employer to accept his left shoulder and right ankle claim. See Bauman v. SAIF, supra; Tony N. Bard, supra. We also find that claimant's misrepresentation was material to the employer's decision to accept the claim. Ebbtide Enterprises v. Tucker, supra; SAIF v. Abbott, supra; Tony N. Bard, supra. At the time of its acceptance, the employer did not have evidence of claimant's misrepresentation regarding the circumstances of the alleged injury and the existence of preexisting shoulder problems. Therefore, we conclude that the employer's acceptance was properly revoked, and the issuance of a "back-up" denial is appropriate. Tony N. Bard, supra. Therefore, claimant must prove the compensability of his claim.

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[1] The record reveals additional instances of claimant engaging in intentional misrepresentation. On January 4, 1989, claimant's return-to-work assistance was terminated because he filed falsified flight logs, a misrepresentation of a matter material to vocational assistance support for training as a commercial pilot. (Ex. 2AA). In addition, claimant told Dr. Gardner that he had about 700 hours flying time, an instrument rating, a commercial rating and a Class I physical. However, his medical and pilot's license showed that he had only a private pilot's license and a Class II physical. Moreover, claimant has misrepresented his educational, work and parental status. (Ex. 5AA).

Compensability

A compensable injury is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death. A compensable injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991).

Left Shoulder Injury

We affirm and adopt that portion of the Referee's opinion which concludes that it is improbable that claimant injured his left shoulder at work on or about August 2, 1990.

Right Ankle Injury

The employer's records and testimony indicate that claimant stepped off a platform that had a loose railing while performing his work duties for the employer. This incident caused ankle pain for which he sought medical treatment from Dr. Kleeman. Dr. Kleeman found tenderness over the medial malleolus and opined that claimant might have a possible avulsion fracture. We conclude that the evidence establishes that claimant injured his right ankle during the course of employment and that the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); Mark N. Weidle, supra. Consequently, we conclude that claimant has established the compensability of his right ankle claim.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review on the issue of compensability of the right ankle injury. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability of his right ankle claim is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by 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 February 27, 1992 is reversed in part and affirmed in part. That portion of the order that set aside the denial of claimant's left shoulder injury claim is reversed. That denial is reinstated and upheld. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
LUCILLE K. JOHNSON, Claimant
WCB Case No. 91-11404
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of Referee McWilliams' order that assessed a penalty for its allegedly unreasonable delay in paying claimant's temporary and permanent disability compensation. On review, the issues are stay of compensation and penalties. We reverse.

FINDINGS OF FACT

Claimant compensably injured her right knee on November 14, 1989. A July 31, 1991 Opinion and Order set aside SAIF's denial of claimant's right knee claim and ordered payment of temporary disability. SAIF timely appealed that order.

A December 20, 1991 Determination Order granted claimant temporary disability benefits and 27 percent scheduled permanent disability for the right leg. SAIF did not appeal that order.

On April 15, 1992, the Board affirmed the prior Referee's decision that found the claim compensable.

On May 1, 1992, SAIF paid the benefits awarded by the December 20, 1991 Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF's stay of compensation amounted to an unreasonable delay in payment of compensation under ORS 656.262(10) and assessed a penalty on that basis. In reaching this result, the Referee relied on Carole A. Vanlanen, 43 Van Natta 1614 (1992) and Carol A. Goss, 43 Van Natta 2637 (1991).

Since the Referee's order, the court reversed Vanlanen citing Diamond Fruit Growers v. Goss, 120 Or App 390 (1993). See SAIF v. Vanlanen, 120 Or App 613 (1993). In Diamond Fruit Growers v. Goss, the court relied on and cited with approval our decision in Felipe A. Rocha, 45 Van Natta 47 (1993), wherein we specifically disavowed the holding in Carol A. Goss on this issue. Thus, under ORS 656.313(1)(a), a carrier is entitled to stay payment of a worker's temporary and/or permanent disability awards pending its appeal of an earlier referee's compensability decision. See Diamond Fruit Growers v. Goss, supra; SAIF v. Vanlanen, supra; Felipe A. Rocha, supra at page 47 (Where the insurer requested Board review of the earlier Referee's holding that the claim was compensable and because the temporary disability award was not for a period accruing from the date of that Referee's order, the insurer was entitled to stay the payment of that award pending its appeal). That is what SAIF did in the present case.

Although we find that SAIF was entitled to stay payment of claimant's compensation pending its appeal regarding the compensability of the claim, that does not end the inquiry. The question remains whether SAIF's May 1, 1992 payment was timely and, if not, whether it was unreasonably delayed.

SAIF's stay authorization under ORS 656.313 ended when it did not appeal our order affirming the prior Referee's decision that the claim was compensable. In other words, claimant's compensation was no longer stayed when the Board's order became final. In this case our order awarding temporary and permanent disability benefits issued on April 15, 1992. Pursuant to that order, SAIF paid the compensation within the 30 day appeal period, on May 1, 1992. SAIF could have exercised its prerogative to wait until the 30th day to decide whether or not to appeal the matter to the court. Instead, SAIF paid the compensation before the appeal period expired. Under these facts, we find SAIF's claims processing actions timely.

The administrative rule, OAR 436-60-150(4)(f), requires payment of temporary disability 14 days after the date of any litigation authorizing retroactive temporary disability becomes final. OAR 436-60-150(6)(d) requires payment of permanent disability no later than the 30th day after the date of any litigation authorizing permanent partial disability becomes final. Thus, under the administrative rule, OAR 436-60-150, payment of compensation was timely.

In Carole A. Vanlanen, 45 Van Natta 290 (1993) (herein referred to as Vanlanen II), the facts were similar except that there the carrier, SAIF, did not pay ordered temporary disability during the appeal period. Because SAIF refused to pay until 5 additional days had passed, the Board found SAIF's conduct to be unreasonable and assessed a penalty. The Vanlanen II decision did not discuss the administrative rule, OAR 436-60-150(4).

Although we note the apparent inconsistency present between the administrative rule and the decision in Vanlanen II, we conclude that we need not resolve the conflict. Here, SAIF's conduct was in accordance with the administrative rule, OAR 436-60-150, as well as the court's holdings in Diamond Fruit Growers v. Goss, supra, and SAIF v. Vanlanen, supra. Accordingly, because SAIF paid claimant's compensation within the appeal period, we find SAIF's conduct in this matter to be reasonable. Claimant is not entitled to penalties and attorney fees.

ORDER

The Referee's order dated December 7, 1992 is reversed.

In the Matter of the Compensation of
DEANNA F. MARSHALL, Claimant
WCB Case No. 92-09708
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of Referee Thye's order that set aside its denial of claimant's right shoulder and arm condition claim. On review, the issue is compensability.

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

Claimant is a sole proprietor. Sole proprietors may elect coverage of workers' compensation benefits under ORS 656.128(1). Furthermore, ORS 656.128(3) provides that "[n]o claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant." SAIF argues that ORS 656.128(3) should be construed so as to require that persons who have elected coverage under ORS 656.128 must prove compensability with corroborative evidence of work exposure or causation. In other words, SAIF asserts that sole proprietors have the additional burden of offering corroborative evidence that an injury or work conditions caused the need for treatment.

In Ricky A. Stevens, 38 Van Natta 148, 151-52 (1986), the Board stated that under ORS 656.128(3), "the claimant's testimony, standing alone[,] is insufficient evidence of coverage under the statute." (Emphasis supplied). The Board went on to hold that the claimant's testimony that he informed an insurance broker of his desire to obtain coverage under ORS 656.128, and testimony by other witnesses, was insufficient to prove that he elected coverage under the statute. In short, the Board concluded that the requirements of ORS 656.128(3) relate to coverage, rather than compensability.

We adhere to our conclusion in Ricky A. Stevens that ORS 656.128(3) relates to coverage rather than compensability. In particular, we agree with the Referee that this result is most reasonable in light of the language in the provision that no claim shall be allowed or paid "under this section" without corroborative evidence. We find that such language is evidence of legislative intent to limit the application of ORS 656.128(3) to questions of coverage arising under 656.128. Furthermore, we note that subsections (1) and (2) refer to "this chapter." Had the legislature intended to apply subsection (3) to questions other than coverage arising outside of ORS 656.128, we believe that subsection (3) would likewise refer to "this chapter," rather than to this "section." Consequently, we hold that ORS 656.128(3) requires corroborative evidence of coverage rather than corroborative evidence of compensability.

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

ORDER

The Referee's order dated January 13, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MICHELE A. MONTIGUE, Claimant
WCB Case Nos. 91-07603 & 91-05247
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

The SAIF Corporation requests review of Referee Myzak's order that awarded 23 percent (73.6 degrees) unscheduled permanent partial disability for a low back injury whereas an Order on Reconsideration reduced claimant's prior award to 0. On review, claimant contends that she was not medically stationary until October 4, 1991. On review, the issues are medically stationary date and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Finding of Facts" with the exception of the first sentence of the second paragraph. Claimant last became medically stationary on October 4, 1991.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

A November 12, 1991 Determination Order provided a medically stationary date of October 4, 1991. The Referee reinstated the Determination Order; however, she found that claimant last became medically stationary on September 18, 1991. On review, claimant contends that the Referee erred in changing the medically stationary date.

The medically stationary issue was not raised by either party at hearing. The only discussion between the parties concerned extent of unscheduled permanent disability. As this issue was not raised or litigated at hearing, we conclude that the appropriate medically stationary date is October 4, 1991, the date established by the reinstated Determination Order.

Credibility

The Referee found claimant to be a credible witness. She based her conclusion on claimant's manner and consistency at hearing and while testifying. We defer to that finding because of the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). Further, on de novo review, we find that SAIF has not established that, based on the record, claimant is not credible.

Extent of Permanent Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f). Evaluation of the worker's disability shall be as of the date the reconsideration order was issued pursuant to ORS 656.268. ORS 656.283(7).

The applicable standards are those in effect on the date of the November 12, 1991 Determination Order. (WCD Admin. Orders 2-1991, 7-1991 and 93-052).

The parties stipulated to the values for claimant's age (0), education (1), training (0), and skills (3). Therefore, we address only the values for adaptability and impairment.

Adaptability

The Referee determined that claimant's work as a psychiatric aide is classified with a strength of medium and she has a residual functional capacity to perform light work. Thus, the Referee concluded that claimant's adaptability value is three. See OAR 436-35-310(3). Claimant contends that her work involved lifting patients weighing over 100 pounds; therefore, her work at injury should have been classified as heavy.

The temporary rules contained in WCD Admin. Order 93-052 apply to all ratings of permanent disability made on or after June 17, 1993. OAR 436-35-003(4) (WCD Admin. Order 93-052) (Temp.); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993). In determining the extent of permanent disability, the adaptability factor is a comparison of the highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination as compared to the worker's maximum residual capacity at the time of determination. OAR 436-35-310(1). For a job to qualify, the worker must meet the requirements as outlined in OAR 436-35-300(3). OAR 436-35-310(1)(a). If a worker does not meet these requirements, or if a worker's highest prior strength has been reduced as a result of an injury that is not an accepted Oregon workers' compensation claim, the prior strength is based on the worker's job at the time of injury. OAR 436-35-310(1)(b) and (c). The requirements listed in OAR 436-35-200(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the Specific Vocational Preparation (SVP) category assigned by the DOT. See OAR 436-35-300(3).

Here, claimant's job title as a psychiatric aide is classified as requiring medium strength. DOT # 355.377.014. The SCODDOT description of a psychiatric aide includes tasks such as assisting patients in bathing, dressing and grooming and performing routine nursing procedures. However, we find that significant elements of claimant's job at injury also included work as an "orderly." DOT # 355.674-018. The orderly job lists a worker's duties as lifting patients onto and from bed, and transporting patients to other areas, by rolling a bed or using a wheelchair or stretcher. The orderly job falls within the category of heavy work. DOT # 355.674-018.

Claimant testified that on a daily basis she lifted by herself at least 100 pounds frequently. (Tr. 25). She testified that she lifted patients by herself who weighed over 100 pounds three or more times a day. (Tr. 10, 25). She testified that as a "break aide" (the person who gave other workers their breaks), she would perform 45 patient lifts in 45 minutes. (Tr. 19-20). She also testified that she often did two-person lifts of patients who weighed from 200 to 275 pounds. (Tr. 9-12). She testified that, on a regular basis, she lifted patients from the floor to raised mats, beds and wheelchairs; from beds to the floor and wheelchairs; she transferred patients out of wheelchairs; and she assisted patients into vans and lifted patients while adjusting their tilt back wheelchairs. (Tr. 9-12, 27).

Therefore, even though claimant's job involved some work in the "medium" category as she assisted patients and performed routine nursing procedures, we conclude that claimant's "regular" job also entailed lifting patients of at least one hundred pounds throughout the work day, which constituted work in the "heavy" category. See William L. Knox, 45 Van Natta 854 (1993).

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 her job in determining a proper DOT to be assigned to her job. Consequently, after reviewing the record and claimant's testimony, we find that "orderly" (DOT # 355.674-018) most appropriately describes claimant's job at injury. See William L. Knox, supra (In determining the proper DOT job description, the Board considers 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). We, therefore, modify the Referee's adaptability finding.

In reaching this decision, we note that the record contains no evidence that claimant had successfully performed a job with a greater strength demand during the previous 10 years than the job she held at the time of injury. We have concluded that the DOT code which most accurately describes its duties is the code for "orderly" (DOT. # 355.674-018). The "orderly" job falls within the category of heavy work. Accordingly, we conclude that the highest prior strength based on the jobs claimant's has performed during the ten years preceding the time of determination is heavy, based upon claimant's job at injury. Claimant's Residual Functional Capacity (RFC) is in the light category. Therefore, the appropriate adaptability value is 5. OAR 436-35-310(2).

Impairment

ORS 656.726(3)(f)(B) provides that under the standards for rating permanent disability, "[i]impairment is established by a preponderance of medical evidence based upon objective findings." Therefore, interpreting ORS 656.268(7) consistently with ORS 656.726(3)(f)(B), we concluded that the level of claimant's impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior findings. Id.

SAIF contends that claimant has a history of functional overlay and invalid range of motion testing. SAIF further argues that based on the preponderance of the medical evidence, claimant has no permanent impairment. We disagree.

First, we have deferred to the Referee's credibility finding. Moreover, here, Dr. Ouellette, claimant's attending physician, found claimant medically stationary and found limitations on claimant's ranges of lumbar motion with palpation and muscle spasm. Dr. Avery, the medical arbiter, noted pain behavior and concluded that claimant was without permanent impairment. Although Dr. Avery noted some pain behavior and questioned whether this interfered with claimant's efforts, we do not agree with SAIF's contention that those comments undercut the accuracy of the objective findings. In this regard, Dr. Avery noted that imaging studies showed "a mild lateral bulging of L4-5 on the right." Further, Dr. Avery reported that claimant's mechanical ligamentous low back pain was secondary to her back strain. We conclude that Dr. Avery's statements are not inconsistent with a finding of permanent impairment.

After reviewing the aforementioned opinions, we are most persuaded by Dr. Ouellette's findings of reduced ranges of motion. In this regard, we note that Dr. Ouellette was claimant's treating physician and has treated her since August 1990. Further, Dr. Ouellette repeatedly requested modified work to be provided for claimant, opining that claimant would not ever be "able to lift and transfer patients on a regular basis, as she has done in the past." Accordingly, we conclude that a preponderance of the medical evidence establishes that claimant has sustained permanent impairment in the low back. See Joaquin M. Betancourt, 44 Van Natta 1762 (1992).

Accordingly, we agree with the Referee's finding regarding claimant's impairment value (11) and we adopt her conclusions on that issue.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to her education value 4, the sum is 4. When that value is multiplied by her adaptability value, 5, the product is 20. When that value is added to claimant's impairment value 11, the result is 31 percent unscheduled permanent partial disability. OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 31 percent.

ORDER

The Referee's order dated October 30, 1992 is modified. In addition to the Referee's award of 23 percent (73.6 degrees), claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, giving her a total award to date of 31 percent (99.2 degrees) unscheduled permanent disability for her low back condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and the Board orders shall not exceed $3,800.

In the Matter of the Compensation of
TIBURCIO NAVARRO, Claimant
WCB Case No. 92-10131
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee M. Johnson's order that: (1) declined to award claimant temporary disability compensation; and (2) concluded that the issue of whether the self-insured employer unreasonably failed to pay temporary disability compensation was moot. On review, the issues are temporary disability compensation and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

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

Acceptance of claimant's nondisabling claim was initially deferred. It was not formally accepted until August 7, 1992. (Exs. 1 and 18).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not entitled to time loss because the employer properly terminated time loss pursuant to ORS 656.268(3) and because claimant left work for reasons unrelated to his injury. Claimant contends that he left work because he was unable to continue his modified work. We affirm the Referee for the following reasons.

Claimant was injured on May 3, 1992. The employer initially deferred acceptance of his claim. Claimant missed no work until June 22, 1992. The claim was not accepted until August 7, 1992. Accordingly, the issue is whether claimant was entitled to interim compensation after he left work on June 22, 1992.

A claimant is entitled to temporary disability (in the form of interim compensation) pending acceptance or denial of a claim for a disabling injury if he "leaves work" due to the injury. Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). Because claimant's claim had been neither accepted nor denied on June 22, 1992, the date he left work, claimant must prove that he left work due to the injury.

As noted above, claimant missed no work from the date of injury until June 22, 1992. Dr. Cummings, chiropractor, initially restricted claimant to light work lifting no more than 10 pounds for two weeks. (Exs. 4, 8 and 9). On June 9, 1992, claimant changed his attending physician to Dr. Stringham, who continued the same work restrictions. (Ex. 12-3). On June 18, 1992, claimant requested a work release from Dr. Stringham, who told claimant he needed to be seen first. On June 24, 1992, claimant sought treatment from Dr. Stringham for pain in the left neck and shoulder extending to the low back, which had begun two days earlier. (Ex. 14). Dr. Stringham opined that this left shoulder and neck pain was not related to his low back injury and declined to authorize a work release. Claimant discussed with Stringham the possibility of accepting a job offer with another employer. (Ex. 14). At this time, Dr. Stringham gave him a work limitation of no lifting over 30 pounds and no repetitive bending and twisting, which was less restrictive than his earlier lifting limit of 10 pounds. (Ex. 23). Dr. Stringham opined that claimant was capable of work within those limits and did not release claimant from work. (Ex. 23). Claimant did not return to the employer. At hearing, he testified that he did not continue to work at the employer because he had been offered a job at a cannery and expected to begin work there on July 7, 1992. (Tr. 18 and 22).

We consequently conclude that claimant has failed to prove that he left work due to his injury.

ORDER

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

In the Matter of the Compensation of
RICHARD D. NORMAN, Claimant
WCB Case No. 92-07465
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Hoguet's order that: (1) found that the SAIF Corporation correctly based claimant's temporary disability rate on wages of $10 per hour; (2) found claimant entitled to temporary partial disability benefits for periods from February 7, 1990 through March 30, 1990 and February 8, 1991 through March 18, 1991; (3) awarded no permanent disability in addition to the 9 percent (28.8 degrees) unscheduled permanent partial disability granted by the Order on Reconsideration; and (4) affirmed a Director's order which found that claimant was not entitled to vocational assistance. In his brief, claimant renews his objection to evidence concerning his alleged alcohol use/abuse and requests that the case be remanded to the Director for promulgation of a temporary rule to address permanent disability not contemplated by the standards. On review, the issues are evidence, temporary disability, rate of temporary disability, extent of unscheduled permanent disability, remand, and vocational assistance. We deny claimant's motion to remand and affirm.

FINDINGS OF FACT

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

The Referee found that claimant's time loss rate is $10 per hour. Instead, we find that claimant's time loss is based on a wage rate of $10 per hour.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee found that claimant's work attitude deteriorated around the end of April/beginning of May 1990 (about two months post-injury) and that there were indications that claimant had been drinking on the job. Significantly, the Referee concluded that claimant was fired on May 23, 1990 for drinking on the job. (O&O p. 3).

Claimant argues that the Referee improperly admitted and relied on evidence concerning claimant's alleged use or abuse of alcohol. Specifically, claimant contends that this evidence is hearsay and irrelevant and, further, that any probative value it may have is outweighed by unfair prejudice. Alternatively, claimant asks that this evidence be accorded no weight.

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).

At the outset, we acknowledge that claimant's alcohol consumption is relevant only insofar as it was the reason for claimant's firing and his nonworking status after job termination. In other words, the question is not whether claimant abused alcohol, but whether the employer fired claimant for reasons unrelated to his injury, e.g., drinking. See Cutright v. Weyerhaeuser, 299 Or 290, 298 (1985).

The Referee found the employer's witnesses credible and reliable and concluded that claimant's drinking led to his firing. We agree. Claimant has not proven that his drinking was injury-related, or that his nonworking status after job termination was injury-related until he was released from work on February 8, 1991 by Dr. Hulse, chiropractor. Because claimant's substantive entitlement to temporary disability compensation is at issue, we conclude that the Referee properly considered evidence regarding claimant's alcohol use, for the limited purpose of determining the reason for claimant's off-work status after he was fired. See ORS 656.283(7). Accordingly, we find no abuse of discretion.

Extent and rate of temporary disability

We adopt the Referee's "Conclusions of Law and Opinion" concerning these issues as well as the section entitled "Credibility," except that we do not adopt the Referee's incorporation of SAIF's closing argument on page 6 of the Opinion and Order. Instead, we find that claimant was medically stationary on March 19, 1991, based on the opinion of Dr. Cohen. (See Ex. 11). In sum, because we find that claimant was off-work after job termination for reasons other than his compensable injury, claimant has not proven entitlement to time loss for the period from March 31, 1990 through February 7, 1991, when he was released from work. See Cutright v. Weyerhaeuser, supra.

Finally, we correct an apparent scrivener's error on page 7 of the Opinion and Order, so that claimant is entitled to temporary disability benefits for periods from February 7, 1990 through March 30, 1990 and from February 8, 1991 through March 18, 1991.

Extent of unscheduled permanent disability/remand

We agree with the Referee that claimant has not established entitlement to greater permanent disability compensation than awarded by the Order on Reconsideration. In reaching this conclusion, we acknowledge claimant's request that we adopt a rule to accommodate claimant's alleged additional permanent impairment or remand the case to the Director for that purpose. See ORS 656.726(3)(f)(C). However, because neither the Referee nor the Board has authority to adopt temporary rules amending the standards or to remand this matter to the Director for adoption of such rules, claimant's request is denied. See Gary D. Gallino, 44 Van Natta 2506 (1992).

Vocational assistance

We agree with the Referee that the Director's June 28, 1992 Order finding claimant likely ineligible for vocational assistance must be affirmed. We reach this result because claimant has not established that the Director's order may be modified under ORS 656.283(2). See Colclasure v. Washington County School District No. 48-I, 117 Or App 128 (1992). We do not adopt SAIF's closing arguments on this issue.

ORDER

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

In the Matter of the Compensation of
EILEEN B. PALMER, Claimant
WCB Case No. 92-09614
ORDER ON REVIEW
Welch, Brunn & Green, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Bethlahmy's order that upheld the self-insured employer's denial of her low back injury claim. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the third sentence in the seventh paragraph and the second sentence in the last paragraph, as clarified and supplemented herein.

Claimant was required to carry prescription drug samples in the trunk of the company automobile. Claimant also kept a large file box containing clinical drug information in the trunk of the automobile. Claimant removed the file box from the trunk of the car in order to perform the required monthly inventory.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant suffered an injury to her low back when she removed a file box from the trunk of the company car. However, finding that claimant removed the file box for personal reasons rather than to take inventory, the Referee concluded that claimant's injury did not occur while she was performing her work duties. On review, claimant challenges the Referee's finding that there were inconsistencies in her testimony and discrepancies between her testimony and her husband's. Further, claimant argues that the Referee erred in not applying all the factors set forth in Jordan v. Western Electric, 1 Or App 441 (1970), to determine whether claimant's injury arose out of and in the course of her employment.

The Board ordinarily will defer to a Referee's assessment of witness credibility based on demeanor. However, where, as here, claimant's credibility or lack thereof is apparent from the substantive record, the Board has an equal advantage in evaluating claimant's credibility. See Davies v. Hanel Lumber Co., 67 Or App 35 (1985). The Referee did not identify the discrepancies and inconsistencies she perceived. After our review of the record, we find no material inconsistencies. Instead, we find that claimant's statements and testimony at hearing were consistent throughout.

Turning to the merits, traditionally, we have determined whether an activity is work-related by analyzing the seven Jordan factors in order to establish compensability. Claimant need not satisfy all seven 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 was injured 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.

Claimant works as a sales representative for a pharmaceutical company. She maintains an office in her home, a locked drug storage cabinet in her garage, a lap-top computer in the company automobile, and clinical drug information and prescription drug samples in the trunk of the car. Although the employer suggests that claimant's low back injury occurred while she was performing other nonwork-related activity, based on the medical record and claimant's testimony, we find, as did the Referee, that claimant injured her back when she removed the file box from the trunk of the car.

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 monthly drug inventory was required by federal law. The activity that resulted in claimant's injury was for the benefit of the employer.

2. Whether the activity was contemplated by the employer and employee.

The employer expressly required claimant to take inventory of all prescribed drugs in her possession on the last working day of each month. The activity was contemplated by the employer and claimant.

3. Whether the risk was an ordinary risk of, and incidental to, the employment.

Claimant contends that moving the file box was an ordinary risk of her employment. The employer, on the other hand, contends that because the file box contains clinical drug information rather than drug samples, claimant did not need to remove the file box in order to perform the inventory.

The employer relies on the testimony of claimant's supervisor, Mr. Bright. We do not find Mr. Bright's opinion persuasive for several reasons. First, Mr. Bright conceded that he does not have a file box. Further, he admitted that he does not know whether other sales representatives move their file

boxes in order to perform their monthly inventories. Finally, claimant has never stated that she kept drug samples in the file box. Rather, she has consistently explained that she moved the file box in order to locate all the samples in the trunk as a prerequisite to performing a complete inventory. Claimant testified that it is imperative to remove everything out of the car, out of the trunk, and out of her briefcase in order to "count each tablet, each box, everything." On cross-examination, claimant reiterated that she had to unload the car and empty the trunk to assure that she got an accurate count of all the drug samples in her possession.

On this record, we find that removing the file box from the trunk of the car to perform the inventory was a risk inherent in claimant's employment.

4. Whether the employee was paid for the activity.

Claimant is a salaried employee. She was paid for taking the required monthly inventory.

5. Whether the activity was on the employer's premises.

The employer has no premises in Oregon. Claimant works out of an office in her home, her garage and the company car. The injury occurred in claimant's garage while she was removing the employer's file box from the trunk of the employer's car in order to perform a required inventory. Therefore, the activity was not on the employer's premises. Under the unique circumstances of this case, however, we accord little weight to this factor.

6. Whether the activity was directed by or acquiesced in by the employer.

The employer directed claimant to take inventory on the last working day of each month.

7. Whether the employee was on a personal mission of her own.

The employer argues that the only reason claimant removed the file box from the automobile was to provide trunk space for a personal trip. We disagree.

From the outset, claimant has acknowledged that she planned to take vacation time from the afternoon of December 23, 1991 through January 2 of the new year. Because the twenty-third was the last working day that month, claimant was required to take inventory on that date. The fact that claimant or her husband would have emptied the trunk in preparation for the family's Christmas vacation does not negate the fact that, prior to leaving on vacation, claimant had to complete her work duties, paramount of which was performing the required monthly inventory.

Because we have found that claimant moved the file box in order to perform the required inventory, it follows that claimant was in the course of her employment at the time she injured her low back.

Having considered all of the Jordan factors, we find that claimant has established a compensable relationship between the injury and her employment. Rogers v. SAIF, supra. Accordingly, the employer's denial is set aside.

Claimant's attorney is entitled to an assessed 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 fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated November 13, 1992 is affirmed in part and reversed in part. That portion of the order that upheld the self-insured employer's denial is reversed. The employer's denial is set aside, and the claim remanded to the employer for processing in accordance with the law. Claimant's counsel is awarded an assessed fee of $3,500 for services at hearing and on review, to be paid by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN W. SAILY, Claimant
WCB Case No. 92-07595
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Davis, Bostwick, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee McWilliams' order that: (1) set aside its partial denial of claimant's occupational disease for a left ear hearing loss condition; and (2) awarded claimant's counsel an assessed fee of $2,600 for his services at hearing. On review, the issues are compensability and the amount of the attorney fee.

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 his hearing loss. The employer asserts that claimant had off-the-job exposures that contributed to the loss and that he had used ear protection on the job for the last five years, matters that allegedly were not addressed by Dr. Owens, upon whom the Referee relied.

For three and a half years, beginning in 1983, claimant worked as a plug cutter for the employer. This work entailed the use of a radial saw close to his left ear. (Tr. 17-20). Claimant used no ear protection either at that time or during his earlier employment with this employer from 1970 to 1973, when he worked as a dryer utility man inside the noisy mill. At the end of this period, in 1986 or 1987, claimant first sought treatment for his bilateral hearing condition and began using hearing aids. At about the same time, he also began using ear protection at work.

Dr. Owens, claimant's treating otolaryngologist, had a full history of claimant's off-the-job exposures and his use of hearing protection on the job for five years prior to his December 1991 examination. (Ex. 7). Dr. Owens found that an audiogram of April 6, 1970 showed a left ear monaural hearing loss of 11.25 percent. Other audiograms, dated October 15, 1969 and April 7, 1970, showed no ratable hearing loss. (Ex. 14). Based on the comparison of those audiograms with claimant's current left ear hearing loss of 49.5 percent, Dr. Owens opined that the cause of at least 38.25 percent of claimant's 49.5 percent left ear hearing loss was his work exposures at the employer. (Ex. 14). The Referee correctly concluded that claimant had proved that employment conditions were the major contributing cause of his left ear hearing loss.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved. We further find 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 September 30, 1992, as reconsidered January 28, 1993, is affirmed. Claimant's attorney is awarded an assessed fee of $1,200 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
EDWARD D. SWOR, Claimant
WCB Case No. 92-07203
ORDER ON REVIEW (REMANDING)
Bennett & Hartman, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Nielsen's order which upheld the SAIF Corporation's denial of his occupational disease claim for an inguinal hernia. In his brief, claimant contends that the Referee erred by not permitting him an opportunity to rebut evidence submitted prior to the hearing. On review, the issues are evidence and compensability. We remand.

Claimant contends that the Referee erred by admitting into evidence Exhibit 11, a note from Dr. Jackson who performed claimant's physical for a commercial driver's license, which was submitted by SAIF four days before the hearing. Claimant contends that the Referee should have permitted him to depose Dr. Jackson or rebut the evidence. (Tr. 5). The Referee reasoned that, because the evidence contained in Exhibit 11 was the same evidence found in Exhibit 3, the exhibit would be admitted and claimant's objection would go to the weight of the evidence. Claimant argues that the Referee relied on the evidence in her order and contends that, because cross-examination was not allowed, the Referee's action constitutes reversible error. SAIF did not object to claimant's request to cross-examine the doctor. (Tr. 1, 2).

The Referee properly admitted Exhibit 11 at hearing because SAIF submitted it within seven days of its receipt. See OAR 438-07-015. Nevertheless, the Referee is vested with discretion to continue the hearing or allow post-hearing cross-examination and/or rebuttal if claimant was put at a disadvantage by the delay in obtaining the report. See Chester S. Ostrowski, 44 Van Natta 848, 849, on recon, 44 Van Natta 966 (1992); Oliver F. Coon, 42 Van Natta 1845 (1990). Here, because the Referee concluded that the evidence contained in Exhibit 11 was the same evidence as found in Exhibit 3, she did not allow post-hearing cross-examination or rebuttal of Exhibit 11. We conclude that the Referee abused her discretion.

Exhibit 3 is Dr. Jackson's March 11, 1992 report that was written after claimant's commercial driver's license physical. It notes the presence of a right inguinal hernia, and states that the doctor discussed the hernia with claimant and told claimant that it needed to be fixed.

Exhibit 11 is an August 5, 1992 note from Dr. Jackson discussing the rate of recurrence of hernias and possible causes of recurrence. This evidence could be damaging to claimant's case. Thus, we conclude that claimant was put at a disadvantage because the report was obtained close to the time of hearing and claimant was not given the opportunity to cross-examine the doctor or rebut the evidence.

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).

Here, because the Referee refused to hold the record open for cross-examination or rebuttal, we find that the record has been incompletely or otherwise insufficiently developed, and that claimant has established a compelling reason to grant the motion for remand.

Therefore, we remand to the Presiding Referee for assignment of the case to a referee. The designated referee shall allow claimant an opportunity to cross-examine or rebut this late-produced evidence. The submission of this additional evidence shall be made in any manner in which the designated referee determines will achieve substantial justice.

Accordingly, the Referee's order dated August 28, 1992 is vacated. This matter is remanded to the Presiding Referee for further proceedings consistent with this order. Following these further proceedings, the designated referee shall issue a final, appealable order.

IT IS SO ORDERED.

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
SECOND ORDER OF DISMISSAL
Scheminske & Lyons, Attorneys
O'Connell, et al, Attorneys
Larry D. Schucht (Saif), Defense Attorney

The alleged noncomplying employer, Spitulski Enterprises, has requested reconsideration of our August 12, 1993 order which dismissed its request for Board review. Specifically, Spitulski seeks remand to the Referee for the issuance of an order which contains an accurate statement of the parties' appeal rights.

In dismissing Spitulski's request for Board review, we found that claimant's hearing request from Spitulski's invalid denial did not involve a matter concerning a claim. Thus, we reasoned that Spitulski's appeal from the Department's noncomplying employer order was not contested at the same hearing as a matter concerning a claim. Accordingly, relying on ORS 656.740, we held that appellate jurisdiction over the Referee's order rested with the Court of Appeals.

In reaching our conclusion, we recognized that the Referee's order had contained an incorrect statement regarding the parties' rights of appeal. Notwithstanding this unfortunate oversight, we further concluded that, since our jurisdiction is limited, an incorrect statement of appeal rights could neither expand nor contract our statutory authority. See Larry J. Powell, 42 Van Natta 1594 (1990); Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Citing ORS 656.295(5) and (6), Spitulski requests that we return this case to the Referee for the issuance of an order which contains an accurate statement explaining the parties' rights of appeal. We are without authority to grant such a request.

Our authority to remand or to take any other action we deem appropriate is premised on our jurisdiction to review the Referee's order. As explained in our dismissal order, we lack appellate jurisdiction to review the Referee's order because the Department's noncomplying employer order was not contested at the same hearing as a matter concerning a claim. See ORS 656.740(4)(c). Thus, the Referee's order constituted a final order of the Director. ORS 656.740(4)(a). As such, the order was not subject to the statutory requirements of ORS 656.289 which expressly pertain to a Referee's order that is subject to Board review under ORS 656.295. Likewise, since the Referee's order was subject to judicial review under ORS 656.740(4), we are without authority to take any action regarding the order other than to dismiss the request for Board review. See Sunset Siding Construction, Inc., 44 Van Natta 1587 (1992).

Accordingly, our August 12, 1993 order is withdrawn. On reconsideration, as supplemented herein, we republish our August 12, 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
TIMOTHY K. NOFFSINGER, Claimant
WCB Case No. 91-17914
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The self-insured employer requests review of those portions of Referee Nichols' order that: (1) Awarded interim compensation; and (2) assessed a penalty and related attorney fee for allegedly unreasonable claims processing. In its brief, the employer contends that the Referee had no jurisdiction to hear claimant's claim for interim compensation. On review, the issues are jurisdiction, interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

On January 8, 1992, claimant filed a request for hearing raising the issues of compensability and temporary total disability compensation. On February 24, 1992, claimant clarified the issues as compensability and interim compensation from November 18, 1991 to December 13, 1991.

Claimant withdrew the issue of compensability at hearing.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

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

ORS 656.283(1) provides in pertinent part: "Any party or the director may at any time request a hearing on any question concerning a claim." Claimant requested a hearing on two issues and withdrew one at hearing. The Referee, therefore, had jurisdiction to address the remaining issue.

Furthermore, a claimant's entitlement to interim compensation is not dependent upon the compensability of the injury or disease claim being asserted. Jones v. Emanuel Hospital, 280 Or 147 (1977); Spivey v. SAIF, 79 Or App 568 (1986); Stone v. SAIF, 57 Or App 808 (1982). Therefore, claimant's withdrawal of the compensability issue does not deprive the Hearings Division of jurisdiction over the interim compensation issue.

Interim Compensation

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

The processing of claims and providing compensation for a worker is the responsibility of the insurer or self-insured employer. ORS 656.262(1). 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 an employer has notice or knowledge. ORS 656.005(6) (emphasis added). "The compensation due * * * shall be paid periodically, promptly and directly 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). The first installment of compensation must be paid no later than the 14th day after the employer has notice or knowledge of the claim. ORS 656.262(4)(a).

Claimant complained of chest pain at work on November 18, 1991. Emergency medical technicians were called and claimant was taken to the hospital by ambulance. (Exs. 1 and 2). Claimant's supervisor filed a preliminary accident report on November 18, 1991. (Ex. 2). The employer filled out an 801. Box 22 of the 801 originally stated that the employer knew of the injury or occupational disease on November 18, 1991. (Ex. 1). The employer issued a denial on December 13, 1991, more than 14 days later. Claimant did not return to work between November 18, 1991 and December 19, 1991.

Under such circumstances, the Referee correctly concluded that the employer was required either to issue a denial within 14 days of its knowledge of the claim or to pay interim compensation while deciding whether to accept or deny the claim. ORS 656.262(4)(a). As noted above, claimant's entitlement to interim compensation is not dependent upon the compensability of the claim being asserted. Jones v. Emanuel Hospital, supra; Spivey v. SAIF, supra; Stone v. SAIF, supra.

Penalty and Attorney Fee

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

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the jurisdiction 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 and statement of services), the complexity of the issues, and the value of the interest involved. Because penalties and attorney fees are not compensation, claimant is not entitled to an assessed fee for defending on those issues. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated January 21, 1993 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
ROBERT M. BREWER, Claimant
WCB Case No. 92-11462
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of our August 24, 1993 Order on Review. In that order, we adopted the Referee's order which concluded that this case presented an uncomplicated situation in which expert medical evidence was not necessary to establish compensability of claimant's headaches. We supplemented the Referee's order to address whether claimant's condition should be analyzed as an industrial injury or an occupational disease. Reasoning that claimant's condition was unexpected and arose within a discrete, relatively short period of time, we concluded that claimant's condition should be analyzed as an injury claim.

On review, the employer contends that we did not address the Referee's evidentiary ruling in which he admitted a paint can and its warning label into evidence. In addition, the employer objects to the Referee's "apparent reliance" on the paint can warning label in reaching his decision. The employer also contends that we failed to address whether claimant was required to prove compensability of his claim by medical evidence.

Regardless of whether the paint can was admissible evidence, the Referee's order does not refer to it. Moreover, we did not rely upon the paint can label in reaching our decision to affirm the Referee's compensability decision. As to the employer's final contention regarding whether medical evidence was necessary to establish compensability, that issue was adequately addressed by the Referee's order (which we have adopted). See Barnett v. SAIF, 122 Or App 279 (1993).

We withdraw our August 24, 1993 order. On reconsideration, as supplemented herein, we republish our prior 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
CHRISTINE A. ANDERSON, Claimant
WCB Case No. 92-08208
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Black's order that: (1) upheld the SAIF Corporation's denial of her injury claim for a left wrist condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

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

Citing Uris v. Compensation Department, 247 Or 420 (1967), the Referee found that this case presented a complex medical question of causation which required expert medical opinion for its resolution. On review, claimant contends that this is an uncomplicated situation which does not necessitate medical opinion regarding causation.

Although it is true that an emergency room physician initially diagnosed a left wrist sprain, Dr. Watrous, who treated claimant for her left arm and neck pain, subsequently diagnosed cervical spondylosis, which he described as degenerative disc disease with associated arthritis of the facet joints. We note that claimant's counsel tried diligently to obtain a supportive report from Dr. Watrous. Despite such efforts, Dr. Watrous opined that claimant's left arm symptoms were related to irritation of cervical nerve roots rather than to local wrist pathology.

Based on the medical record, it is not clear whether claimant's subsequent left arm and neck symptoms were separate from her initial left wrist symptoms or were a continuation of that original problem. Under such circumstances, we agree with the Referee that this case presents a complex medical question of causation, concerning not only the nature of her condition (i.e., the validity of the initial diagnosis by the emergency room doctor), but also concerning whether the condition is causally related to claimant's work activities on May 11, 1992.

Claimant contends that Dr. Dickerman, independent medical examiner, supports her contention that she suffered a simple left wrist strain injury as a result of work activities on May 11, 1992. We disagree.

Dr. Dickerman noted a "history of left wrist strain." However, he stated: "If the patient in fact did sustain a wrist strain, she is medically stationary, with no objective findings." In the body of his report, Dr. Dickerman opined that claimant had subjective complaints without objective findings. Dr. Dickerman also opined that claimant's pain complaints were motivated by secondary gain. In short, we understand Dr. Dickerman to say that the nature and course of claimant's initial and subsequent complaints are very much in doubt.

ORDER

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

In the Matter of the Compensation of
DOROTHY F. KNIGHT, Claimant
WCB Case No. 90-19278
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial, on behalf of the noncomplying employer, of claimant's injury claim for a right hand condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. In her brief, claimant also raises a jurisdictional objection to the Referee's order. On review, the issues are jurisdiction, compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

A hearing was originally convened before Referee Harri on May 2, 1991. The noncomplying employer was not independently represented by legal counsel at the May 2, 1991 hearing. At the hearing, the noncomplying employer was not given, either orally or in writing, the information required by ORS 183.413. Referee Harri issued an Opinion and Order on May 28, 1991 setting aside SAIF's denial on behalf of the noncomplying employer. On June 26, 1991, the noncomplying employer, which had obtained legal counsel subsequent to the hearing, filed a motion with Referee Harri seeking an order vacating the May 28, 1991 order and reopening the record for the introduction of additional evidence. That same day, Referee Harri abated his May 28, 1991 order and granted the remaining parties 14 days to respond to the employer's motion. Also on June 26, 1991, SAIF's request for Board review of the Referee's May 28, 1991 order was filed with the Board.

On June 28, 1991, we issued an Order of Dismissal remanding this matter to Referee Harri for further proceedings. On August 26, 1991, Referee Harri issued an Interim Order on Reconsideration. The order stated, in part: "Having received the responses of the various parties, and having independently reviewed the file, it appears that the employer did not receive at hearing a specific delineation of all rights to which she was entitled pursuant to ORS 183.413." On this basis, Referee Harri reopened the record and transferred the file to the presiding Referee for further proceedings. Hearing was reconvened before Referee Quillinan on August 3, 1992. On September 3, 1992, Referee Quillinan issued an Opinion and Order, upholding SAIF's denial on behalf of the noncomplying employer.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On review, claimant first contends that SAIF's request for review of Referee Harri's May 28, 1991 order was "filed" with the Board on the date of mailing, rather than on the date of receipt by the Board. Claimant argues that Referee Harri lacked jurisdiction to abate and reconsider his Opinion and Order because SAIF requested Board review the day before Referee Harri abated his order. However, we have already decided this issue in our June 28, 1991 Order of Dismissal (Remanding). In that order, we stated:

> "Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. [citation omitted] Here, because the Referee abated his order the same day that SAIF filed its request for Board review, we shall give effect to the abatement order."

In our dismissal order, we concluded that SAIF's request for Board review (which was not mailed by certified or registered mail) was filed on the date the request was received by the Board (the same day Referee Harri abated his May 28, 1991 order). See OAR 438-05-046(1)(b). We continue to adhere to that conclusion.

However, even if SAIF's appeal had preceded the Referee's abatement order, we would have considered the record insufficiently developed for the reasons expressed by Referee Harri's August 26, 1991 order. Therefore, this case would have been remanded to the Hearings Division for further proceedings. See ORS 656.295(5). Consequently, regardless of whether SAIF's appeal had preceded the Referee's abatement order, the outcome of this case would have been unaffected.

Hearing Procedure

Next, claimant contends that Referee Harri erred in his August 26, 1991 Interim Order on Reconsideration when he reopened the record for further proceedings after concluding that the noncomplying employer was not given notice of its rights under ORS 183.413. We disagree.

In Bryan Eubanks, 43 Van Natta 2319 (1991), a noncomplying employer moved for reconsideration of a referee's order which set aside SAIF's denial of a claimant's low back injury claim on its behalf. The noncomplying employer sought reopening of the record, inclusion of new evidence and a new hearing. Finding that the unrepresented noncomplying employer had not been informed of its rights pursuant to ORS 183.413, the referee withdrew his Opinion and Order and concluded that a new hearing should be held. On Board review in Eubanks, we affirmed the referee's order. Specifically, we concluded that the referee in Eubanks retained jurisdiction, upon a motion for reconsideration, to review the hearing procedures and withdraw his order. We reach the same conclusion here. Referee Harri correctly withdrew his order after determining that the noncomplying employer, which was not independently represented by counsel at hearing, was not given the information required by ORS 183.413. Accordingly, we reject claimant's contention that Referee Harri incorrectly withdrew his Opinion and Order and reopened the record.

Finally, to the extent that claimant's arguments can be interpreted as a contention that the noncomplying employer waived the opportunity to be informed of its rights under ORS 183.413, we would reject that argument on the following grounds. In order for a waiver to have occurred, the noncomplying employer must have intentionally relinquished a known right. See Drews v. EBI Companies, 310 Or 134 (1990). Here, we have found that the noncomplying employer was not made aware of its rights under ORS 183.413. Under such circumstances, we cannot conclude that the noncomplying employer knowingly and intentionally relinquished those rights.

Compensability

We adopt the Referee's conclusions and reasoning as set forth in her September 3, 1992 order with the exception of the first full paragraph on page 4 of the order.[1]

Penalties and Attorney Fees

We adopt the Referee's conclusions and reasoning as set forth in her September 3, 1992 order.

ORDER

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

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[1] We have not adopted the paragraph on page 4 of the Referee's order because we are not confident that it is accurate. As the Referee correctly observed, Dr. Button's opinion is confusing. As we read his report, Button did not differentiate between cysts and tumors as the Referee's order suggests. In any event, the remainder of the Referee's reasoning (with which we agree) supports her ultimate conclusion, as does the evidence.

In the Matter of the Compensation of
ROBERT D. PECK, Claimant
Own Motion No. 92-0587M
OWN MOTION ORDER OF ABATEMENT
Black, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant requests reconsideration of our August 10, 1993 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The insurer is requested to file a response to the motion within 14 days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID J. PHELPS, Claimant
WCB Case Nos. 92-10160, 92-09827 & 92-08892
ORDER OF DISMISSAL (REMANDING)
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Claimant requested Board review of Referee McWilliams' order which: (1) set aside a Director's order concerning a bona fide medical services dispute; and (2) declined to resolve a responsibility issue between K-Mart, Inc., a self-insured employer and Liberty Northwest. Subsequent to requesting Board review, claimant requested that this matter be remanded to the Hearings Division for consolidation with a case which is presently pending before Referee Black. The other parties concur with claimant's motion. We grant the request.

We may remand to the Referee for further development of the case, 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).

It is our general practice to defer consideration of remand motions until we conduct our review of the merits of the case. We follow such a practice because normally a record has already been developed and it is necessary to review that record in light of "extra-record" information. See Joan C. Gillander, 45 Van Natta 1629 (1993).

In contrast to the usual situation, this case involves issues that are intrinsically intertwined with the issues in the case currently pending before Referee Black in WCB Case Nos. 93-04115 and 93-04116. (In this case, the Referee had set aside the Director's order because the order was considered inadequate for a "substantial evidence" review; the case pending before Referee Black pertains to the Director's order issued in response to the Referee's order, as well as the responsibility issue deferred in the first case). Furthermore, all parties have agreed that our review is unnecessary and that remand is appropriate and will likely result in final resolution of all issues. Under these particular circumstances, we hold that remand is warranted. ORS 656.295(5).

Accordingly, the Referee's order is vacated. This matter is remanded to Referee Black for reconsideration of the prior order and consolidation with the case currently before him. Thereafter, Referee Black shall issue a final, appealable order addressing all relevant issues.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGG R. BURTIS, Claimant
Own Motion No. 93-0298M
OWN MOTION ORDER
Jolles, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back, cervical spine, bilateral knee, right ankle, and left elbow injuries. Claimant's aggravation rights expired on June 27, 1985. SAIF does not dispute the compensability of claimant's current condition and resulting need for treatment, but it opposes reopening claimant's claim for temporary disability benefits on the grounds that: (1) claimant's compensable injury has not worsened; (2) his hospitalization on March 4, 1993 was for diagnostic purposes; and (3) claimant was not in the work force at the time of the hospitalization.

Claimant's claim was last closed on February 24, 1993 by a Determination Order which was issued following a program of vocational training. Claimant has requested reconsideration of this February 24, 1993 Determination Order, contending that his claim was prematurely closed. Claimant also has a hearing pending on a 1988 Determination Order in which the issue is extent of disability. (WCB Case No. 88-09553). That hearing has yet to be scheduled. Claimant indicates that he is seeking permanent total disability on this claim.

It is the Board's policy to postpone action regarding own motion relief until any subsequent litigation on related issues has been resolved. Nevertheless, postponement is not necessary where the claimant is not entitled to own motion reopening.

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, 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 making reasonable efforts to obtain employment; 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).

A worker who has voluntarily withdrawn from the work force at the time of disability is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). Claimant has the burden of proof on the work force issue.

Dr. Pulito, claimant's treating physician, admitted claimant to the hospital on March 4, 1993. Dr. Pulito stated that this action was taken due to marked swelling in claimant's left lower leg and Dr. Pulito's concern that claimant may have deep vein thrombosis. (Letter from Dr. Pulito dated June 18, 1993). In a chart note dated March 4, 1993, Dr. Pulito stated that he was admitting claimant to the hospital to "obtain [a] sonography and get a CBC, sed rate, etc., to make sure there is no septic component to this [swelling]." The sonogram was negative for deep vein thrombosis and the swelling improved with claimant being off of his leg and with leg elevation. (Letter from Dr. Pulito dated June 18, 1993). Claimant was discharged from the hospital on March 5, 1993.

Assuming without deciding that claimant's hospitalization for diagnostic tests qualifies as a worsening of the compensable condition that requires treatment requiring hospitalization, we do not find claimant entitled to temporary disability benefits on the ground that he was not in the work force at the time of the disability.

Claimant has not worked since the November 21, 1980 work injury. (Ex. 1). On December 9, 1991, Dr. McKillop, orthopedic surgeon, examined claimant in an independent medical examination and performed an extensive record review. (Ex. 33). Dr. McKillop opined that claimant was physically

capable of doing sedentary work. Claimant reported to Dr. McKillop that he had looked for work and made hundreds of job applications but that no employer would hire him after he told them that he must lay on the floor with his legs elevated up to 45 minutes out of every hour. (Ex. 33-8, -14). Dr. McKillop opined that claimant's "physical exam does not give any obvious reason to explain why [claimant] would need to lie down at all during an eight hour work period." (Ex. 33-14). Dr. McKillop also found that claimant was "quite comfortable in the role that he is currently playing as a completely disabled person." Id.

On January 17, 1992, Dr. Olmscheid, claimant's treating neurologist, concurred with Dr. McKillop's report. (Ex. 32). Dr. Olmscheid also noted that he saw nothing from an objective standpoint that would prevent claimant from performing sedentary work. (Ex. 32-2). In addition, Dr. Olmscheid stated that he had "no objective evidence to indicate that [claimant] should, from a medical standpoint, spend the majority of his time lying down with his legs up." Id. Dr. Olmscheid concluded that, although claimant was capable of returning to sedentary work, "from a practical standpoint, [claimant] appears firmly entrenched in a dependent disabled life style." Id.

Although not explicitly addressing the work force issues, Dr. Pulito and Dr. Wells, treating orthopedic surgeon, both agreed with Dr. McKillop's report, on November 23, 1992 and December 31, 1992, respectively. (Exs. 18, 21). Furthermore, on June 18, 1993, Dr. Pulito stated that he saw nothing to change his December 1992 opinion regarding claimant's condition. We note that Dr. Pulito continued to treat claimant following his December 1992 opinion. In fact, Dr. Pulito was the physician who admitted claimant to the hospital in March 1993.

On July 9, 1993, the Director issued an order reviewing claimant's request for additional vocational training. (Ex. 1). The Director noted that, in discussing possible participation in further vocational training, claimant first reported that he was "physically unable to work because of permanent and total disability." (Ex. 1-2). A few weeks later, claimant reported that he felt able to participate in training and would like to train for a data entry job. However, when confirming the details of the data entry training, claimant stated that "he would have to keep his left leg elevated almost all of the time and his right leg elevated part of the time; and he would have to lie down on the floor as needed." (Ex. 1-2).

The Director found that: (1) claimant was capable of performing sedentary work; (2) the medical record did not support claimant's contention that he must lie on the floor for part of every hour; and (3) there was no job for which claimant could be trained which could accommodate his request. (Ex. 1-2). The Director concluded that claimant had removed himself from the labor market and was not eligible for vocational assistance.

There is no indication that the Director's order has been appealed. However, even without the Director's order, the record establishes that claimant has effectively withdrawn from the work force. Claimant is able to perform sedentary work. Furthermore, there is no medical evidence to support claimant's contention that he must lie on the floor up to 45 minutes out of every hour. Instead, the medical record establishes that claimant is able to work full time at sedentary job.

In support of his assertion that he remains in the work force, claimant submits a list of names and phone numbers of employers he has contacted within the last year. However, given the facts of this case, a simple list of names and phone numbers is insufficient to meet claimant's burden of proving that he was in the work force at the time of disability. We reach this conclusion because the record establishes that claimant reports to potential employers that he must lie on the floor for extended periods each hour and these subjective limitations are refuted by the medical evidence. Given this, a list of names and phone numbers does not establish a reasonable job search.

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.

In the Matter of the Compensation of
JAMES L. EMERICH, Claimant
Own Motion No. 93-0408M
OWN MOTION ORDER
Scott McNutt, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable abdominal injury. Claimant's aggravation rights expired on April 27, 1989. SAIF opposes the authorization of temporary disability compensation on the ground that claimant has withdrawn from the work force.

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

In a letter dated April 8, 1993, Dr. Keizer, claimant's treating physician, requested authorization for surgical repair of claimant's recurrent hernia. In a letter dated May 24, 1993, Dr. Bascom, surgeon, also recommended that claimant undergo an extensive surgical reconstruction and repair of his recurrent umbilical hernia.

On this record, we find that, as of April 8, 1993, claimant's compensable condition worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In support of his contention that he remains in the work force, claimant submits an affidavit in which he states that he has been working since May 1, 1990 as a watchperson for a storage business. Claimant states that, although he receives no salary for his services, he does receive the use of a trailer to live in and all of his utilities. In support of his affidavit, claimant submits a statement from Mr. Ashcroft, the owner of the storage business, who confirms claimant's statements. In addition, Mr. Ashcroft states that he pays claimant for any jobs he performs that are unrelated to the watchperson job, such as repair work or yard work.

On this record, we find that claimant was in the work force in April 1993, at the time of disability. In making this finding, we note that ORS 656.005(27) defines "wages" to include the "reasonable value of board, rent, housing, lodging or similar advantage received from the employer[.]" Thus, although claimant is not paid a salary or an hourly wage for his watchperson job, he does receive "wages" for his work in the form of housing and utilities. In addition, he is paid for any additional work he performs outside of his watchperson duties.

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

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GLORIA C. GARCIA, Claimant
WCB Case Nos. 91-07655 & 91-00667
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Sedgwick James & Co., on behalf of the self-insured employer, requests review of those portions of Referee Hoguet's order that: (1) set aside its denials of claimant's claims for current low back and mental depression conditions; and (2) upheld the denials of AIMS, on behalf of the same employer, of these conditions. Claimant cross-requests review of that portion of the Referee's order that awarded an assessed fee of $6,737.50. On review, the issues are compensability and, if the claimed conditions are compensable, responsibility and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Low back condition

We adopt those portions of the Referee's "Conclusions of Law and Opinion" entitled "Credibility," "Compensability of Claimant's Pars Defect, Spondylolisthesis and Spondylolysis (hereinafter Preexisting Conditions)" and "Responsibility," with the following supplementation.

On review, Sedgwick James argues that the Referee's order should state that Sedgwick James is not responsible for claimant's low back condition and treatment preceding the 1990 injury for which it accepted responsibility. We decline to do so, because there is no indication in the record that claimant filed a claim against Sedgwick James for that condition and treatment. Rather, it appears that the issue in dispute is the compensability of and responsibility for claimant's low back condition following the 1990 injury. (See Exs. 57, 59, 72, 91).

In finding Sedgwick James responsible for claimant's low back condition following the 1990 injury, the Referee relied on the opinions of Drs. Franks, Rosenbaum and Gehling. Sedgwick James argues that the Referee's reliance on Dr. Franks' opinion is misplaced because Dr. Franks' history was incomplete and inaccurate.

However, even if we disregard Franks' opinion, we nonetheless conclude that claimant has proven that her low back claim is compensable. In reaching this result, we find the opinion of Dr. Rosenbaum to be the most persuasive, as it is well-reasoned and based on an accurate and complete history. (See Exs. 67, 68, 71, 74, 95). See Somers v. SAIF, 77 Or App 259 (1986).

Finally, Sedgwick James argues that claimant's 1990 accepted injury resolved so that her current low back condition is not compensable. Alternatively, it contends that, even if the injury was the major cause of claimant's disability or need for treatment in the past, it no longer is and the Referee erred in failing to identify which disability and treatment is compensable and which is not.

As we have stated, we agree with the Referee that claimant's current condition is compensable. In other words, the 1990 injury-related condition has not resolved, i.e., her symptoms are not yet the result of the natural progression of her preexisting diseases. As for Sedgwick James' "partial denial," the carrier appears to argue that a portion of the denial should be upheld, based on claimant's concession that her work injuries have not pathologically worsened her preexisting pars defect, spondylolisthesis and spondylolysis. However, because these preexisting conditions are not claimed, except insofar as the 1990 injury has caused them to become symptomatic, and we hold that the claim is compensable, no portion of the denial survives to be upheld.

Psychological condition

Compensability

The Referee found that claimant's depression condition is a primary consequence of her compensable injuries with AIMS and Sedgwick James and that claimant need only prove that her injuries are a material cause of her disability and need for treatment for this condition. The Referee further concluded that the claim is compensable, even if the applicable standard was "major contributing cause." See ORS 656.005(7)(a)(A). We agree with the Referee's conclusion that claimant satisfied the major contributing cause test and adopt the Referee's reasoning on that point, with the following supplementation.

Because claimant's depression first arose as a result of her injury-related pain and work limitations following the accepted 1988 injury with AIMS, we find that it is an indirect, rather than direct or primary, consequence of that injury. See Laura A. Ward, 44 Van Natta 1101 (1992). Therefore, to establish entitlement to compensation for this condition, claimant bears the burden of proving that the 1988 compensable injury was the major contributing cause of the depression. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Dr. Johnson, treating psychiatrist, opined that the 1988 injury (while AIMS was on the risk) was the major contributing cause of the depression which developed prior to the August 1990 work incident (while Sedgwick James was on the risk). (Exs. 55, 98). Based on his opinion, we conclude that claimant has established the necessary causal relationship. Consequently, the depression first arose as a compensable consequence of the 1988 injury accepted by AIMS.

Responsibility

The Referee assigned initial responsibility for claimant's depression with AIMS; determined that claimant's injury during Sedgwick James' coverage constituted a "new injury" under ORS 656.308; and concluded that responsibility for the depression shifted to Sedgwick James. We agree.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

Sedgwick James contends that ORS 656.308 does not apply because there is no accepted claim for a psychological condition. We disagree.

The application of ORS 656.308(1) is not limited to "accepted" conditions; it expressly applies to "compensable" conditions, i.e., conditions related to the compensable injury. Although AIMS did not accept claimant's psychological condition, we have concluded in this order that the condition first arose as a compensable consequence of the accepted 1988 back injury with AIMS. Thus, the psychological condition is a compensable condition and, therefore, ORS 656.308(1) applies to this case.[1]

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[1] We have previously held that ORS 656.308(1) does not apply to determine the initial assignment of responsibility for a condition which has not been found compensable as to a particular employer/insurer. See Eleanor G. Castrignano, 44 Van Natta 1134 (1992); Fred A. Nutter, 44 Van Natta 854 (1992). We specifically held in Castrignano and Nutter that ORS 656.308(1) did not alter the application of the last injurious exposure rule. Whereas the last injurious exposure rule assigns initial responsibility for a condition between successive employers/insurers, ORS 656.308(1) applies to shift responsibility only after it has been determined that the condition is compensable as to a particular employer/insurer. Because we have determined in this case that claimant's psychological condition is compensable under an accepted low back claim with AIMS, AIMS may shift further responsibility for the condition to the subsequent carrier (Sedgwick James) in accordance with ORS 656.308(1).

Applying ORS 656.308(1), AIMS remains responsible for future medical services and disability relating to the psychological condition unless claimant sustains a "new compensable injury involving the same condition." See SAIF v. Drews, 117 Or App 596, 599 (1993). The phrase "same condition" refers to the condition for which the first carrier is responsible. See Rodney H. Gabel, 43 Van Natta 2662 (1991); Beverly R. Tillery, 43 Van Natta 2470 (1991). Therefore, responsibility for the psychological condition shifts only if claimant sustains a new compensable injury involving the psychological condition.[2]

Because the psychological condition is not alleged to have resulted directly from the 1990 accident itself, but rather, from the low back pain/injury due to the accident, we analyze the psychological condition as a "consequential condition." See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra. Accordingly, in order to establish that claimant sustained a new compensable injury involving the psychological condition, AIMS bears the burden of proving that the 1990 injury with Sedgwick James was the major contributing cause of the subsequent condition. See id.

Claimant sustained a new compensable injury in August 1990 while Sedgwick James was the employer's claim processor. Dr. Johnson opined that the 1990 injury caused a significant exacerbation in, or aggravation of, claimant's depression. (Ex. 98). He also noted that, whereas claimant functioned adequately in spite of her depression prior to the 1990 injury, since that injury, the depression has been contributing to her disability. (Id.) Dr. Colbach also reported that claimant's level of functioning became worse following the 1990 injury, though he could not state whether the worsening was due to the injury or due to the steady progression of the depression since 1988. (Ex. 85-5).

As the treating physician, Dr. Johnson's opinion is entitled to greater weight. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Finding no persuasive reason not to defer to his opinion, we find that the 1990 injury was the major contributing cause of claimant's subsequent disability and need for treatment for her depression. Although Dr. Johnson did not use the words "major contributing cause," such "magic words" are not essential. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Accordingly, we agree with the Referee that claimant sustained a new compensable injury involving the psychological condition. See SAIF v. Drews, supra. Therefore, pursuant to ORS 656.308(1), responsibility for further disability and treatment relating to the depression shifted to Sedgwick James as of the August 3, 1990 injury.

Attorney Fees

The Referee awarded a $6,737.50 attorney fee for claimant's counsel's services at hearing. Claimant requests additional fees, for a total of $8,000, based on the complexity of the issues and his counsel's risk of taking nothing for his efforts.

After considering the factors in OAR 438-15-010(4) and applying them to this case, we find that the Referee's award constitutes a reasonable attorney fee for claimant's counsel's services at hearing.

However, inasmuch as we have concluded that AIMS is responsible for claimant's psychological condition preceding the 1990 injury with Sedgwick James, that portion of AIMS' denial must be set aside. Therefore, a portion of the Referee's attorney fee award must be paid by AIMS. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the hearing level in partially prevailing against AIMS' denial is $1,000. Accordingly, $1,000 of the Referee's $6,737.50 attorney fee award shall be paid by AIMS, and the remainder shall be paid by Sedgwick James.

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[2] Our analysis of the psychological condition in this case is based, in part, on the fact that a claim for the psychological condition was filed with AIMS on claimant's behalf prior to the 1990 accident with Sedgwick James. For that reason, we first analyze the compensability of that condition as it relates to the 1988 injury with AIMS and then determine whether further responsibility for that condition shifted to Sedgwick James as a result of the 1990 accident.

In addition, claimant is entitled to an assessed attorney fee for her attorney's services on Board 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 attorney's services on review regarding the low back and mental depression issues is $1,300, payable by Sedgwick James. We further note that claimant is not entitled to an attorney fee for services devoted to her unsuccessful cross-request.

ORDER

The Referee's order dated April 23, 1992 is modified in part and affirmed in part. AIMS' denial is set aside to the extent it denied responsibility for claimant's psychological condition prior to the August 3, 1990 injury with Sedgwick James. The claim for that condition is remanded to AIMS for processing according to law. AIMS' denial is otherwise upheld. Sedgwick James' May 20, 1991 denial is upheld to the extent it denied responsibility for claimant's psychological condition prior to the August 3, 1990 injury. AIMS shall pay to claimant's attorney $1,000 of the Referee's $6,737.50 attorney fee award, with the remainder to be paid by Sedgwick James. The remainder of Referee's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,300, payable by by Sedgwick James.

In the Matter of the Compensation of
JULIE A. GROS (POOL), Claimant
WCB Case No. 92-01099
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Referee Thye's order that: (1) set aside its denial insofar as it denied claimant's left arm condition; and (2) assessed an attorney fee for setting aside the denial. In addition, the employer seeks review of the Referee's ruling allowing claimant to amend her Request for Hearing to include new diagnoses. Claimant cross-requests review of that portion of the order that limited disability and medical treatment for the left arm condition to that received prior to December 2, 1991. On review, the issues are hearing procedure, compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Amended Hearing Request

We affirm and adopt the Referee's reasoning and conclusion on this issue, with the following comments.

At hearing, the issue was identified as the compensability of claimant's left neck and shoulder sprain and cervical radiculopathy. The record was left open to allow the employer to depose Dr. Ellis. At oral closing arguments, claimant moved to amend her hearing request to include the diagnoses of left arm tendinitis and nerve entrapment syndrome discussed by Dr. Ellis during the deposition. The employer declined to seek a continuance of the hearing. In his order, the Referee granted claimant's motion and considered the compensability of all diagnosed conditions.

On review, the employer asserts that it was prejudiced by the Referee allowing claimant to raise new "issues" in closing arguments. 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." Therefore, we review the Referee's ruling for abuse of discretion. Rodney D. Jacobs, 44 Van Natta 417 (1992); Renia Broyles, 42 Van Natta 1203 (1990).

Relying on Edward R. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989), the employer argues that issues raised for the first time in closing arguments should not be considered by the Referee or the Board. We have consistently held that a party cannot raise a new issue during closing arguments. Felipe A. Rocha, 44 Van Natta 797 (1992); Leslie Thomas, 44 Van Natta 200 (1992); Karel L. Nelson, 42 Van Natta 1206 (1990); Edward R. Rankin, supra. For reasons of fundamental fairness, we reasoned that an issue is not properly raised when first raised in closing arguments. We conclude, however, that the Rankin line of cases is distinguishable from the present case and does not control.

The cited cases all concerned the introduction of separate and distinct issues from those raised by a carrier's denial or a party's hearing request. Here, in contrast, claimant has not raised a new "issue." Rather, the issue remains the compensability of claimant's neck and left upper extremity condition. Only new diagnoses (left arm tendinitis and nerve entrapment syndrome) have been added in an attempt to explain claimant's symptoms. We agree with the Referee that the addition of different diagnoses does not constitute a new, separate issue, but instead constitutes merely another component of the compensability issue. Moreover, we note that the employer specifically declined to seek a continuance of the hearing. Under these circumstances, the Referee did not err in considering the compensability of claimant's alleged left arm tendinitis and nerve entrapment syndrome.

Compensability

The Referee concluded that claimant's neck and left shoulder strain and cervical radiculopathy are not work-related. The Referee further concluded that she does not have left arm tendinitis or nerve entrapment syndrome. Therefore, the Referee upheld the employer's denial as to those conditions. Notwithstanding his conclusion as to the non-compensability of all diagnosed conditions, the Referee found that the left arm complaints for which claimant sought treatment from Dr. Falley in August through October 1991 were compensable. The employer argues that claimant has failed to prove either that she has an occupational disease affecting the left arm or that such condition is work-related. We agree.

In order to establish a compensable occupational disease claim under ORS 656.802(1)(c), claimant must prove that her work exposure included a series of traumatic events which were the major cause of the onset or worsening of the left arm condition, requiring medical services or resulting in disability, established by medical evidence supported by objective medical findings. See ORS 656.005(7)(a); 656.005(19); Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1993); Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991); Suzanne Robertson, 43 Van Natta 1505 (1991).

In finding claimant's left arm condition compensable, the Referee relied on the opinions of Dr. Falley and Dr. Ellis. Dr. Falley's initial impression was work-related tendinitis and nerve entrapment syndrome. When electrodiagnostic testing revealed no abnormal findings, Dr. Falley conceded that claimant had no objective evidence of injury. Nevertheless, and without explanation, he asserted that "some" work-related injury had occurred. We do not find such a conclusory opinion to be persuasive as to either the existence or cause of a left arm condition.

Dr. Ellis examined claimant one time in December 1991. In deposition, Dr. Ellis stated that he had none of Dr. Falley's examination notes, had not examined claimant in the fall of 1991, and that it was impossible for him to provide a meaningful assessment of claimant's condition at that time or to establish a causal relationship between claimant's condition and her work activities. In light of these comments, we do not find Dr. Ellis' single response to claimant's hypothetical question (whether it was reasonable that the symptoms which claimant experienced during the course of her work were related to and caused by her work) sufficient to establish that the left arm condition for which she sought treatment from Dr. Falley is compensable.

As the Referee noted, the lack of a specific diagnosis is not fatal to a claim. Here, however, all possible diagnoses for claimant's left upper extremity complaints have either been ruled out or found not to be work-related. Under such circumstances, we find that claimant has not established a compensable left arm occupational disease by medical evidence supported by objective medical findings. See Georgia Pacific Corp. v. Ferrer, supra.

Because claimant does not have a compensable left arm condition, we do not consider claimant's argument that the Referee should not have limited disability and medical treatment for the condition to that received prior to December 2, 1991.

Finally, because we have reversed the Referee's compensability finding, his award of an assessed attorney fee for prevailing over the employer's denial is also reversed.

ORDER

The Referee's order dated August 21, 1992 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's denial insofar as it denied claimant's left arm condition is reversed. The employer's denial is reinstated and upheld. The Referee's award of an assessed attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
TAMARA D. HERGERT, Claimant
WCB Case No. 91-14418
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Ray W. Miller (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Barber's order which upheld the SAIF Corporation's denial of claimant's claim for a positive tuberculosis test. On review, the issue is compensability.

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

It is claimant's burden to prove compensability of her condition, whether as an injury or as an occupational disease. ORS 656.266. The statute further provides that the worker cannot carry the burden of proving compensability of a condition "merely by disproving other possible explanations of how the injury or disease occurred." Id.

In Ruben G. Rothe, 45 Van Natta 369, 372 (1993), we held that ORS 656.266 requires a claimant to affirmatively prove that his or her condition was, in fact, related to the work environment. In doing so, we relied on legislative history preceding enactment of ORS 656.266 in 1987, in which Representative Shiprack, among others, expressed the view that ORS 656.266 was designed to require the Board and courts to decide cases on "clearly proven facts instead of deductive reasoning. . ." See Transcript of Proceedings, Senate Committee on Labor, April 23, 1987, at 3; Ruben G. Rothe, supra, 45 Van Natta at 371.

Here, claimant has not affirmatively proven any exposure to tuberculosis in the course of her work as an Emergency Medical Technician. (See e.g., Tr. 29). Nor has claimant even disproven other possible sources of exposure. (See Ex. 8-27 to -28). At best, claimant has proven, viewing the evidence in the light most favorable to claimant, only that she was at increased risk of exposure to tuberculosis due to the nature of her job as a health care professional. (See Ex. 7-35). This is insufficient to prove that her exposure, in fact, occurred at work. See Ruben G. Rothe, supra, 45 Van Natta at 372. Accordingly, we agree with the Referee that claimant failed to carry her burden of proving that her employment, in fact, caused exposure to tuberculosis and resulted in a positive TB test.

ORDER

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

In the Matter of the Compensation of
MELVIN K. KUYKENDALL, Claimant
WCB Case No. 92-09575
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of Referee Galton's order which set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had met his burden of proving that his herniated disc condition was compensably related to his accepted strain injury and he, therefore, proved a compensable aggravation. The insurer argues that claimant's current condition, diagnosed by Dr. Gower as lumbar 4-5 stenosis with lumbar 4-5 herniated disc, is not compensably related to his accepted lumbar strain. Thus, the issue is causation. We agree with the Referee's conclusion.

In this case, the insurer accepted a lumbar strain after claimant's July 2, 1990 work injury. (Ex. 14). A CT scan on July 24, 1990, and subsequent radiographic studies, revealed a bulging L4-5 disc. (Exs. 9, 13). By April 1992, an MRI and myelogram revealed a herniated disc at L4-5, and first noted degenerative disc disease at L3-4 and L4-5. (Exs. 48, 49, 50). Degenerative changes were not noted on the July 1990 CT scan. (Ex. 62-14). Thus, because degenerative changes were not present at the time of the 1990 injury, there is no evidence of a pre-existing degenerative condition with which the strain injury "combined" to cause claimant's current low back condition. Therefore, ORS 656.005(7)(a)(B) does not apply.

In order to prove compensability, claimant must establish either that his current condition and need for treatment were directly caused by the industrial accident (in which case, the material contributing cause standard applies) or that the current condition arose as a consequence of the compensable injury, which is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992)

The insurer, relying on the opinions of Dr. Freede, argues that claimant never had an actual herniated disc and, absent a frank rupture, claimant's 1992 condition was not related to the 1990 injury. The Referee concluded that Dr. Freede's opinion was not persuasive and, thus, afforded it little weight. Somers v. SAIF, 77 Or App 259 (1986). We agree. Further, contrary to the insurer's contention, Dr. Freede was not claimant's attending physician. Rather, Dr. Freede conducted independent medical examinations and record reviews for the insurer. (Exs. 13, 53, 56).

The Referee was persuaded by the opinion of Dr. Long, who stated that claimant's need for surgery in 1992 was caused by a disc lesion which had been present since his July 1990 injury. The insurer argues that Dr. Long is not persuasive because he changed his opinion without explanation. After considering all of Dr. Long's reports, including his testimony at deposition, we are satisfied by Dr. Long's explanation for his change of opinion.

Dr. Long, specialist in physical medicine and rehabilitation, first examined claimant in June 1991. At that time, Long felt that claimant's back problems were mechanical because there had never been any clear evidence of lumbar disc disease (Ex 36-3), and because he was not able to document EMG abnormalities (Ex. 59). In retrospect, however, after reviewing medical reports and radiographic reports that had been obtained subsequent to his first examination, Dr. Long stated:

> "[G]iven all this (sic) additional imaging studies and the surgical report and so on and recognizing that there was a certain amount of controversy among examiners as to whether actually a significant disk lesion had been present and needed to be treated surgically and so on, I think when I wrote the report 10/15/92, in light of all that, I think I felt that more probably than not that [claimant] had in fact had a disk lesion 7/6/90 * * * ."

(Ex. 61-13).

Dr. Long also stated that the results of the good quality MRI in April 1992 convinced him that it was reasonably medically probable that the significant central and right-sided L4-5 disc lesion encroaching the right L5 and S1 root sleeves resulted from claimant's original July 6, 1990 injury. (Ex. 59). After our review of Dr. Long's entire testimony concerning his analysis of claimant's continuing symptoms following the July 1990 injury, we conclude that Dr. Long has persuasively explained the reasons for his change of opinion following his initial examination of claimant. We also find his conclusion to be supported by the opinion of Dr. McElroy, claimant's attending physician (see Ex. 62-13, 14), and the operative findings of Dr. Gower, confirming Gower's pre and post-operative diagnoses of lumbar 4-5 stenosis with lumbar 4-5 herniated disc. (Ex. 55, 57).

Moreover, we are persuaded by Dr. Long's opinion that the disc injury/bulge that was present after claimant's 1990 work injury caused his herniated disc and required surgery. Accordingly, thematerial contributing cause standard applies. Albany General Hospital v. Gasperino, supra. We are satisfied that claimant has carried that burden of proof.

Furthermore, even if claimant's current condition were deemed a consequence of the compensable injury, we would conclude that claimant's compensable injury was the major contributing cause of the consequential condition. Albany General Hospital v. Gasperino, supra. Notwithstanding the fact that Dr. Long's opinion does not contain the "magic words," see McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we conclude that his opinion supports a finding the work injury was the sole cause of the herniated disc, as there is no indication of any contribution by other factors. Accordingly, claimant has met his burden of proving that his current condition is compensably related to his accepted lumbar strain.

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

ORDER

The Referee's order dated February 1, 1993 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $850, payable by the insurer.

In the Matter of the Compensation of
DOLORES M. LEIBEE, Claimant
WCB Case No. 92-04052
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael V. Johnson's order that upheld the SAIF Corporation's denial of her aggravation claim for a current neck and back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

An aggravation has two components: causation and worsening. We first address whether claimant's current condition is compensable. If it is compensable, then we determine whether the condition is worse. See Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993); see also Thomas L. Fitzpatrick, 44 Van Natta 877 (1992).

Compensability

The Referee concluded that claimant's current cervical/thoracic condition is not compensably related to the 1988 accepted cervical/thoracic strain. Analyzing claimant's accepted 1985 cervical/thoracic strain as a "preexisting condition" which combined with the 1988 injury, the Referee found that claimant did not sustain her burden of proving that the 1988 injury remains the major contributing cause of her current condition. See ORS 656.005(7)(a)(B). We disagree with the Referee's analysis and find that claimant's current condition is compensable.

Subsequent to the Referee's order, the Court of Appeals has held that ORS 656.005(7)(a)(B) defines what is compensable when a work-related injury combines with a preexisting noncompensable disease or condition to cause or prolong disability or a need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594 (1993); SAIF v. Drews, 117 Or App 596, 599 (1993). Therefore, we do not regard claimant's compensable 1985 injury as a "preexisting disease or condition" for purposes of ORS 656.005(7)(a)(B).

Further, we do not find that any preexisting noncompensable disease or condition is contributing to claimant's current cervical/thoracic condition. Dr. Kemple, rheumatologist, diagnosed "degenerative disease and chronic unstable myofascial reactivity," as well as fibromyalgia, but he does not explain whether those conditions preexisted or were caused by the compensable strain injuries. (See Ex. 53). Dr. Stevko testified that fibromyalgia relates to soft tissue injuries, thus supporting a finding that claimant's condition resulted from his previous compensable injuries. (See Tr. 33). In addition, although Drs. Tesar and Wilson diagnosed degenerative disc disease at C5-6, there is no evidence that that disease has contributed to the current condition. (See Ex. 52A-7).

Because we do not find that a "preexisting disease or condition" has combined with the compensable injury to cause disability or a need for treatment, ORS 656.005(7)(a)(B) does not apply. Instead, we analyze claimant's claim under the material contributing cause standard in ORS 656.005(7)(a). That is, claimant's claim is compensable if she proves that the compensable 1988 injury was a material contributing cause of her disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

A preponderance of the medical evidence proves a material relationship. Dr. Kemple opined that claimant's increased symptoms following her return to work (for Safeway) in October/November 1991 represented an "aggravation" of the 1988 accepted injury. (Exs. 53-1, 55-2). Dr. McComb also described claimant's condition as an "aggravation" of her 1988 injury. (Ex. 44). Dr. Yates, who was the first to treat claimant following her 1991 exacerbation, diagnosed "aggravation C[cervical]-T[thoracic] strain." (Ex. 40). Drs. Tesar and Wilson diagnosed a cervicodorsal strain that aggravated claimant's preexisting chronic pain syndrome (dating back to the 1985 accepted injury). (Ex. 52A). Although their report does not expressly relate the current condition to the 1988 injury, inasmuch as the 1988 injury contributed, in part, to the "chronic pain syndrome," we find their opinion supports a finding that the 1988 injury materially contributed to the current condition. Based on this evidence, therefore, we conclude that claimant's current condition is compensably related to the 1988 injury.

Worsening

In order to prove a compensable worsening of her 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). The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1), (3).

Claimant testified that, prior to working for Safeway in October/November 1991, she had pain in her neck, shoulders and upper back that waxed and waned depending on her activity. She estimated that, on a one-to-ten scale, her pain at that time was a five or six. (Tr. 18-19).

At Safeway, claimant worked in the bakery reaching, lifting and carrying trays and pushing carts and bread racks. On the second or third day of work, her pain began to worsen. She estimated that by the end of the first week, her pain was a ten on a one-to-ten scale. (Tr. 17). She sought treatment and was released from work. (Ex. 44). She has not returned to the Safeway job. Claimant's pain subsided a few weeks after leaving the Safeway job, but it still flares up occasionally. (Tr. 22-23).

Claimant's persuasive testimony, as well as the medical reports discussed above, establish that claimant experienced increased symptoms following the Safeway job that rendered her less able to work. The medical reports provide ample medical evidence, supported by objective findings, of the worsening.

Finally, we do not find any medical evidence prior to the last award of compensation of the possibility of future flare-ups of symptoms. See ORS 656.273(8). The last award of compensation was made by Stipulation dated October 15, 1990, which increased claimant's unscheduled permanent disability award from 14 percent to 28 percent. (Ex. 31). The stipulation makes no mention of future symptomatic flare-ups, nor was there any evidence that such flare-ups were anticipated at the time of the stipulation. Therefore, we do not find that claimant's previous permanent disability award contemplated any waxing and waning of symptoms. See Lucas v. Clark, supra, 106 Or App at 691; Dana J. Fisher, 45 Van Natta 225 (1993). Accordingly, ORS 656.273(8) is not applicable here.

Based on these findings, we conclude that claimant has established a compensable aggravation claim for her current condition. In this regard, we do not find sufficient proof in the record that claimant sustained an independent, compensable injury at Safeway, so as to shift responsibility for the current condition to Safeway. See ORS 656.308(1); SAIF v. Drews, 117 Or App 596, 599 (1992); Ricardo Vasquez, 43 Van Natta 1678 (1991). The medical record establishes that claimant had chronic strain symptoms following the 1988 injury and that those symptoms persisted through the date she began working for Safeway. The medical record also establishes that claimant's current condition represented an exacerbation of chronic symptoms. Further, we note that no specific incident preceded the exacerbation of symptoms. Rather, claimant's testimony establishes that her chronic symptoms worsened soon after beginning her work duties. Based on this evidence, as well as the medical evidence discussed above, we do not find that responsibility for claimant's current condition shifted to Safeway under ORS 656.308(1).[1]

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate brief, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 8, 1992 is reversed. The SAIF Corporation's denial of claimant's aggravation claim is set aside, and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review concerning the aggravation issue, to be paid by the SAIF Corporation.

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[1] We note that SAIF issued a notice of disclaimer of responsibility, naming Safeway as a potentially responsible employer, pursuant to ORS 656.308(2). However, claimant has not pursued a claim against Safeway, and Safeway was not joined as a party to this proceeding.

In the Matter of the Compensation of
ALBERT LEWIS, Claimant
Own Motion No. 93-0176M
OWN MOTION ORDER
Whitehead, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right knee injury. Claimant's aggravation rights expired on January 29, 1990. SAIF recommends that we authorize the payment of temporary disability compensation. SAIF also requests authorization for reimbursement from the Reopened Claims Reserve.

On March 30, 1993, SAIF issued a partial denial for compensability of claimant's current varicose vein condition. Claimant requested a hearing on the denial. WCB Case No. 93-05118. SAIF also contended that surgery or hospitalization was not reasonable or necessary for the compensable injury, that claimant had not sustained a worsening of the compensable injury, and that claimant was not in the work force at the time of current worsening. The Board issued an order postponing action on May 18, 1993. Claimant's hearing was subsequently postponed. On August 19, 1993, SAIF withdrew its partial denial after receiving additional information regarding claimant's claim. In addition, SAIF now recommends reopening claimant's claim.

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 a May 8, 1992 letter, Dr. Gaiser, consulting surgeon, noted that he had ordered a vascular lab vein study for claimant. Dr. Gaiser stated that if claimant's deep vein system is competent, he should undergo a limited vein stripping on his right leg. The lab tests showed that claimant's deep vein system was normal. However, there is no subsequent report from Dr. Gaiser in the record, although a March 2, 1993 letter from claimant's attorney requests that SAIF pre-authorize a surgery for claimant.

In a July 29, 1993, Dr. Arbeene, examining orthopedist, stated that claimant suffered from "chronic venous insufficiency, right lower extremity, with diffuse varicose vein formation and early development of stasis ulcerations of the right leg." In another report dated July 29, 1993, Dr. Acker, examining vascular surgeon, stated claimant's "varicosities have become severe enough where it is felt that the only effective current treatment would be their surgical removal and then the wearing of a properly fitted below-knee support hose after the surgery to help contain the swelling."

On this record, we conclude that claimant has sustained a worsening of the compensable injury which requires surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In the July 29, 1993 report, Dr. Arbeene stated that claimant has been a home builder for the last six years. Dr. Acker stated that claimant "is now working in construction, and he states he works up to 16 hours a day doing mainly foundation work." Therefore, we are persuaded claimant has demonstrated he was in the work force at the time of worsening of the compensable injury.

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

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

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

IT IS SO ORDERED.

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

Claimant requests review of the SAIF Corporation's June 3, 1993 Notice of Closure which closed his claim with an award of temporary disability compensation from July 8, 1991 through May 25, 1993. SAIF declared claimant medically stationary as of May 25, 1993. 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). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 3, 1993 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). Claimant bears the burden to establish that he was not medically stationary when the claim was closed. 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).

On May 25, 1993, Dr. Antimisiaris, claimant's treating physician, stated he did "not think that [claimant] will have any further material improvement from medical treatment or the passage of time." On July 15, 1993, Dr. Antimisiaris stated that while he did believe claimant was stable clinically, his condition was quite poor.

We agree that claimant appears severely debilitated. However, the definition of "medically stationary" does not take into account the severity of claimant's debilitation. Furthermore, although claimant contends his case should remain open for vocational services, the need for vocational services is also not a standard for determining whether a claimant is medically stationary. Instead, the standard is whether any further material improvement would be reasonably expected from medical treatment or the passage of time. ORS 656.005(17).

Therefore, based on Dr. Antimisiaris' statements, we find claimant was medically stationary at claim closure, and conclude that SAIF's closure was proper.

Accordingly, SAIF's June 3, 1993, Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JO WANDA ORMAN, Claimant
Own Motion No. 91-0707M
RECONSIDERATION OF OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Olson, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 10, 1993 order in which we affirmed the SAIF Corporation's March 9, 1993 Notice of Closure in its entirety. On reconsideration, claimant argues that she was not medically stationary at claim closure.

We withdraw our order for purposes of reconsideration. After conducting our reconsideration and reviewing claimant's motion and supporting argument, we adhere to our prior conclusions. In addition, we note that claimant apparently presupposes that her psychological condition must be medically stationary before her claim may be closed. However, it is the law of the case that claimant's psychological condition is not compensable. (See Referee Holtan's order issued on September 18, 1991, as reconsidered on October 25, 1991, aff'd Jo W. Orman, 44 Van Natta 1863 (1992)). In any event, we continue to rely on Dr. Hall's March 29, 1993 opinion in reaching our conclusion that SAIF's March 9, 1993 Notice of Closure was proper.[1]

Accordingly, we adhere to and republish our August 10, 1993 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] This case presents an unusual set of circumstances. Claimant's psychological condition (for which she was hospitalized) was held not compensable by order of the Board. Jo W. Orman, 44 Van Natta 1863 (1992). Although the psychological condition is not causally related to the compensable injury as a matter of law, the Board concluded that the psychological condition had to be "stabilized" in order to effectively treat the compensable physical condition. Thus, claimant's requested hospitalization for the psychological problem was deemed a reasonable and necessary medical service under ORS 656.245. See Jo W. Orman, an unpublished Own Motion Order dated October 16, 1992, as reconsidered on November 25, 1992.

Claimant's aggravation rights expired on July 5, 1983. Thus, her claim is within the Board's own motion jurisdiction. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Accordingly, to be entitled to temporary disability compensation, claimant was required to show "a worsening of a compensable injury that requires * * * hospitalization." ORS 656.278(1)(a) (emphasis added). By Own Motion Order dated October 16, 1992, we inappropriately authorized payment of temporary disability compensation because claimant's psychological condition required hospitalization. That condition, however, is not compensable. To obtain any temporary disability compensation, ORS 656.278(1)(a) requires the worsening of claimant's compensable condition requiring surgery or hospitalization. There has been no such worsening of claimant's compensable condition.

However, we emphasis that, although claimant's psychological condition is not compensable, she was entitled to the psychological treatment as a matter of law. Jo W. Orman, 44 Van Natta 1863 (1992). Our error was in reopening claimant's claim to authorize payment of temporary disability benefits when there was no worsening of the compensable condition requiring surgery or hospitalization.

In any event, claimant was discharged from the hospital on July 10, 1990. Dr. Hall, who had followed her progress and signed the discharge summary stated that claimant's psychological condition was medically stationary upon her release from the hospital. SAIF accordingly closed the claim.

We continue to find that the claim closure was proper.

In the Matter of the Compensation of
SUSANN V. REDBERG, Claimant
WCB Case No. 92-12087
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Podnar's order that set aside its denial of claimant's carpal tunnel condition. In its brief, the insurer cites a supplemental document which had been submitted as part of its request for reconsideration but was not submitted at hearing. We treat this citation as a request for remand. ORS 656.295(5). On review, the issues are remand and compensability. We deny the motion for remand and affirm.

FINDINGS OF FACT

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

On January 29, 1993, the Referee denied the insurer's motion for reconsideration, which included as an attachment a medical article that appeared in the April 1992 Journal of Occupational Medicine, Volume 34, Number 4. The article was not submitted at hearing.

CONCLUSIONS OF LAW AND OPINION

Remand

In its brief, the insurer cited in its findings of fact an article written by Dr. Nathan which it had submitted as part of its request for reconsideration. On review, we are limited to the record developed at hearing. ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). We, therefore, treat this citation as a motion for remand and consider it only to determine whether remand is appropriate.

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. Olson, 37 Van Natta 1054, 1055; (1986), aff'd mem 80 Or App 152 (1986).

The insurer cited the article in order to provide additional evidence of Dr. Nathan's expertise as a specialist and to bolster his theory of causation. (See Insurer's Brief at 3). The article appeared in April 1992. The hearing was held on December 15, 1992. The insurer offers no reason for not submitting this material at hearing. We conclude that it was obtainable with due diligence at the time of the hearing. Furthermore, the article is a statistical study of 429 workers regarding the etiology of carpal tunnel syndrome in industry. We find that the exhibits already in the record regarding the specifics of claimant's condition were sufficient to completely, sufficiently, and adequately develop the record. See ORS 656.295(5); Compton v. Weyerhaeuser Co., supra; Bernard L. Olson, supra. The motion to remand is denied.

Compensability

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

The record establishes that claimant worked as a restocking clerk in the employer's retail department for over 20 years. (Exs. 3 and 6). Her duties required that she repetitively use her wrists in the process of labelling stock, operating a hand truck, gripping a price gun, and operating a cash register. (Tr. 11 through 15). We have interpreted such physical overuse to be a subset of the "series of traumatic events" as used in ORS 656.802(1)(c). See, e.g., Mary L. Goudy, 42 Van Natta 1140 (1990); Ronald Dickson, 42 Van Natta 1102 (1990).

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 $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 8, 1993 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ELAINE R. SANMANN, Claimant
Own Motion No. 93-0074M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys

Claimant requested reconsideration of our July 2, 1993 Own Motion Order in which we declined to reopen her claim for own motion relief on the ground that she had not established she was in the work force at the time of her disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our July 2, 1992 order and granted the insurer an opportunity to respond to the motion. No response has been received from the insurer. We proceed with our reconsideration.

In a December 14, 1992 chart note, Dr. Malkin, claimant's consulting physician, considered hospitalization if claimant's condition did not improve. On December 16, 1992, claimant was hospitalized for intravenous antibiotic treatment. Claimant had surgery on December 23, 1992.

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). Here, claimant must prove that she was in the work force on December 16, 1992, when her condition worsened requiring hospitalization. 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).

In a July 27, 1993 affidavit, claimant stated that she was "not employed at this time, but I am willing to work." Claimant stated that in early November 1992, she attempted to find work to have extra money for Christmas. Before she could obtain work, she was walking with crutches. On December 5, 1992, Dr. Tripp, claimant's treating physician, referred claimant to Dr. Malkin, a foot and ankle specialist. On December 10, 1992, Dr. Malkin ordered claimant to stay off of her left leg. By December 14, 1992, claimant was using a walker. On December 16, 1992, claimant was hospitalized for treatment of her compensable condition. This condition ultimately required surgery on December 23, 1992.

On this record, we conclude claimant was willing to work and making reasonable efforts to find work until her compensable condition made such efforts futile. We conclude that any efforts to find work became futile at least by December 10, 1992 when Dr. Malkin ordered claimant to stay off of her left leg.

Furthermore, we note that, after recovering from surgery, claimant applied for a bookbinding job in July 1993. Although this application was not made during the relevant time period, it does support claimant's contention that she is willing to work.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning December 16, 1992, the date she was hospitalized for treatment. When claimant is medically stationary, the insurer 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 the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
BEVERLY M. BROWN, Claimant
WCB Case No. 93-07620
ORDER OF DISMISSAL (REMANDING)
Schneider, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant has has requested Board review of Referee Tenenbaum's August 12, 1993 order which denied claimant's motion to recuse Referee Galton from presiding over claimant's scheduled hearing. We have reviewed the request to determine whether we have authority to consider this matter. Because we conclude that Referee Tenenbaum's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

Claimant's hearing request was acknowledged and a hearing was scheduled before Referee Galton. Prior to the scheduled hearing, claimant requested that Referee Galton be disqualified from presiding over the hearing.

On August 12, 1993, Presiding Referee Tenenbaum issued an order denying claimant's motion to recuse Referee Galton. See OAR 438-06-095(2). On August 20, 1993, the Board received claimant's request for Board review of the Presiding Referee's order.

FINDINGS OF ULTIMATE FACT

The Presiding Referee's August 12, 1993 order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, Presiding Referee Tenenbaum's August 12, 1993 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order was interim in nature since it addressed claimant's pre-hearing motion to have Referee Galton recused from presiding over the scheduled hearing. See OAR 438-06-095(2). As a result of Presiding Referee Tenenbaum's denial of the recusal motion, Referee Galton remains the assigned referee for claimant's scheduled hearing. In other words, further proceedings are required to determine claimant's entitlement to, and/or the amount of, compensation.

Inasmuch as further action before the Hearings Division was required as a result of Presiding Referee Tenenbaum's order, we hold that it was not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Therefore, we lack jurisdiction to consider claimant's request for Board review.

In reaching this conclusion, we acknowledge claimant's adamant disagreement with Presiding Referee Tenenbaum's decision. Should claimant's disagreement with the decision continue following the eventual issuance of Referee Galton's order regarding the merits of claimant's hearing request, claimant may seek review of the pre-hearing ruling on Board review of Referee Galton's final order.

Accordingly, this case is returned to Referee Galton for further action consistent with this order and Presiding Referee Tenenbaum's August 12, 1993 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ENID S. CROWE, Claimant
WCB Case No. 92-02229
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel 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's work activities require her to repetitively use her right hand for six and a half hours of her eight hour work day.

In 1978, claimant first noticed right fingertip (not hand) numbness when she was using a sewing machine.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to prove that her employment conditions were the major contributing cause of her right carpal tunnel condition. We disagree.

Dr. Smith, orthopedic surgeon, diagnosed right median nerve entrapment and performed a right carpal tunnel release in December 1991. Claimant's work consisted of the constant and repetitive use of her right hand for almost 19 years. Given the repetitive nature of claimant's work activities, we analyze her 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 employment conditions were the major contributing cause of her carpal tunnel 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 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).

As noted above, claimant's work consisted of the constant and repetitive use of her right, dominant hand for six and one-half hours of her eight hour workday. She worked for the same employer, performing the same duties, for almost 19 years. During this period, claimant's work load increased and, about six years prior to hearing, she began entering data by computer rather than by hand, although the bulk of her work was still done by handwriting. (Tr. 11-17 and Ex. 11). Although claimant had first noticed mild symptoms of numbness and tingling in the tips of three fingers of her right hand in 1978 (after she had worked for the employer for about four years), she did not seek medical attention for her condition until July 1991, when her symptoms increased. (Ex. A, Tr. 18-21).

Dr. Button performed an independent medical examination. Dr. Button based his conclusion that the major cause of claimant's condition is "idiopathic" on the apparent premise that she has the condition in both hands. Button also assumed that, if the major cause of claimant's condition was her work, the symptoms would have developed years before. (Ex. 12). Yet, the record does not establish that claimant's left hand is symptomatic. In addition, claimant first noticed tingling in her right fingers in 1978. These symptoms increased in 1991, causing her to seek medical treatment at that time. Button does not explain how this apparent discrepancy in the onset of symptoms would affect his conclusion.

Finally, Button mentioned claimant's heritage, gender, and obesity as other potential factors in her carpal tunnel syndrome. Minimal explanation was also provided to support these conclusions.

In contrast to Dr. Button's opinion, Dr. Smith, claimant's attending physician, offered a thorough opinion addressing claimant's current condition and explaining the relationship between that condition and her work activities. Specifically, Dr. Smith opined that claimant's right carpal tunnel syndrome was caused in major part by her job duties that require constant writing, some lifting and carrying, and computer data entry, all predominantly with the right hand. Smith explained that claimant had a cumulative trauma disorder as the underlying cause of her carpal tunnel condition and, because the trauma is cumulative, the time line for the onset of the condition is not diagnostically relevant.

When there is a dispute between medical experts, we give the most weight to those opinions that are both well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). We also, absent persuasive reasons not to do so, generally give greater weight to opinions from the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983). For the reasons previously discussed, we conclude that Dr. Smith's opinion satisfies these standards. Consequently, based on Dr. Smith's persuasive conclusion, we hold that claimant's work activities were the major contributing cause of her carpal tunnel condition. ORS 656.802(2).

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 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 December 18, 1992 is reversed. The self-insured employer's denial of claimant's right carpal tunnel condition is set aside and the claim remanded to the employer for processing according to law. Claimant's attorney is awarded $3,500 for services at hearing and on review, to be paid by the employer.

In the Matter of the Compensation of
DARLENE K. BENTLEY, Claimant
WCB Case No. 92-00660
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Myers' order which: (1) found that, for purposes of rating claimant's unscheduled permanent disability, claimant was barred from challenging the age, education and adaptability factors at the hearings level, on the basis that she had waived her right to do so by her failure to raise these issues in her request for reconsideration; and (2) increased 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 Order on Reconsideration, to 15 percent (22.5 degrees). On review, the issues are extent of scheduled and unscheduled permanent disability. 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 43 years old at the time of determination. She worked as a dietary aide, DOT # 311.677-010, for the employer at the time of injury. The job title for which claimant met the highest SVP number during the 10 years prior to the time of determination was Sales Clerk/Cashier, DOT # 211.462-014.

The SAIF Corporation closed claimant's claim by Notice of Closure on May 10, 1991, with an award of 17 percent unscheduled permanent disability. In rating claimant's unscheduled disability, SAIF assigned the following values: 1 for age; 5 for education; 1 for adaptability; and 12 for impairment. (Ex. 6A).

Claimant requested reconsideration of the closure notice by completing a form prepared by the Department of Insurance and Finance. On the form, claimant specified that she disagreed with: (1) the impairment findings used in rating her disability at the time of claim closure; and (2) the rating of scheduled permanent disability. Claimant checked a box on the form which indicated that she did not object to the age, education or adaptability values used in rating her unscheduled permanent disability. (Ex. 7).

By Order on Reconsideration dated January 3, 1992, the Department increased claimant's unscheduled permanent disability award to 30 percent and awarded 11 percent scheduled permanent disability for the loss of use or function of the right leg. In rating claimant's unscheduled disability, the Department assigned the following values: 1 for age; 2 for education; 4 for adaptability; and 18 for impairment.

Claimant requested a hearing, seeking additional awards for scheduled and unscheduled permanent disability. Regarding unscheduled disability, claimant specifically challenged the values assigned for the non-impairment factors (age, education and adaptability).

CONCLUSIONS OF LAW AND OPINION

Waiver

The Referee held that, because claimant had declined to challenge the non-impairment factors at the reconsideration proceeding, she had waived her right to challenge them at hearing. On review, claimant argues that, because the non-impairment factors were considered by the Appellate Unit, those factors were properly before the Referee. We conclude that the non-impairment factors were properly before the Referee.

Subsequent to the Referee's order, we held in Raymond L. Mackey, 45 Van Natta 776 (1993), that a party is barred from raising at hearing an issue which stems from a notice of closure or determination order, if that issue was not first raised on reconsideration before the Department. See also Todd M. Brodigan, 45 Van Natta 438 (1993). Our holding in Mackey was based on language in ORS 656.268(4)(e) and (5) providing that a party which objects to a notice of closure or determination order must first request reconsideration before requesting a hearing.[1] We reasoned that the mandatory language of the statute evidenced a legislative intent to provide an administrative remedy at the Department level for issues involving extent of permanent disability. We also relied on legislative history indicating that a significant goal of the reconsideration process was to reduce the number of appeals to the Hearings Division, thereby reducing costs to the system. We concluded 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 circumvent the administrative review process created by the legislature and would run counter to the expressed legislative goal of reducing litigation.

Our opinion in Mackey also addressed ORS 656.283(7), which provides, in pertinent part:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by 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."

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[1] ORS 656.268(4)(e) provides: "If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section." In pertinent part, ORS 656.268(5) provides:

> "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 of the order. 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."

In Mackey, we interpreted that subsection to mean that no provision in ORS 656.283(7) should prevent claimant from arguing that the standards were incorrectly applied on reconsideration. That limited interpretation, we reasoned, was not inconsistent with our holding that, for the reasons discussed above, a party is nonetheless precluded from raising an issue at hearing that was not specifically raised on reconsideration.

For the reasons discussed below, however, we now conclude that our decision in Mackey is inconsistent with the statutory scheme of the reconsideration and hearing proceedings. Subsequent to Mackey, the Court of Appeals issued its opinion in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). Reversing our decision in Heather I. Smith, 44 Van Natta 2207 (1992), the court held that the claimant's adaptability, for purposes of rating permanent disability, must be determined on the basis of her work status as of the date of the reconsideration order, not the earlier date of the determination order. In so holding, the court briefly discussed the statutory scheme for reconsideration of and hearings on permanent disability awards. That discussion is instructive here.

The Smith court noted that ORS 656.268(5) limits the evidence that may be submitted during the reconsideration process to correcting erroneous information and medical evidence that should have been but was not submitted at the time of claim closure. By contrast, the court found no similar limitation on the evidence that the referee may consider in evaluating disability at hearing. Rather, the court quoted the part of ORS 656.283(7) that provides that "[n]othing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing * * *." The court then stated:

> "The result of ORS 656.268(5) and ORS 656.283(7) is to allow the referee to consider evidence that could not have been submitted to [the Department] on reconsideration. Although that result seems curious, it is compelled by the statutes." Safeway Stores, Inc. v. Smith, supra, at 163.

Thus, the court declined to apply ORS 656.268(5) as a limitation on evidence that may be considered at hearing. Instead, the court interpreted ORS 656.283(7) as authorizing, indeed requiring, the referee to consider evidence that the Department could not consider on reconsideration. Despite the incongruity of having two separate bodies reviewing a permanent disability award based on different evidentiary records, the court was compelled to follow the unambiguous language of the statutes.

We are likewise compelled to follow the unambiguous language of ORS 656.283(7). Hence, subject to the requirement of ORS 656.268(4)(e) and (5) that a party request reconsideration by the Department before requesting a hearing, the party has the right to establish at hearing that the standards were incorrectly applied in the reconsideration order. The claimant, insurer or self-insured employer may raise for the first time at hearing a challenge to one or more of the factors used by the Department in rating permanent disability. See ORS 656.283(7).

We recognize the value of stare decisis. However, the rule of stare decisis has never prevented the Board or appellate courts from reversing precedent that was "inadequately considered or wrong when it was decided." See Heino v. Harper, 306 Or 347, 373 (1988). Our holdings in Mackey and Brodigan were premised on the erroneous proposition that the reconsideration and hearing proceedings were components of the same process for reviewing closure orders. That is, the evidentiary record developed at, and the issues raised during, the reconsideration proceeding were the same record and issues to be considered at the subsequent hearing. As explained by the Smith court, the two review proceedings are separate and distinct; evidence precluded from the reconsideration proceeding may still be admissible at the hearing level. Inasmuch as the record in the two proceedings may be significantly different, it follows that the issues for consideration in each proceeding may likewise be different.

We are persuaded that the implementation of the reconsideration process itself and its objective to take appropriate corrective action are consistent with the legislative goal of reducing litigation. In any event, legislative history notwithstanding, we must, like the courts, apply the unambiguous language of the statutes. See Safeway, Inc. v. Smith, supra. In this case, claimant requested reconsideration of the closure notice, and requested a hearing concerning the Order on Reconsideration, thereby objecting to the Department's application of the standards in rating her scheduled and unscheduled permanent disability. Pursuant to ORS 656.283(7), therefore, we conclude that claimant did not waive her challenge to the age, education and adaptability factors used in rating her unscheduled permanent disability.

Our conclusion here avoids the anomalous result which would obtain were we to apply the Mackey holding and reasoning to this case. Whereas the Mackey holding places limitations on extent of disability issues that may be considered at hearing, the Department has not imposed similar limitations at the reconsideration proceeding. Here, the Department modified the education and adaptability values assigned by SAIF, and increased the unscheduled permanent disability award, although claimant made no challenge to the award on those grounds. We find no statute which prohibits the Department's action. The Department has the authority to increase or reduce the award on reconsideration, based on evidence presented to it, without regard to the specific issues raised by the parties, and despite the requirement of ORS 656.268(4)(e) and (5) that the party request reconsideration before requesting a hearing. Given the broad authority exercised by the Department and the unambiguous language of ORS 656.283(7), we decline to limit the extent of disability issues at hearing to those specifically raised at the reconsideration proceeding.

Unscheduled Permanent Disability

Turning to the merits, for purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f). OAR 436-35-003(4) provides that the temporary rules contained in WCD Admin. Order 93-052 shall apply to all ratings of permanent disability made on or after June 17, 1993. We accordingly apply these temporary rules to our rating of claimant's permanent disability. See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

The parties do not dispute the values the Department assigned for the factors of age (1), adaptability (4) and impairment (18 percent). Therefore, we proceed to the disputed education value.

Education

The appropriate value for claimant's formal education, including a high school diploma, is 0. OAR 436-35-300(1)(a).

Based upon claimant's job performance, the job title describing the job for which claimant met the highest SVP number during the 10 years prior to the time of determination was Sales Clerk/Cashier, DOT # 211.462-014. That job title is assigned an SVP number of 3 by the SCODDOT. Therefore, claimant is entitled to a skills value of 3. OAR 436-35-300(2)(e) (Temp.).

Claimant does not hold a current license or certificate of completion necessary for employment in an Oregon job with an SVP of 4 or less and has not achieved an SVP of 5 or higher for the ten years preceding the time of determination. Thus, an additional value of 1 is allowed. OAR 436-35-300(4).

Claimant's total education value is 4, the sum of the values obtained for formal education and skills. OAR 436-35-300(5) (Temp.).

Computation

Having determined each of the values necessary under the standards, claimant's unscheduled permanent disability is calculated as follows. The sum of the value (1) for claimant's age and the value (4) for claimant's education is 5. The product of that value and the value (4) for claimant's adaptability is 20. The sum of that product and the value (18) of claimant's impairment is 38. That value represents claimant's unscheduled disability. OAR 436-35-280 (Temp.).

Scheduled Permanent Disability

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

ORDER

The Referee's order dated April 6, 1992, as reconsidered April 21, 1992, is reversed in part and affirmed in part. That portion of the order that declined to address the extent of claimant's unscheduled permanent disability is reversed. In addition to the 30 percent (96 degrees) unscheduled permanent

disability awarded by Order on Reconsideration, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, giving her a total unscheduled award of 38 percent (121.6 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800. The remainder of the order is affirmed.

Chair Neidig dissenting.

The majority concludes that the court's decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) requires the Board to disavow its decision in Raymond L. Mackey, 45 Van Natta 776 (1993). Because I believe that the majority decision is an unwarranted expansion of the court's holding in Smith, I dissent.

In Smith, the court reversed the Board's holding that a claimant's adaptability value, for purposes of determining permanent disability, is to be evaluated at the time of the determination order rather than at the time of the reconsideration order. Relying on ORS 656.283(7), the court held that the claimant's permanent disability, including adaptability, is determined by a Referee "as of the date of the reconsideration order pursuant to ORS 656.268." Id. The court went on to discuss the application of ORS 656.268(5). The court noted that while ORS 656.268(5) limits the evidence that can be submitted to DIF during the reconsideration process, it did not apply to evidence submitted to a Referee at hearing. Rather, the court concluded that ORS 656.283(7) directed the Referee to evaluate claimant's disability, pursuant to the standards, as of the date of the reconsideration order.

The Smith decision, however, spoke to limitations on evidence which could be used in evaluating a worker's permanent impairment. Specifically, it discussed a portion of ORS 656.268(5)(which allows for the submission of corrective or supplemental medical evidence) as a limitation on evidence submitted to DIF. However, the question in the present case, as well as the question in Mackey, is not whether the parties' right to present evidence are limited. Rather, it is what issues a party may raise at hearing and on review of an Order on Reconsideration. In particular, the question before the Board is the preclusive effect of a party's failure to challenge a specific component of a permanent disability award during a reconsideration proceeding which is expressly designed to resolve such deficiencies. I would continue to adhere to the rationale articulated in Mackey, as I beleive to do otherwise would permit parties to circumvent the reconsideration process in its entirety.

In 1990, the legislature amended ORS 656.268 to establish a reconsideration process. The statutory language used to create this process clearly indicates that it is a mandatory 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. Hildebrand, 43 Van Natta 2721 (1991). In addition, the Hearings Division's review authority under ORS 268(6)(b) is expressly contingent on the issuance of a reconsideration order. Thus, we have held that the Hearings Division does not have jurisdiction to consider a request for hearing prior to the issuance of a reconsideration order. See Larry R. Hudnall, 44 Van Natta 2378 (1992).

To facilitate the reconsideration process, the Director adopted rules requiring that the parties' request for reconsideration list the specific reason(s) for objection to the Determination Order or Notice of Closure. OAR 436-30-050(4)(c). The reason for such a rule is clear. There would be no reason to ask reconsideration of a Determination Order or Notice of Closure if there were no objections to it by either party. Similarly, if a party did not object to a portion of a Determination Order or Notice of Closure, there would be no reason to ask for reconsideration of that issue.

As we noted in Mackey, allowing a party to raise an issue at hearing, that was not raised on reconsideration, would circumvent the mandatory reconsideration process created by the legislature and would effectively render that process meaningless. While I agree that the Smith decision impacts the reconsideration process and subsequent hearing with regard to evidentiary limitations, the majority's holding makes an unnecessary expansion of the holding by removing the preclusive effect of a party's knowing and voluntary decision during the reconsideration proceeding. The majority's interpretation essentially nullifies the reconsideration process. Furthermore, the majority's expansion runs contrary to the stated purpose behind the reconsideration process to reduce litigation. In addition, the party not

requesting reconsideration will be prejudiced by allowing any issue to be raised at such a late date in the process. In order to cure such prejudice, that party would have to be allowed time to gather contrary evidence which in turn would lead to further litigation. Finally, the majority's expansion of Smith also effectively allows a party to request a hearing without exhausting the required administrative remedies.

In sum, I don't believe that the Smith decision requires us to disavow our holdings in Mackey. Moreover, I think such an expansion is unwise in light of the significant consequences it may have on the reconsideration process. For these reasons, I would continue to adhere to our decision in Mackey.

In the Matter of the Compensation of
TOM D. BROWNING, Claimant
WCB Case No. 92-11534
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of Referee Podnar's order that: (1) set aside a disputed claim settlement (DCS); and (2) set aside the insurer's denial of claimant's current herniated disc condition. In its brief, the insurer contends that neither the Referee nor the Board has jurisdiction to set aside the DCS. On review, the issues are jurisdiction, validity of a DCS, and, if the settlement is not valid, compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer, citing Howard v. Liberty Northwest Ins., 94 Or App 283 (1988), argues that neither the Referee nor the Board has jurisdiction to set aside a DCS, based on the theory that once a DCS is approved by a Referee, it is either a final judgment or a contract and can no longer be characterized as "a matter concerning a claim." We disagree.

As noted by the insurer, the Howard court was not presented with the specific issue before us. Instead, the issues in Howard were whether the Hearings Division had jurisdiction to enforce a DCS and whether penalties could be assessed for a carrier's delay in paying the 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, the issue is jurisdiction over the validity of a DCS. ORS 656.289(4) authorizes settlement of claims "where there is a bona fide dispute over compensability." Although we have never directly addressed the issue of jurisdiction, we have previously concluded that, if a party seeks to have a disputed claim settlement set aside, the proper remedy is to request a hearing before the Hearings Division pursuant to ORS 656.283. George T. David, 35 Van Natta 1703 (1983); Timothy D. Martinez, 35 Van Natta 1315 (1983); Lawrence Woods, 34 Van Natta 1671 (1982); Mary Lou Claypool, 34 Van Natta 943, 946 (1982). Furthermore, the Court of Appeals has stated that, where there is no bona fide dispute over compensability, settlements entered into pursuant to ORS 656.289(4) violate the statute and should be set aside. Kasper v. SAIF, 93 Or App 246, 250-51 (1988). See also Roberts v. Willamette Industries, 82 Or App 188 (1986). Moreover, if the agreement in question is determined to be invalid on any ground, then the original claim remains in effect and any hearing resulting therefrom clearly involves a "question concerning a claim" under ORS 656.283(1).

In this light, we find the Howard court's analysis of our jurisdiction instructive. The Howard court found that the claimant filed a claim which the insurer denied. Thus, the dispute directly involved the worker's right to receive compensation and could be resolved only within the workers' compensation system, either by order or, if there were a bona fide dispute over the compensability of the claim, by agreement, with the approval of the referee, the Board or the court. ORS 656.289(4). The Howard court concluded that the Board (and thereby the Hearings Division) has jurisdiction to approve or disapprove a DCS, and thus to supervise its enforcement, and a claimant is entitled to a hearing on any question concerning the agreement. Howard, supra.

As in Howard, the DCS before us purports to resolve a dispute involving claimant's right to receive compensation. Claimant is therefore entitled to a hearing on any question concerning the agreement. Howard, supra. We therefore conclude that the Referee and the Board have jurisdiction to address the issue of the validity of the DCS. We further note that the second issue in Howard, concerning the proceeds, is not before us.

In addition, contrary to the employer's suggestion, the passage of 30 days after the date of the original order approving the settlement does not divest claimant of the right to a hearing on the agreement's validity if the original order did not dispose of a contested matter after a hearing. See, e.g., Kasper v. SAIF, supra; Mary Lou Claypool, supra.

Validity of the Disputed Claim Settlement

We affirm and adopt the Referee's opinion on this issue. See Pruitt Watson, 45 Van Natta 1633 (1993).

Compensability

We affirm and adopt the Referee's opinion on this 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 is $1,930.50, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated Janaury 8, 1993 is affirmed. Claimant's attorney is awarded $1,930.50 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
PAMELLA K. DORAN, Claimant
WCB Case No. 92-11125
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Nichols' order that affirmed a Determination Order and Order on Reconsideration award of 30 percent (96 degrees) unscheduled permanent disability for her upper extremity condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

The sole issue at hearing and on review is the adaptability factor to be used in rating claimant's permanent unscheduled disability.

The temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. OAR 436-35-003(4) (WCD Admin. Order 93-052); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993). In determining the extent of permanent disability, the adaptability factor is a comparison of the highest prior strength (physical demand) based on the jobs the worker has performed during the ten years preceding the time of determination, as compared to the worker's maximum residual capacity at the time of determination. OAR 436-35-310(1).

For a job to qualify, the worker must meet the requirements as outlined in OAR 436-35-300(3). OAR 436-35-310(1)(a). If a worker does not meet these requirements, or if a worker's highest prior strength has been reduced as a result of an injury that is not an accepted Oregon workers' compensation claim, the prior strength is based on the worker's job at the time of injury. OAR 436-35-310(1)(b) and (c). The requirements listed in OAR 436-35-200(3) include identification of the DOT code which most accurately describes the duties of each job and meeting the Specific Vocational Preparation (SVP) category assigned by the DOT. See OAR 436-35-300(3).

In the ten years preceding the time of determination, claimant worked as a dietary cook/dishwasher and a counterperson. Therefore, claimant's highest strength demand in the prior ten years was as a cook. DOT# 318.361-010. Claimant contends that the aforementioned DOT does not accurately describe her job duties as the DOT has a strength category of medium. Claimant argues that, because her job involved regular lifting of four and five gallon pots, her strength category was actually medium/heavy.

We do not agree that claimant's testimony establishes that the assigned DOT is inappropriate. Claimant testified only that, in addition to her work activities of preparing, cooking and serving food, she also lifted different sized pots. However, claimant did not testify how often she was required to lift the pots and she also stated that she had no idea what they weighed. Under the circumstances, we conclude that the DOT assigned to claimant's job as a cook most appropriately describes her highest strength demand in the ten years prior to determination. Therefore, we agree with the Referee's conclusion that claimant's strength category in that position was medium.

The Referee found that claimant returned to light work. However, on review, claimant contends that she returned to work in the light/sedentary category. After reviewing the record, we agree with the Referee's conclusion that claimant's maximum residual functional capacity at the time of determination was light, and we adopt her reasoning on that issue.

Because we have affirmed the Referee on the issue of adaptability, which was the sole issue on review, we conclude that the Order on Reconsideration was properly affirmed.

ORDER

The Referee's order dated November 27, 1992 is affirmed.

In the Matter of the Compensation of
ERIC S. GEHRS, Claimant
WCB Case No. 92-00321
ORDER ON REVIEW
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of Referee Baker's order which found that claimant had not established an entitlement to temporary disability benefits beginning July 12, 1991. With his Appellant's Brief, claimant has submitted evidence not admitted at hearing. We treat such submissions as a motion for remand. ORS 656.295(5). On review, the issues are remand and temporary disability benefits. We deny the motion for remand and affirm the Referee's order.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the following supplementation. Claimant sustained a compensable neck and back injury on January 15, 1991, while working for the employer. In June 1991, claimant returned to modified work.

In early July 1991, the employer directed claimant to work as a flagger at a designated job site. Claimant did not appear at the job site that day, and he was subsequently fired for his failure to report to work.

Claimant requested a hearing on the issue of entitlement to temporary disability benefits. The Referee's order, dated August 2, 1992, found that claimant had failed to establish that he was unable to work due to the compensable injury. The Referee also concluded that claimant had not established that he was terminated due to his workers' compensation claim.

In September 1992, a state Bureau of Labor and Industries (BOLI) "Notice of Administrative Determination" issued, finding substantial evidence of an unlawful employment practice (termination) by claimant's employer.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant moves to remand this case to the Referee for inclusion of evidence regarding a Bureau of Labor and Industries (BOLI) administrative determination concerning his termination. Claimant contends that the Referee erred in finding that he had not established that he left work in July 1991 because of the compensable injury. Claimant argues that the BOLI determination establishes that he was terminated because of his workers' compensation claim, rather than because he did not appear at the job site.

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

The BOLI determination might arguably be relevant and justify remand if the determination had been made after a full evidentiary hearing. The Oregon appellate courts have held that express findings and conclusions of an administrative agency after a full evidentiary adjudicative hearing involving an essential and disputed issue would be entitled to preclusive effect in a court proceeding involving the same issue. Heller v. Ebb Auto, 308 Or (1989); North Clackamas School Dist. v. White, 305 Or 48 (1988).

Here, however, the BOLI determination is not the product of any hearing. Rather, it was a

In conclusion, we do not find that the BOLI determination or the additional exhibits submitted by claimant constitute a compelling basis for remand. Additionally, we do not find that the record was improperly or insufficiently developed at hearing. Claimant's motion to remand is, therefore, denied.

Temporary Disability Benefits

We adopt the Referee's "Opinions and Conclusions" on the issue of temporary disability benefits.

ORDER

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

In the Matter of the Compensation of
JACK S. KOEHLER, Claimant
WCB Case No. 92-13830
ORDER ON REVIEW (REMANDING)
Gloria D. Schmidt, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee McWilliams' order which dismissed her October 22, 1992 Request for Hearing. With its brief, the self-insured employer attached fifteen exhibits which had previously been submitted to the Referee. On review, the issue is dismissal. We vacate the Referee's order and remand.

FINDINGS OF FACT

On October 22, 1992, claimant requested a hearing, contesting the self-insured employer's refusal to pay a medical bill for an MRI. Claimant also requested review of an October 1, 1992 Director's Order of Dismissal, which had dismissed claimant's request to determine whether the employer was obligated to pay the bill. Hearing was set for January 25, 1993.

On October 29, 1992, the self-insured employer submitted its response to claimant's hearing request. It also submitted a motion to dismiss the hearing request, stating that claimant had not pursued her request for reimbursement for medical services in a timely manner.

On January 4, 1993, the Referee granted the self-insured employer's motion to dismiss. No hearing was convened and no exhibits were admitted into evidence.

CONCLUSIONS OF LAW AND OPINION

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 of why the facts supported by evidence lead to the conclusion. Nancy L. Cook, 45 Van Natta 977 (1993); see also Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). Here, no hearing was convened and, therefore, neither party had an opportunity to clarify the reason the medical bill was in dispute, nor present evidence concerning the issue. For example, was the bill contested based on a lack of causal connection to the compensable injury, or on an "inappropriate/ineffective" treatment basis, or was it essentially a medical fee dispute? Clarification of the basis for the dispute will likewise resolve any jurisdictional question, as well as identify the appropriate review standard. See ORS 656.283(1), 656.327(2), 656.248.

Here, because there has been no record submitted for review, we conclude that the record is not sufficiently developed to address the parties' contentions and, therefore, a compelling basis for remand exists. See Malcom R. Taylor, 43 Van Natta 1850 (1991).

Accordingly, we remand this matter to Referee McWilliams. The parties shall have the opportunity to clarify the issues for resolution, as well as present evidence regarding those issues. The Referee shall have the discretion to proceed in any manner that will achieve 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 January 4, 1993 is vacated. This matter is remanded to Referee McWilliams for further proceedings consistent with this order.

In the Matter of the Compensation of
KENNETH D. NICHOLS, Claimant
WCB Case No. 92-09639
ORDER ON RECONSIDERATION
Dean Heiling, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our August 23, 1993 Order on Review which upheld the insurer's partial denial of claimant's current low back condition.

In his motion for reconsideration, claimant contends that we erred in applying the analysis of Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993), because there is no evidence that claimant's preexisting degenerative disease caused his current herniated disc. Claimant asserts that his compensable sprain/strain caused his current disc herniation, or that the work injury directly caused the herniated disc.

We withdraw our August 23, 1993 order for reconsideration. After consideration of claimant's motion and review of the record, we continue to find that claimant's current low back condition, diagnosed as a herniated L3-4 disc, is not compensable.

On review, claimant argued that the 1992 compensable injury worsened his preexisting degenerative disc disease, and that both the degenerative disease and herniated disc are compensable. Furthermore, claimant apparently agreed that the applicable standard for proving compensability is major contributing cause as provided in ORS 656.005(7)(a)(B). See Appellant's Brief at 3-4.

Now, on reconsideration, claimant raises new theories of compensability which he did not raise below. Claimant now apparently contends either that his compensable strain/sprain caused his herniated disc, or that his herniated disc was directly caused by his work injury. Generally, we do not consider for the first time on review a theory that was not raised at hearing. See Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993). We find that the same principle applies when a party raises a new theory for the first time on reconsideration.

Moreover, were we to consider the merits of claimant's theories, we would find them unsupported by the medical evidence.

Dr. Sirounian, claimant's treating physician, believed that the February 1992 work injury aggravated claimant's preexisting degenerative disease. (Ex. 13; see also, Ex. 11A-2). He also observed that claimant has significant preexisting degenerative disease of the "lower three disks," and that he was unable to determine whether the "disease at the L3-4 level was either new or old." (Ex. 11A-1).

This evidence suggests that claimant's preexisting degenerative disease combined with the work injury to prolong disability or the need for medical treatment. Therefore, we again conclude that it is appropriate to analyze the compensability of claimant's current herniated disc condition under ORS 656.005(7)(a)(B). See also Tektronix, Inc. v. Nazari, supra. Furthermore, although Dr. Sirounian opines that the February 1992 work injury is the major contributing cause of claimant's current condition, we again find his opinion unpersuasive.

The only medical opinion supporting claimant's position that his work injury directly caused his current herniated disc is from Dr. Harris, his treating chiropractor. (See Ex. 15). Dr. Harris states that claimant's February 1992 work injury "resulted in a herniated disc, which has left him with a permanent impairment." (Id). In light of Dr. Sirounian's opinion that claimant has preexisting degenerative disease in his lower back, and that he cannot tell whether the disease at L3-4 is old or new, we find Dr. Harris' one-sentence opinion to be conclusory and unpersuasive. Dr. Harris' opinion fails to address the relationship between the preexisting degenerative disease and the L3-4 herniated disc, and he fails to explain the basis for his opinion that the February 1992 work injury caused the herniated disc. Therefore, we decline to rely on Dr. Harris' opinion. Accordingly, we find that claimant failed to establish that the February 1992 work injury directly caused his current herniated disc.

Finally, we find no medical evidence, and claimant points to none, that establishes that the herniated disc was caused by the compensable strain/sprain and, therefore, is compensable as a consequential condition. Furthermore, under this theory claimant would also have to prove that his work injury was the major contributing cause of his current condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We again find no persuasive medical evidence that claimant's work injury is the major contributing cause of his current condition.

Accordingly, we republish our August 23, 1993 order in its entirety, as supplemented herein. 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 N. REID, JR., Claimant
WCB Case No. 93-04050
ORDER DENYING MOTION TO DISMISS
Rex Q. Smith, Claimant Attorney
Vestigo & Associates, Defense Attorneys

Claimant has moved to dismiss a request for Board review of a Referee's order which was filed by MCI Welding (a noncomplying employer). Specifically, claimant asserts that MCI Welding "has no standing to prosecute Board review in this case" because SAIF did not request Board review on the noncomplying employer's behalf. The motion to dismiss is denied.

FINDINGS OF FACT

A January 5, 1993 Director's order found MCI Welding to be a noncomplying employer. Thereafter, claimant's injury claim was referred to the SAIF Corporation for processing under ORS 656.054.

When SAIF denied the claim, claimant requested a hearing. Claimant, SAIF, and MCI Welding (as well as their respective legal counsels) appeared at the hearing. On July 26, 1993, the Referee set aside SAIF's denial and remanded the claim for further processing.

On August 23, 1993, within 30 days of the Referee's order, MCI requested Board review and provided notice of its request to all parties to the proceeding.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20). When the Director has found an employer to be noncomplying, the claim is referred to the SAIF Corporation, who is required to process the claim as it would if the employer was carrier-insured. See ORS 656.054(1).

Here, SAIF has not requested Board review of the Referee's order which set aside its denial of claimant's injury claim. Nevertheless, MCI Welding, claimant's employer at the time of injury, has requested Board review. Inasmuch as the employer is a statutory party to this proceeding and has timely filed its request for review, we have jurisdiction to consider its appeal. See Bryan E. Mitchell, 44 Van Natta 1270 (1992) (Notwithstanding SAIF's failure to appeal referee's compensability decision, noncomplying employer was statutorily entitled to seek Board review).

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

IT IS SO ORDERED.

September 14, 1993 Cite as 45 Van Natta 1731 (1993)

In the Matter of the Compensation of
BEVERLY A. WALTERS, Claimant
WCB Case No. TP-93008
THIRD PARTY DISTRIBUTION ORDER
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Claimant has petitioned the Board for resolution of a dispute concerning a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). The self-insured employer, Aratex Corporation, claim administered by Alexsis Risk Management, contends that it is entitled to a share of the settlement between claimant and a third party that was achieved while claimant's current condition and aggravation claim was in denied status. We hold that the employer was not a paying agent when the settlement was reached and, therefore, may not share in claimant's recovery.

FINDINGS OF FACT

Claimant compensably injured her low back on July 28, 1989. The claim was accepted in March 1990 and benefits were paid. Claimant's last temporary disability check was issued on December 11, 1991 for the period November 26, 1991 through December 19, 1991.

On December 28, 1989, claimant was involved in a motor vehicle accident. Claimant was involved in another motor vehicle accident on June 3, 1991.

On December 6, 1991, the employer issued a current condition and aggravation denial. Compensability was denied on the basis that claimant's current condition and worsening was unrelated to the July 1989 compensable injury claim. Claimant requested a hearing.

Prior to the hearing, on February 28, 1992, the employer served claimant with a "Notice of Lien" against any recovery claimant might obtain with regard to the motor vehicle accident.

The hearing convened on June 19, 1992 before Referee Gruber.

On July 7, 1992, claimant and the third party entered into a settlement for $5,000. Settlement proceeds were distributed except for $2,050.58 which was held in trust by claimant's attorneys pending resolution of the employer's lien claim.

On August 27, 1992, Referee Gruber's Opinion and Order issued. The Referee found claimant's current condition and aggravation claim compensable. He ordered the December 6, 1991 denial set aside and remanded the claim to the employer for processing.

On October 14, 1992, the employer issued a check for temporary disability for the period August 27, 1992 through September 29, 1992. Subsequently, no other benefits have been paid.

On January 26, 1993, claimant's counsel informed the employer of his intent to disburse the balance of the settlement proceeds to claimant. In response, on February 9, 1993, the employer continued to assert its entitlement to its statutory share of the settlement proceeds pursuant to ORS 656.593(3).

On May 12, 1992, an Order on Review issued affirming the Referee's August 27, 1992 Opinion and Order.

FINDING OF ULTIMATE FACT

At the time the third party settlement was entered into between claimant and the third party, the employer was not a "paying agent" in accordance with ORS 656.576.

CONCLUSIONS OF LAW

In SAIF v. Wright, 113 Or App 267 (1992), the court held that a carrier must be paying benefits at the time of the settlement or distribution in order to qualify as a "paying agent" under ORS 656.576. In Wright, the court noted that at the time of settlement the issue of compensability was in dispute. Thus, there was no entity paying benefits. Moreover, there was no certainty that there would be an entity paying benefits in the future. Under such circumstances, the court, adopting the reasoning of the Board, rejected an approach which would require a claimant, who is not receiving benefits, to not only support himself, but also provide for his medical services, without the financial benefit available from the third party recovery. See also Donna M. Wolfe, 44 Van Natta 1785 (1992) (relying on the SAIF v. Wright, 113 Or App 267 (1992) holding).

Here, at the time of the July 7, 1992 settlement claimant's current condition and aggravation claim was in denied status. There is no evidence to suggest that claimant was receiving benefits from her July 1989 compensable claim. In addition, the August 27, 1992 Opinion and Order awarding her benefits had yet to issue. Thus, there was no certainty, at that point in time, that claimant would receive further benefits.

The employer asserts that the Wright and Wolfe holdings are distinguishable from this case. The employer argues that although claimant's current condition and aggravation claim was denied, the July 1989 injury remained an accepted claim, the compensability of which was not contested. Thus, the employer's status as a "paying agent" did not change and it remained liable for claim costs.

Although the employer may have remained responsible for the original accepted claim, it had denied compensability of claimant's current condition and refused to reopen the claim. It is this aggravation claim which involves the third party action and settlement, not claimant's initial injury claim. Moreover, at the time of the settlement no "actual, present payment of benefits" was being made. Under such circumstances, we conclude that, since claimant's aggravation claim (which involved the third party action) was in denied status at the time of claimant's third party settlement, we hold that the employer at the time of settlement was not a "paying agent" as defined by ORS 656.576. See Wright, supra. For that reason, we find the employer is not entitled to a share of the settlement proceeds.

IT IS SO ORDERED.

In the Matter of the Compensation of
PRUITT WATSON, Claimant
WCB Case No. 92-04422
ORDER OF ABATEMENT
Bennett & Hartman, Claimant Attorneys
VavRosky, et al., Defense Attorneys

The self-insured employer requests reconsideration of that portion of our August 24, 1993 order which authorized an offset in the amount of $11,250, the amount claimant received under a Disputed Claim Settlement which our order set aside, against future awards of permanent disability. The employer contends that the offset should be against all future compensation benefits.

In order to allow us sufficient time to consider the employer's motion, we withdraw our August 24, 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
WARREN W. WEBBER, Claimant
WCB Case No. 92-08301
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Barber's order that affirmed the Order on Reconsideration that awarded 29 percent (92.8 degrees) unscheduled permanent partial disability for a left shoulder injury. In his brief, claimant contends the Referee erred in excluding Exhibit 51, a note from the treating physician. On review, the issues are evidence and extent of unscheduled permanent disability.

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

Claimant became medically stationary on January 29, 1992, and his claim was closed by Notice of Closure on February 12, 1992. The disability rating standards in effect on the date of issuance of the Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C) control. OAR 438-10-010 (effective June 29, 1992); OAR 436-35-003(2)(effective June 1, 1992). However, notwithstanding OAR 436-35-003(2), the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). Thus, the applicable "standards," as amended by the temporary rules, are those in effect at the time of the Notice of Closure. WCD Admin. Orders 11-1992, 93-052.

The Referee found that claimant had returned to his regular work as a bus driver, but was now performing that job with limitations. He therefore determined that claimant's adaptability factor was 2, based on the medium strength requirement of claimant's regular work and the medical arbiter's finding that claimant was capable of light/medium work.

The employer contends that claimant returned to his regular work, as defined in OAR 436-35-270(3)(c), and therefore, he is not entitled to values for the age, education, and adaptability factors.

However, subsequent to the Referee's order, the Supreme Court held that a claimant's age, education and adaptability factors must be considered under the Director's "standards." England v. Thunderbird 313 Or 633 (1993). In response to the Supreme Court's decision, the Director amended OAR 436-35-280 through 436-35-310. (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052). The rules now allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work following a compensable injury. See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

Thus, the Referee did not err in considering claimant's age, education and adaptability factors in determining the extent of claimant's permanent disability. We further conclude that claimant's adaptability value is 2. We base this conclusion on the following reasoning.

Claimant has been a bus driver for 17 years. The Dictionary of Occupational Titles lists bus driver as medium work. (DOT # 913.463-010). On February 3, 1992, Dr. McNeill, claimant's treating physician, released claimant for regular work without restrictions. Claimant testified that, subsequent to his injury, he was unable to drive certain buses because of the lack of power steering or the size of the steering wheel, that he was unable to work overtime, and that he needed assistance adjusting side mirrors and loading wheelchair passengers. Dr. Burr, medical arbiter, opined that claimant had a chronic condition which limited his physical capacity status and the function of the left shoulder to light medium. Notwithstanding Dr. McNeill's release and claimant's return to the same job he held at the time of injury, we conclude that, based on Dr. Burr's opinion as supported by claimant's testimony, claimant's RFC is medium/light. Therefore, claimant is entitled to an adaptability value of 2. OAR 436-35-310(2)(Temporary Rules, June 17, 1993, WCD Admin. Order 93-052).

Applying the above mentioned rules to this case, OAR 436-35-280(4) provides that the values for age and education are added together. OAR 436-35-280(6) provides that the resultant sum is then multiplied by the adaptability factor. The result is then added to claimant's impairment value to arrive at the percentage of unscheduled permanent disability to be awarded. OAR 436-35-280(7).

Accordingly, when the total value for claimant's age and education (5) is multiplied by the adaptability value (2), the total is 10. When this value is added to the value for impairment (19), the result is 29 percent unscheduled permanent disability. Thus, we affirm the Referee's order which affirmed the Order on Reconsideration.

Considering our finding on the appropriate adaptability value, we need not address the evidentiary issue raised by claimant. Even if the Referee had erred in excluding the exhibit, the error would be harmless. We have determined claimant's adaptability factor based on claimant's testimony and the medical evidence in the record. Thus, the exhibit would have been cumulative.

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

ORDER

The Referee's order, as reconsidered on November 13, 1992, is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $750, payable by the self-insured employer.

In the Matter of the Compensation of
CYNTHIA L. LUCIANI, Claimant
WCB Case No. 92-05124
ORDER ON REVIEW
Reeves, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of that portion of Referee Mills' order that: (1) admitted a post-closure medical report for the purpose of determining claimant's permanent disability; (2) awarded claimant 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the right arm, whereas an Order on Reconsideration did not award any scheduled permanent disability; and (3) awarded claimant 16 percent (51.2 degrees) unscheduled permanent disability, whereas an Order on

FINDINGS OF FACT

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

Claimant's claim was closed by an October 24, 1991 Notice of Closure. The closure was based on a September 30, 1991 closing report from Dr. Greenfield, claimant's attending physician. Although, in his report, Dr. Greenfield did list range of motion findings regarding claimant's cervical spine and right shoulder, his findings did not conform with the Director's standards.

Dr. Greenfield examined claimant again on March 2, 1992. At the request of claimant's counsel, Dr. Greenfield submitted a report based on that examination which responded to questions concerning claimant's permanent disability under the Director's "standards." In his report, Dr. Greenfield indicated that under the Director's standards, claimant did have lost range of motion in the cervical spine and right shoulder. Dr. Greenfield further indicated that claimant had a chronic condition rendering her unable to repetitively use her cervical spine and right shoulder. Greenfield also reported that claimant had loss of strength due to nerve root injuries. Finally, Dr. Greenfield reported that claimant's condition had not changed since October 24, 1991.

On April 8, 1992, the Appellate Unit issued an Order on Reconsideration which affirmed the Notice of Closure in all respects. The Appellate Unit declined to consider Dr. Greenfield's March 2, 1992 report because it was based on a post-closure examination. Instead, the Appellate Unit relied on Dr. Greenfield's September 30, 1991 closing report.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee relied on Exhibit 34, Dr. Greenfield's March 2, 1992 report, to rate claimant's permanent disability. The insurer contends that the Referee erred in relying on Exhibit 34 because it is based on a post-closure examination. We agree with the Referee.

The question before the Board turns on the meaning and appropriate application of ORS 656.268(5). Subsequent to the Referee's order, the Court of Appeals issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In Smith, the court reversed the Board's holding that a claimant's adaptability value, for purposes of determining permanent disability, is to be evaluated at the time of the determination order rather than at the time of the reconsideration order. Relying on ORS 656.283(7), the court held that the claimant's permanent disability, including adaptability, is determined by a Referee "as of the date of the reconsideration order pursuant to ORS 656.268." Id. The court went on to discuss the application of ORS 656.268(5). It stated:

> "Further, the Board's reliance on ORS 656.268(5) is misplaced. Although the evidence that may be submitted on reconsideration before DIF is limited to correcting erroneous information and certain medical evidence that should have been but was not submitted at the time of claim closure, ORS 656.268(5), the evidence that may be submitted at the hearing before a referee is not so limited . . . The referee is directed to evaluate disability as of the date of the reconsideration order. ORS 656.283(7). There is no limitation similar to ORS 656.268(5) on evidence that the referee may consider in making that evaluation. The result of ORS 656.268(5) and ORS 656.283(7) is to allow the referee to consider evidence that could not have been submitted to DIF on reconsideration. Although that result seems curious, it is compelled by statute." Id.

Here, Dr. Greenfield's March 2, 1991 report (Ex. 34) was not considered by the Appellate Unit because it was not within the limitations imposed by ORS 656.268(5). However, as stated by the Smith court, there is no similar limitation on such evidence when presented to the Referee. Specifically ORS 656.283(7) states that nothing in this section shall be construed to prevent or limit a party's right to present evidence at hearing regarding the application of the Director's standards for evaluation of a worker's permanent disability. See ORS 656.283(7). While there are other statutory limitations on evidence that may be presented at hearing (ORS 656.245(3)(b)(B); 656.268(7); 656.283(7)), none of those limitations are applicable with regard to Dr. Greenfield's report, as he is claimant's attending physician. Under these circumstances, we agree with the Referee that Exhibit 34 may be used to determine the extent of claimant's permanent disability.

Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the extent of claimant's scheduled permanent disability.

Unscheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the extent of claimant's unscheduled permanent disability with the following supplementation.

In his September 30, 1992 report, Dr. Greenfield indicated that claimant's current industrial problems, including her cervical condition, were the result of the compensable injury. There is no contrary medical evidence. (Ex. 29). Accordingly, the Referee correctly took claimant's cervical condition into account when rating her unscheduled permanent disability.

Rate of Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the rate of claimant's scheduled permanent disability award. See SAIF v. Herron, 114 Or App 64, rev den 315 Or 217 (1992).

Penalties

We adopt the Referee's conclusions and reasoning concerning the penalty issue with the following supplementation.

ORS 656.268(4)(g) provides for a penalty 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 disabled . . ." (Emphasis supplied). The emphasized language is unambiguous and provides for a penalty if the Department awards the requisite increase. The provision does not provide for a similar penalty if the increase is awarded by a Referee or the Board. Accordingly, we agree with the Referee that claimant is not entitled to a penalty under ORS 656.268(4)(g) based on the increased permanent disability awarded by the Referee.

Attorney Fees/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 extent of scheduled and 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 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 July 23, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

Chair Neidig, specially concurring.

I agree that the court's decision in Safeway Stores, Inc. v. Smith, supra requires that Exhibit 34 be considered in evaluating the extent of claimant's permanent disability. I write to express my concerns about Smith court's interpretation of ORS 656.268(5) and its effect on the reconsideration process as a whole.

The legislative history concerning the reconsideration process in general reveals a legislative purpose to provide a nonlitigious administrative forum for resolving extent of disability issues. A significant step in furthering this purpose was the requirement that the medical evidence used to close a worker's claim be the same at all levels of the reconsideration and appeals process. In this regard, the following conversation between Cecil Tibbets, co-chair of the Governor's Worker's Compensation Labor-Management Advisory Committee and Representative Edmundson at the May 3, 1990 meeting of the Interim Special Committee on Workers' Compensation is instructive:

"Rep. Edmunson: I want to put something on the record that we discussed privately. Let's say that a claim is closed and information is presented to the Evaluation Division and a rating is made and then unexpectedly the worker's physician says after that time - no the disability is more than I thought it was. Is it your intent that additional information that's generated after the determination order comes out of reconsideration wouldn't be considered in evaluating disability? But it would be considered, I guess in the context of whether there was a worsening for aggravation.

Mr. Tibbets: Yes, our intent here is that if the worker's situation changes after the determination order and gets more severe, that is an aggravation claim. So we're trying in this process we want to deal with the worker's medical situation at the time of the determination order and all appeals should be based on that and all decisions made on that. And if something has changed subsequent to that, we shouldn't have a surprise in a hearing. Instead we should have an aggravation claim filed. That is our intent.

Rep. Edmunson: And I guess if that situation, because it's dependent upon the medical evidence, that the situation regarding the change as you characterize it might be the change in the medical evidence.

Mr. Tibbets: If there is medical evidence - that's what I was just talking about briefly a moment ago - if there's medical evidence that should have been forwarded by the attending physician but wasn't, that can be, during the reconsideration process, that can be forwarded so that the people reconsidering have all of the evidence that should have been there. So if there's a mistake made by a physician - I didn't get this in and I had done this test. I'm sorry I didn't get the results to you - yes, he can put those in if they actually occurred on a timely basis. But we're not looking for new medical evidence - we're going to go out and get a new exam after the determination order - that would not be allowed.

Rep Edmunson: As far as the determination goes.

Mr. Tibbets: As far as the original determination order and any appeal of that, yes." (Emphasis supplied). Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 2, Side B at 127.

The exchange between Co-Chair Tibbets and Representative Edmundson is particularly noteworthy as it addresses both the evidence that was contemplated to be admissible under ORS 656.268(5) and the evidence that was not to be considered. Moreover, their discussion is immediately prefaced by Senator Kitzhaber's statement that "[t]he Evaluation Division can make their judgment either based on the original recommendation of the attending physician or the medical arbiter." In addition, during the Senate floor debates, Senator Shoemaker explained that as a 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 the 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 may then appeal and go up to the referee, the Worker's Compensation Board and into the courts 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 examinations." (Emphasis supplied). Senate Floor Debates on SB 1197, May 7, 1990.

The Smith court's interpretation of ORS 656.268(5) conflicts with the legislative intent behind the reconsideration process. The decision returns the workers' compensation system, with regard to extent of disability issues, to where it was prior to the 1990 amendments. That is, it returns the system to a process whereby the Evaluation Section and the Hearings Division are deciding the same issue based on different evidence. The legislative goal of reducing litigation on extent of disability questions will be effectively nullified.

Finally, the Smith decision creates an imbalance between the parties that choose to have a medical arbiter appointed pursuant to ORS 656.268(7) and those parties that do not. Parties using the medical arbiter proceeding under ORS 656.268(7) would not be allowed to present further evidence at a hearing due to that provisions clear language. However, parties that do not invoke the arbitration process will be free to submit further evidence. I do not believe such an imbalance was contemplated by the legislature.

As an adjudicative fact-finder, the Board has an interest in developing the factual record to the greatest extent possible. Any limitation on the parties' ability to generate -- and our ability to consider -- all relevant evidence runs counter to that interest. Nevertheless, my review of the legislative history, discloses that the legislature, and in particular the Interim Special Committee, heard and considered substantial testimony on the evidentiary issues relating to the process of determining awards of permanent disability. The legislature then made certain policy choices presumbly based in part on that testimony. I believe that the court's interpretation of ORS 656.268(5) in Smith is contrary to those policy choices.

September 15, 1993 Cite as 45 Van Natta 1738 (1993)

In the Matter of the Compensation of
MICHAEL L. MILLICAN, Claimant
Own Motion No. 91-0537M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's June 16, 1993 Notice of Closure which closed his claim with an award of temporary disability compensation from March 26, 1990 through May 31, 1993. SAIF declared claimant medically stationary as of June 1, 1993. Claimant contends 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). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 16, 1993 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

Dr. Nash, neurosurgeon, has been claimant's treating physician regarding his low back condition at least since his hospitalization for pain control in August 1991. In a report dated June 1, 1993, Dr. Nash stated that claimant had achieved "maximum medical benefit" and that he expected no further material improvement with the passage of time. Dr. Nash released claimant from his care and noted that claimant was not capable of returning to productive employment, even at a sedentary level.

On July 2, 1993, claimant first saw Dr. Norris, M.D., for treatment regarding his chronic low back pain. In a July 2, 1993 chart note, Dr. Norris noted that claimant's "current management schedule has been counseling through a psychologist, Dr. Fleming." Dr. Norris also noted several prescription medications that claimant was taking. Dr. Norris stated that copies of reports from Drs. Nash, Miller and Fleming were being sent to him as a "package from SAIF." Dr. Norris' recommendation was for claimant to continue his "chronic regimen" for now until Dr. Norris received further documentation. He indicated that he would try to get a written report from Dr. Nash on his prognosis and overall plan. The record contains no subsequent report from Dr. Norris.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 or App 810 (1983). In this case, we find no persuasive reasons not to defer to the opinion of Dr. Nash, claimant's long time treating physician. We find that Dr. Nash's report establishes that claimant's low back condition was medically stationary as of June 1, 1993. Furthermore, although claimant began treating with Dr. Norris on July 2, 1993, Dr. Norris gave no opinion regarding claimant's medically stationary status. In any event, 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). On this record, we find that claimant's low back condition was medically stationary when his claim was closed on June 16, 1993.

However, claimant also has a psychological component to his compensable condition. Thus, even though claimant's physical condition was medically stationary in June 1993, claim closure would nonetheless be premature if his compensable psychological condition was not yet medically stationary when the Notice of Closure issued on June 16, 1993. Rogers v. Tri-Met, 75 Or App 470 (1985); Paul E. Voeller, on recon, 42 Van Natta 1962 (1990).

In a June 23, 1993 report, Dr. Fleming, claimant's treating psychologist, stated that claimant "is going to need continuing psychological care to help him cope with his depression and his frustration." Dr. Fleming noted that claimant may not need psychological treatment on a weekly or even bi-weekly basis, but the treatment "has to be available to him." Dr. Fleming also stated that claimant's "psychological condition is such that he is unable to return to any type of gainful employment." Although Dr. Fleming opined that claimant needed continuing psychological care "to help him cope with his depression and frustration," he did not indicate that claimant's psychological condition will improve with treatment or the passage of time. As indicated above, the term "medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, supra.

We recognize that the use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Austin v. SAIF, 48 Or App 7 (1980). However, Dr. Fleming's report as a whole is insufficient to allow an inference that, at claim closure, there was a reasonable medical expectation of material improvement in claimant's psychological condition with treatment or the passage of time. The record contains no other opinion regarding the status of claimant's psychological condition.

On this record, claimant has failed to prove that he was not medically stationary at claim closure. Accordingly, we affirm SAIF's June 16, 1993 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation
ROSCOE L. HOLLIS, Claimant
WCB Case No. 92-10402
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Thye's order that affirmed an Order on Reconsideration award of 26 percent (83.2 degrees) unscheduled permanent disability for his cervical and left shoulder condition, 17 percent (32.64 degrees) scheduled permanent disability for his loss of use or function of the left arm, and 2 percent (3 degrees) scheduled permanent disability for his loss of use or function of the right forearm. In addition, claimant contends that he is entitled to a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of permanent disability and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Extent

We adopt the Referee's "Conclusions and Opinion" on the issue of extent of permanent disability.

Penalties

On review, claimant contends that the Referee should have assessed a penalty pursuant to ORS 656.268(4)(g). The statute provides that where a claimant's compensation is increased on reconsideration by 25 percent or more and claimant is at least 20 percent permanently disabled, a penalty shall be assessed. ORS 656.268(4)(g).

Here, claimant argues that, upon reconsideration, he was found to be at least 20 percent permanently disabled. Furthermore, claimant contends that, when his unscheduled and scheduled awards are added together, his compensation has been increased by more than 25 percent.

We recently addressed a similar issue in Jay A. Nero, 45 Van Natta 1082 (1993). In Nero, we found that the language of the statute was ambiguous as it did not address a situation where a total of 20 percent permanent disability could be achieved by adding scheduled and unscheduled awards. Relying on a Director's rule (which provided that a worker who received a total sum of 64 degrees of scheduled and/or unscheduled disability would be found to be at least 20 percent disabled), we determined that the two awards could be added in cases in which the rule was not inconsistent with the statute. We, therefore, added the degrees of a claimant's scheduled and unscheduled permanent disability awards together to determine if the total award equalled the threshold 20 percent permanent disability requirement of ORS 656.268(4)(g). Nero, supra.

In the present case, we find, as a result of the Order on Reconsideration, claimant's unscheduled award of 26 percent (83.2 degrees), in addition to his scheduled awards of 17 percent (36.24 degrees) and 2 percent (3 degrees) equals a total sum of 118.84 degrees. Accordingly, claimant has received a total sum of at least 64 degrees and he is, therefore, considered at least 20 percent disabled for purposes of the statute.

We conclude that a similar approach should be taken when determining whether claimant's compensation has been sufficiently increased to meet the requirements of the statute. Pursuant to ORS 656.005(8), "compensation" is defined to include all benefits. Consequently, we conclude that the term "compensation," as used by the statute, pertains to claimant's permanent disability award itself, rather than the dollar value of the award. Therefore, to determine if claimant's compensation has been increased by 25 percent or more, the prior total amount of permanent disability awarded by determination order or notice of closure is compared to the total amount of permanent disability awarded on reconsideration, in order to determine whether the increase is 25 percent or more.

Here, claimant was initially awarded 21 percent (67.2 degrees) unscheduled permanent disability, pursuant to a Notice of Closure. 25 percent of 67.2 degrees equals approximately 17 degrees. Therefore, for claimant's award to have been increased by 25 percent or more, the total award must equal or exceed 84.2 degrees (67.2 degrees + 17 degrees). As explained above, claimant's award was increased on reconsideration to a total of 118.84 degrees. Accordingly, we find that claimant's compensation has been increased by more than 25 percent.

Because the Department's Order on Reconsideration resulted in an increase by 25 percent or more of the amount of compensation to be paid to claimant, and claimant was found upon reconsideration to be at least 20 percent disabled, we conclude that he is entitled to a penalty pursuant to ORS 656.268(4)(g). The Referee's order is modified accordingly.

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 Beverly A. Kirk, 45 Van Natta 1078 (1993); 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 he did, we would decline such a request because we find that the Notice of Closure's permanent disability award was based on the operating physician's closing examination. Under these circumstances, we would not consider the insurer's conduct to have been unreasonable within the meaning of ORS 656.382(1).

ORDER

The Referee's order dated December 21, 1992 is modified in part and affirmed in part. Claimant is awarded a penalty, to be paid by the self-insured employer, in an amount equal to 25 percent of all compensation due claimant under the July 28, 1992 Order on Reconsideration. The remainder of the Referee's order is affirmed.

In the Matter of Complying Status of
NIGHSWONGER'S CONTRACT CUTTING, Employer
WCB Case 89-21286
and, In the Matter of the Compensation of
RICHARD E. VALADE, Claimant
WCB Case 89-20449
ORDER ON REVIEW
Martin McKeown, Attorney
Robert Jackson (Saif), Defense Attorney
Norman F. Kelley, Assistant Attorney General

Reviewed by Board Members Gunn and Westerband.

The alleged noncomplying employer, Nighswonger's Contract Cutting Inc. (Nighswonger's), requests review of Referee Emerson's January 13, 1993 order which republished Referee Seifert's June 27, 1990 order that: (1) amended a Director's order to find Nighswonger's to be a noncomplying employer between April 13, 1989 and April 17, 1989; and (2) upheld the SAIF Corporation's acceptance, on Nighswonger's behalf, of claimant's injury claim for a left knee condition. Asserting that the Referee erred in declining to reopen the record to admit a handwriting expert's report, Nighswonger's moves for remand for that purpose. On review, the issues are evidence, motion to remand, noncompliance, and compensability.

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

Evidence/Motion to Remand

Nighswonger's contends that the Referee erred in declining to receive a handwriting expert's opinion regarding whether claimant filled in a portion of an 801 form which described his injury. Nighswonger's offers this evidence to impeach claimant's credibility concerning the mechanism of his injury.

Two 801 forms were entered into evidence. The two forms had different handwritten descriptions of how the injury occurred. The first form stated: "Slipped off a small log and caught myself with weight on left knee." (Ex. 4). The second 801 stated: "Was bucking logs, logs slid down hill and hit some stumps, I fell over logs and strained left knee." Claimant testified that he did not write the description portion of the first 801. (Tr. 28-29). Claimant acknowledged that the description in the second 801 was written by him.

At the end of the February 13, 1990, hearing, the Referee left the record open for a deposition of Dr. Freudenberg, a legible copy of SAIF's claim acceptance, a possible deposition of Dr. Counts (the emergency room physician who initially treated claimant), and written closing argument. (Tr. 136; O & O, p. 1). On March 14, 1990, Nighswonger's wrote the Referee requesting that he "reopen the hearing" for receipt of a handwriting expert's opinion regarding whether the description portions of both 801 forms were written by the same person. On May 9, 1990, the Referee denied Nighswonger's request. The Referee reasoned that the hearing had been continued specifically for further medical evidence and argument.

When a referee has continued the hearing for particular purposes and a motion is subsequently made for the receipt of other evidence that is not offered for those purposes, we have found that the referee has discretion not to allow such evidence into the record. See OAR 438-07-025; Sharron R. Clark, 44 Van Natta 1556 (1992); T.S. Nacoste, 42 Van Natta 1855, 1856 (1990). Here, the offered evidence went beyond the Referee's ruling to continue the hearing to receive the physicians' depositions, the parties' written closing arguments and a legible copy of the claim acceptance. Accordingly, we conclude that the Referee had discretion not to allow the handwriting expert's report into evidence. Sharron R. Clark, supra.

Asserting that the record is incompletely developed in the absence of the handwriting expert's opinion, Nighswonger's moves for remand. We deny the motion.

We may remand a case for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We are not convinced that the handwriting expert's opinion was not obtainable with due diligence at the time of hearing. Nighswonger's was aware, prior to the close of the hearing, of claimant's testimony concerning the 801 forms. However, in spite of this knowledge, it did not object when the Referee left the record open only for the specific purposes noted above and no attempt was made to hold the record open for evidence concerning who completed the description portion of the 801 forms. Under the circumstances, we conclude that Nighswonger's has not established that it exercised due diligence in failing to obtain the handwriting expert's opinion at the time of hearing. Accordingly, remand is not warranted.

Compensability

The Referee found that claimant suffered a compensable left knee injury while performing his work activities on April 16, 1989. Consequently, the Referee did not disturb SAIF's acceptance of the claim on Nighswonger's behalf. Nighswonger's contends that claimant is not credible, because he has given inconsistent accounts of the mechanism of his injury, which was unwitnessed. We disagree.

The Referee did not make a credibility finding. In the absence of an express credibility finding by the Referee, we make the necessary credibility findings based on the substance of the witnesses' testimony and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we find claimant credible.

In reaching this conclusion, we recognize that there are various descriptions in the medical reports and claims forms as to how claimant came to fall. However, we do not consider these differences to be sufficient to convince us that claimant was not telling the truth when he reported that he fell and injured his knee at work on April 16, 1989. Regardless of the specific descriptions of the fall, claimant has consistently reported that he fell and suffered a severe left knee injury while bucking logs for Nighswonger's on April 16, 1989.

Furthermore, claimant's testimony concerning an injury on April 16, 1989 was corroborated by Burcher's testimony. Burcher, claimant's co-worker, saw claimant the evening of April 15, 1989 and did not notice that claimant was limping or had anything wrong with his leg. (Tr. 85). Claimant told Burcher he planned to work the next day. The next morning, claimant came to Burcher's house at about 10 a.m., told Burcher he had hurt his leg that morning on the job, and was driven by Burcher to the hospital. (Tr. 75).

Claimant's testimony is also supported by Dr. Freudenberg's findings. Dr. Freudenberg performed surgery to repair a torn anterior cruciate ligament and lateral meniscus. He indicated that claimant's knee injury was "fresh" and was consistent with an injury that had occurred within two or three days. (Ex. 28-12, 13). When asked if claimant would be able to walk normally with the injury he had sustained, Dr. Freudenberg responded that claimant would have a noticeable limp.

There is some evidence that claimant injured his knee at work on April 12, 1989, rather than April 16, 1989. Specifically, Mr. Nighswonger's diary states that claimant only worked two hours on April 12, 1989 because he sprained his knee. In addition, the original 801 form gave the date of injury as April 12, 1989. This was changed at some point, to reflect that April 16, 1989 was the date of injury. A time sheet and a termination roster from Nighswonger's indicates that claimant had worked for two hours on April 12, 1989. The termination roster indicates that claimant had left work on April 12, 1989 due to a knee sprain.

Thus, the documents from Nighswonger's do not support a finding that claimant was injured off work, but suggest instead that his injury occurred on April 12, 1989 rather than April 16, 1989.[1] Based on claimant's testimony (which we find credible), and the testimony of Burcher, (who did not notice any problems with claimant's knee on April 15, 1989), as well as the opinion of Dr. Freudenberg, (that claimant's injury was "fresh" and that he would have limped noticeably following such an injury), we conclude that claimant was injured on April 16, 1989, rather than April 12, 1989.

Consequently, in spite of minor inconsistencies in claimant's description of the mechanism of his injury, we are convinced, based on the totality of the evidence, that claimant sustained his left knee injury on April 16, 1989, while bucking logs for Nighswonger's. Accordingly, SAIF's acceptance of the claim on behalf of Nighswonger's will not be altered.

ORDER

The Referee's order dated June 27, 1990, as republished January 31, 1993, is affirmed.

[1] We recognize that such a finding is important concerning whether Nighswonger's was a noncomplying employer, because the parties have stipulated that Nighswonger's was noncomplying from April 13, 1989, through April 16, 1989.

September 16, 1993 Cite as 45 Van Natta 1743 (1993)

In the Matter of the Compensation of
NANCY E. O'NEAL, Claimant
WCB Case No. 91-12978
ORDER OF ABATEMENT
Gatti, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our July 19, 1993 Order on Remand, as reconsidered August 18, 1993, which directed SAIF to pay claimant's attorney an "out-of-compensation" fee and, in the event that such a payment created an overpayment, authorized SAIF to recover the overpayment against claimant's future permanent disability awards. Contending that our reasoning is inconsistent with ORS 656.388(1), (2), and the holding in Mohammad Zarifi, 42 Van Natta 670 (1990), SAIF renews its previous assertion that claimant's attorney should seek the fee from claimant.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNIEL P. ROAM, Claimant
Own Motion No. 92-0675M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 18, 1992 Own Motion Order, as reconsidered on July 1, 1993. In that order, we determined that claimant's condition worsened requiring surgery in February 1992. We based this determination on the fact that the record contained no evidence of any request for surgery until the February 12, 1992 request by Dr. Butters, claimant's treating orthopedic surgeon. We also concluded that, although claimant had proved a worsening of his compensable condition requiring surgery, he had not established that he was in the work force at the time of his disability.

On July 27, 1993, we withdrew our prior December 18, 1992 order, as reconsidered on July 1, 1993, for reconsideration. We also granted the SAIF Corporation an opportunity to respond to claimant's motion. SAIF's response has been received and we proceed with our reconsideration.

On reconsideration, claimant contends that the medical care which resulted in his current request for the reopening of his own motion claim was requested in November 1988. Therefore, he contends, his compensable condition worsened in November 1988 and his testimony at a May 9, 1989 hearing establishes that he was in the work force at the time his condition worsened. On this basis, claimant contends that he is entitled to temporary disability benefits beginning the date of his right elbow surgery, which occurred in December 1992.

There is no dispute that claimant's compensable right arm injury worsened requiring surgery. The issue is the timing of that worsening and whether claimant was in the work force at the time of the disability.

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.

In support of his contention that his right arm condition worsened in November 1988, claimant submits a copy of a November 2, 1988 letter from Dr. Butters, claimant's treating orthopedist, in which Dr. Butters stated that he and claimant:

> "discussed the possibility of doing a one-bone forearm which is a fusion of the radius to the ulna preventing any rotational movement at the wrist or elbow. I think this would be a reasonable thing to offer [claimant] if he can get his psychiatric problems in order. I do not think that he will return to the work force unless both are accomplished."

Claimant also submits a copy of Referee Gruber's June 27, 1989 order which dealt with the issue of the compensability of claimant's psychiatric treatment. Referee Gruber found the psychiatric treatment compensable because it was necessary for the process of recovery from claimant's compensable injury. This order was affirmed by both the Board and the Court of Appeals.

However, Referee Gruber did not find that surgery had been recommended for claimant's compensable injury. Instead, in discussing Dr. Butters' November 7, 1988 letter quoted above, Referee Gruber found that Dr. Butters stated "that he was considering a further major surgical procedure on the claimant's arm." (Opinion and Order, page 2). Referee Gruber also found that Dr. Butters had referred claimant to the Oregon Health Sciences University "for a second opinion regarding the possibility of fusing the radius to the ulna." Id.

On this record, we do not find that surgery was recommended for claimant in 1988. Contrary to claimant's contention, Dr. Butters' November 2, 1988 letter does not represent a recommendation for surgery. Instead, Dr. Butters discusses surgery in terms of a "possibility." Furthermore, Referee Gruber's order supports a finding that only the possibility of surgery was discussed in 1988 and early 1989. In any event, even assuming arguendo that Dr. Butters' November 2, 1988 letter represents a recommendation for surgery, claimant has not established that he was in the work force at that time.

Claimant submits a copy of the transcript of his testimony at a May 9, 1989 hearing as proof that he was in the work force at the time of Dr. Butters' November 1988 letter. At that hearing, claimant testified that he last worked from September 1987 to June 1988 at a fishery. (Tr. 6). Although that testimony may establish that claimant was in the work force at June 1988, it does not establish that he remained in the work force in November 1988. Claimant submits no evidence of a reasonable job search or any other indicia that claimant remained in the work force in November 1988. Dawkins v. Pacific Motor Trucking, supra.

In addition, contrary to claimant's assertion, the medical care which resulted in the present request for own motion relief was not requested in 1988. As quoted above, in November 1988, Dr. Butters discussed the possibility of performing a fusion of the radius to the ulna. However, in a February 12, 1992 letter, Dr. Butters noted "on x-ray there is a broken silastic prosthesis with some erosive changes within the radial neck" and recommended "removal of the prosthesis and curettage of the bone with localized synovectomy." Dr. Butters requested authorization to perform this surgery. It is Dr. Butters' February 1992 request for authorization for surgery that resulted in the current request for own motion relief. The procedure discussed in November 1988 is not the same as that requested in February 1992.

On this record, we continue to find that claimant's condition worsened requiring surgery in February 1992. Furthermore, we continue to find that claimant has not met his burden of proving that he was in the work force at the time of his worsening in February 1992. To the extent that claimant is asserting that he was in the work force in 1988 and has been unable to work since that date due to the compensable injury, he offers no proof of that assertion.

Accordingly, as supplemented herein, we adhere to and republish our December 18, 1992 order, as reconsidered on July 1, 1993, in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
NICK SHEVCHYNSKI, Claimant
WCB Case Nos. 90-05141 & 90-12106
ORDER ON REVIEW
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee Quillinan's order that dismissed his request for hearing on the ground that claimant's lack of cooperation had resulted in an unjustified delay in the hearing of more than 60 days. On review, the issue is the propriety of the Referee's dismissal order.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated December 30, 1992 is affirmed.

Member Gunn specially concurring.

I concur with the result of the Referee's Order of Dismissal. This matter was originally set for hearing on July 26, 1990. Since that time, the case was re-set five times. On September 15, 1992, the sixth date set for hearing, claimant was still unable to attend and he had not yet obtained an attorney. Referee McCullough proposed that the case be decided on the record and claimant was requested to respond and submit exhibits and affidavits necessary to complete the record.

A letter was sent to claimant by Referee McCullough on September 23, 1992, detailing the steps to be taken by claimant. Claimant failed to respond. On December 1, 1992, Assistant Presiding Referee Quillinan wrote to claimant and advised him that, because he had not responded to Referee McCullough's letter, his case would be reset for hearing. On December 14, 1992, claimant was sent a copy of Referee McCullough's letter and was required to respond within ten days. When claimant did not respond, Referee Quillinan issued the Order of Dismissal.

Under the circumstances, I agree with the Referee that claimant's failure to cooperate has resulted in an unjustified delay in the hearing of more than 60 days. Furthermore, although the issue is not squarely before me, I am not convinced that this claim would be compensable on the merits, had it proceeded to hearing. I base my conclusion on the following reasoning.

Pursuant to ORS 656.266, claimant is required to prove, by a preponderance of the evidence, that his claim is compensable. That statute provides:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred." ORS 656.266. (Emphasis added).

Here, claimant asserts, and I suspect, based on the list of proposed defense witnesses, that he is attempting to prove that the insurer's assertions are untrue. However, even if claimant was successful in that exercise, he would nonetheless lose because the statute requires claimant to affirmatively prove his case, not to merely disprove the insurer's contentions.

In his appellant's brief, claimant has expressed his frustration with the workers' compensation system, referees, and with his attorneys. I empathize with claimant's concerns regarding the complexity of the system. However, I believe that it is apparent that even unrepresented parties who have requested a hearing must do their best to make certain that their interests are advanced in this system.

Although claimant is frustrated with attorneys, I would point out to claimant that I am not an attorney, nor even a Klingon. I suppose after this order, claimant will consider me a Ferengi.[1] In sum, I find it to be clear from this record that claimant is wasting his considerable fiction writing skills and talents on the workers' compensation system. Claimant would be better served by channeling those skills in other directions.

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[1] In case claimant has stopped watching "Star Trek: The Next Generation," the Ferengi are troll-like creatures consumed with gaining economic advantage.

In the Matter of the Compensation of
ROBERT K. WILSON, Claimant
WCB Case No. C3-02182
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Richard C. Pearce, Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On August 16, 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 set aside the proposed disposition.

Here, a CDA has been entered into by the insurer, claimant, and claimant's wife. Pg. 1. Furthermore, a portion of the settlement benefits have been assigned to claimant's wife in exchange for releasing her rights to survivor's benefits under ORS 656.208. Pg. 3.

A "beneficiary" as provided by ORS 656.005(2) is "an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter."

ORS 656.208 provides in part:

> "(1) If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving a spouse or any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204." (Emphasis supplied).

Therefore, for purposes of the statute, claimant's wife does not become a beneficiary until claimant dies during the period of permanent total disability (PTD). See ORS 656.208(1). Here, however, there is no indication that claimant has been found to be PTD. Moreover, claimant is not deceased. Accordingly, because claimant's wife is not yet a beneficiary, she may not release benefits to which she is not entitled through claimant's CDA.

Furthermore, ORS 656.234 prohibits the assignment by an injured worker or any other beneficiary of any "moneys payable under ORS 656.001 to 656.807" prior to their receipt. Thus, because the agreement proceeds here are payable under ORS 656.236, such proceeds cannot be assigned by claimant to any entity or individual (including his spouse) prior to their receipt. See Debbie K. Ziebert, 44 Van Natta 51 (1992). Of course following approval of a CDA which provides for payment of all proceeds to claimant and after that full payment is made to claimant, there is no statutory prohibition restricting claimant from distributing all or any portion of the proceeds to his spouse or any other individual or entity. Therefore, for the above reasons, we conclude that the portion of the CDA providing payment to claimant's wife for release of survivors benefits is unreasonable as a matter of law.

Because the offensive 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, supra. 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. 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
RAE L. HOLZAPFEL, Claimant
WCB Case No. 92-12419
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of Referee Holtan's order that awarded claimant 14 percent (21 degrees) scheduled permanent disability for each forearm (wrist), whereas an Order on Reconsideration awarded no scheduled permanent disability. 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 two paragraphs on page 2, and supplement as follows.

The insurer accepted claimant's claim as a nondisabling carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

The issues on review are whether claimant is entitled to a 14 percent award for loss of grip strength and a 5 percent award for a scheduled chronic condition impairment in each forearm (wrist).

It is claimant's burden to prove the extent of disability resulting from her compensable injury or occupational disease. ORS 656.266. Scheduled partial disability is rated on the permanent loss of use or function of a body part. ORS 656.214(1)(b); OAR 436-35-010(2). Physical disability ratings shall be established on the basis of medical evidence supported by objective findings by the attending physician, or by other medical providers if concurred in by the attending physician, or by the medical arbiter. ORS 656.245(3)(b)(B); 656.268(7); 656.283(7).

Claimant's claim was closed on March 9, 1992. Accordingly, we apply the standards effective April 1, 1991, as amended October 1, 1991, and June 17, 1993. OAR 436-35-003 (WCD Admin. Order 93-052) (Temp.).

Grip Strength

The Referee concluded that the preponderance of medical evidence supported an award for decreased grip strength in each hand due to a peripheral nerve injury below the mid-forearm, based on the reports by Dr. Gallant. (Exs. 29 and 30). We disagree.

There is no evidence in the record to establish a peripheral nerve injury, except the "check-the-box" report by Dr. Gallant. We do not find this report persuasive. On October 1, 1991, Dr. Gallant had referred claimant to Dr. Hales, who reported that claimant's nerve conduction studies were normal. (Exs. 24A and 24). On January 21, 1992, Dr. Gallant deferred to Hales' opinion, found claimant medically stationary and released her to regular work. (Ex. 27). Then, on July 17, 1992, Gallant stated that claimant had a permanent loss of grip strength due to peripheral nerve injury. He does not explain the inconsistency in his opinions. Consequently, we are more persuaded by the opinion of Dr. Burr, the medical arbiter, who found no permanent loss of grip strength. (Ex. 31-3).

Chronic Condition

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 condition as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow, and arm."

The rule requires medical evidence of at least a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 1452 (1993).

The Referee relied on the opinions of Drs. Gallant and Burr for the award for chronic condition impairment. However, neither doctor stated that claimant was unable to repetitively use her hands, nor did they make findings from which we can conclude that claimant is unable to do so. Rather, as a result of their assessment of claimant's continuing symptoms of aching and occasional tingling and numbness of her wrists, both doctors merely recommended that claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms. (Exs. 27 and 31-4). This is insufficient to establish a permanent and chronic impairment of the wrists. OAR 436-35-010(6); Lowry, supra. Furthermore, although claimant testified to her pain that limited her ability to engage in activities involving repetitive use of her wrists and hands, lay testimony is insufficient to establish "impairment" under the standards. ORS 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

Based on this record, we conclude that claimant has not sustained her burden of proving that she has a loss of grip strength and a chronic wrist condition that prevents her from repetitively using her wrists. Accordingly, claimant is not entitled to a 14 percent award for loss of strength or a 5 percent chronic condition award for her wrists. See ORS 656.266.

ORDER

The Referee's order dated January 19, 1993 is reversed. The September 15, 1992 Order on Reconsideration, which awarded claimant no permanent disability, is reinstated and affirmed.

In the Matter of the Compensation of
RANDEL G. JENSEN, Claimant
WCB Case No. 92-11915
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
Lane, et al., Defense Attorneys

Reviewed by Board en banc.

The self-insured employer requests review of Referee Lipton's order that: (1) found claimant entitled to temporary disability benefits; and (2) assessed a penalty for unreasonable claim processing. On review, the issues are temporary disability and penalties.

We affirm and adopt the Referee's order, with the following supplementation. Subsequent to the Referee's order, we issued our Order on Reconsideration in regard to the employer's appeal of Referee Mills' order (WCB No. 92-02227) awarding claimant interim compensation. Randel G. Jensen, 45 Van Natta 898 (1993). We found that claimant had lost wages, in whole or in part, as a result of his compensable condition. We therefore awarded interim compensation. Id. Claimant now seeks temporary disability benefits from February 11, 1992 (the date of the employer's denial) to October 12, 1992, the date he underwent surgery for his compensable condition.

The employer contends that claimant is not entitled to temporary disability benefits because he left work for reasons unrelated to his compensable occupational disease. We disagree.

Claimant was terminated on September 16, 1991 for testing positive for drug use. Pursuant to company policy, approximately 30 days after the termination, the employer offered claimant reinstatement to his regular work, which claimant refused. On or about October 20, 1991, claimant worked two days doing roofing. He subsequently worked one day trimming trees. At the time of claimant's termination, there was no medical evidence that he was disabled or entitled to temporary disability benefits.

On November 26, 1991, claimant sought treatment from Dr. Rabie, who restricted him to modified work. Dr. Rabie's November 26, 1991 release for modified work was medical verification of claimant's inability to work. See ORS 656.210(2)(b)(B). Claimant was, therefore, disabled as of that date and entitled to temporary disability benefits.

The employer contends that the only time claimant was physically unable to work was at the time of surgery, because claimant would have continued working if he had not been terminated. The employer argues that under its light-duty program claimant would have been reemployed at a job within Dr. Rabie's restrictions. However, the critical date for determining claimant's initial eligibility for temporary disability benefits is the date of disability associated with the compensable condition. See Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414-415 (1990); Richard N. Harrison, 45 Van Natta 1121 (1993).

Given that claimant's disability first arose after his job termination, the employer's argument invites speculation as to claimant's potential for returning to modified work for the employer. See Randel G. Jensen, supra, (Any discussion of potential modified jobs with the employer at the time of claim filing would only be mere speculation.) The employer has stipulated that it did not offer modified work to claimant following Dr. Rabie's release to modified work.

The employer has not otherwise satisfied any of the elements of ORS 656.268(3) for terminating claimant's temporary disability. Consequently, claimant is entitled to temporary disability benefits from February 11, 1992 to October 12, 1992.

Because there is no evidence in the record that any prerequisites for the employer's unilateral termination of temporary disability benefits prior to claim closure has been met, we conclude that the employer did not have a legitimate doubt concerning its liability for the payment of such benefits. Thus, the employer's refusal to pay was unreasonable. See International Paper Co. v. Huntley, 106 Or App 107 (1991). The Referee's award of a penalty was, therefore, correct.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the temporary disability issue is $500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review concerning the penalty issue. Saxton v. SAIF, 80 Or App 631, 634, rev den 302 Or 159 (1986).

ORDER

The Referee's order dated December 23, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $500, payable by the self-insured employer.

Board Chair Neidig, dissenting.

The majority holds that claimant has established an entitlement to temporary disability benefits based on Dr. Rabie's November 26, 1991 release for modified work, notwithstanding claimant's September 16, 1991 termination for reasons unrelated to his compensable condition. For the reasons stated in my dissent in Randel G. Jensen, 45 Van Natta 898 (1993), and for the reasons stated below, I dissent.

In reaching its conclusion, the majority relies, in part, on the employer's failure to satisfy the elements of ORS 656.268(3), in particular, subsection (c), to justify terminating claimant's entitlement to temporary disability benefits. Arguably, ORS 656.268(3)(c) is inapplicable where, as in this case, the doctor's release for modified work occurred after claimant's termination from employment. Form would be elevated over substance if the employer was obligated to offer claimant modified work, after his termination from work, just for the sake of complying with ORS 656.268(3)(c). The evidence establishes that the employer could have accommodated Dr. Rabie's restrictions and that modified work would have been available within those restrictions, but for claimant's termination. Tr. 16-18, 22.

Claimant is entitled only to the amount of temporary disability benefits he could have received on account of his disability had he not been fired. Safeway Stores v. Owsley, 91 Or App 475, 480 (1988). If claimant was physically able to perform his work and, but for his termination, would have been able to continue working, then he would not be entitled to temporary disability benefits. See Roberta L. Jones-Lapeyre, 43 Van Natta 942 (1991). Based on the evidence in the record, claimant would have been able to continue working for the employer, but for his termination. Claimant was terminated for reasons unrelated to his compensable claim. Therefore, claimant is not entitled to temporary disability benefits.

In the Matter of the Compensation
HOWARD J. PANUKE, Claimant
WCB Case Nos. 92-02384, 92-00879 & 92-01582
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Lumbermen's Underwriting Alliance (Lumbermen's) requests review of that portion of Referee Mongrain's order which assessed a penalty for its unreasonable denial. Lumbermen's also requested the Board to remand the case to the Referee for taking of additional evidence. Lumbermen's has subsequently withdrawn its motion for remand. On review, the sole issue is penalties.

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

The Referee found that Lumbermen's denial was issued following receipt of an 801 claim form describing the 1989 fall, and was issued because Lumbermen's had no information regarding a 1989 claim. The Referee concluded that the insurer failed to investigate the claim before issuing its denial and that, therefore, the denial was unreasonable.

In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. If the insurer had a legitimate doubt as to its liability, then denial the was not unreasonable. Unreasonableness and legitimate doubt are to be considered in light of all the evidence available to the insurer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591-592 (1988).

Lumbermen's contends that its conduct was reasonable when considered in view of the manner in which the claim was presented to it. On February 4, 1992, Lumbermen's received notice of a claim for a 1989 injury when it received SAIF's January 17, 1992 aggravation denial and disclaimer of responsibility. However, SAIF did not provide claim documents until March 12, 1992. Lumbermen's admits that claimant had fallen at work in 1989, but contends that claimant sought no medical treatment nor missed time from work. Lumbermen's asserts that when claimant sought medical attention in 1991 for his low back condition, claimant sought reopening of his 1987 claim with SAIF. Lumbermen's, therefore, contends that the medical treatment in 1991 was sought in conjunction with claimant's 1987 injury claim with SAIF.

Lumbermen's contends that, because the 1989 injury did not require medical treatment or result in disability, it had a legitimate doubt as to its liability in that it doubted whether claimant had sustained a compensable injury as defined by ORS 656.005(7)(a).

Lumbermen's issued its denial on February 10, 1992 on the ground that the June 1989 injury was not a "compensable injury" under ORS 656.005(7)(a) and, in the alternative, that claimant's low back condition was due to his 1987 claim with SAIF. Claimant's supervisor was aware of the 1989 injury/fall the day it occurred. Claimant missed no time from work following the 1989 injury, but did seek medical treatment, albeit, not until September 1991. Whether the 1989 injury was compensable, i.e., whether the 1989 injury was a material contributing cause of claimant's current condition and need for treatment, is a complex medical question. Claimant must be able to prove causation in order to carry his burden of proof. See Edward R. Montpart, 43 Van Natta 34 (1991)(the claimant immediately reported a November 1987 injury, but missed no time from work nor sought medical treatment until June 1989).

Lumbermen's could not have had a legitimate doubt that claimant could meet his burden of proof, where it had no medical evidence on the causation issue because it failed to investigate this issue at the time of its denial. The insurer cannot have a legitimate doubt for lacking knowledge of facts that would have been disclosed by a reasonable investigation. Carolyn S. Farmer, 45 Van Natta 839 (1993); see Kenneth A. Foster, 44 Van Natta 148 (1992). Therefore, we conclude that Lumbermen's did not have a legitimate doubt as to its liability for the claim, and we find its denial unreasonable. Accordingly, we affirm the Referee's penalty assessment.

Inasmuch as penalties are not compensation within the meaning of ORS 656.382(2), claimant is not entitled to an attorney fee for defending against the penalty issue on Board review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 14, 1992 is affirmed.

September 17, 1993 Cite as 45 Van Natta 1752 (1993)

In the Matter of the Compensation of
the Beneficiary of **IRENE F. SHATTUCK, Deceased**
WCB Case No. 92-04392
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant's beneficiary requests review of Referee Menashe's order which upheld the self-insured employer's denial of his claim for survivor's benefits. On review, the issue is compensability.

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

Subsequent to the filing of Board briefs in this case, claimant submitted a letter asking us to consider an additional authority, Montgomery v. SIAC, 224 Or 380 (1960), as if it were incorporated into claimant's appellant's brief. The employer responded with additional argument distinguishing that case from the present one, but did not object to claimant's request to incorporate the case into the appellant's brief.

Any party may 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). Inasmuch as the 1960 case was in existence prior to the close of briefing, the parties' additional arguments regarding that case will not be considered.

Turning to the merits of the Referee's order, we add the following supplementation.

Claimant was fatally injured when she was struck by a co-worker's vehicle in the public roadway, as she was crossing the street to the employer's parking lot after work.

The general rule is that injuries sustained while going to or coming from work are not compensable, unless the employer exercises some control over the area where the injury occurred, which demonstrates the work-connection necessary to make the injury compensable. Cope v. West American Ins. Co., 309 Or 232, 239 (1990). Such control may be evidenced by employer ownership or maintenance of the area, or the presence of employer-created special hazards. See Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52, 56-58 (1981); Janet V. Dollens, 42 Van Natta 2004, 2005 (1990).

Here, as in Adamson, claimant was injured in the public street. We agree with the Referee's finding that employer did not maintain or exercise control over the area where the injury occurred, which was the street between the employer's plant and one of its parking lots. Therefore, on this basis, the claim is not compensable. Adamson, supra, 54 Or App at 59; Janet V. Dollens, supra (claimant's employer had no control over privately-owned walkway where injury occurred).

Next, we consider whether claimant's employer exercised control by the presence of employer-created special hazards.

Subsequent to the Referee's order, the court issued its decision in Kiewit Pacific v. Ennis, 119 Or App 123 (1993), affirming the Board's order in Arthur L. Ennis, 43 Van Natta 1477 (1991). In Ennis, compensability turned on whether the claimant was injured because he was exposed to an employer-created hazard peculiar to his employment which was not experienced by the common, traveling public.

In Ennis, the claimant had stopped on a public highway, attempting to turn into the employer's parking lot where he was required to park, when he was struck from the rear by a truck. We reasoned that the claim was compensable because the claimant was exposed to the greater hazard of potentially being hit from behind than was the general public, which would continue on the road without slowing down to turn. We concluded that, "by requiring claimant to park in this specific area, claimant was exposed to hazards peculiar to his employment and not experienced by the traveling members of the common public." Arthur L. Ennis, supra, 43 Van Natta at 1478.

The court agreed with our reasoning, pointing out that the employer "required claimant to use the designated employee parking lot for its convenience," and that 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." Kiewit Pacific v. Ennis, supra, 119 Or App at 126. The court concluded that under these circumstances, the claimant's injury had a sufficient work relationship because the claimant was exposed to a "hazard peculiar to his employment and not experienced by traveling members of the public." 119 Or App at 127. In finding the claim compensable, the court distinguished Adamson, supra, where the injury occurred on a public street which was not part of the employer's premises, and over which the employer exercised no control of the street traffic. 119 Or App at 128.

We find the present case distinguishable from Ennis and more akin to Adamson. Here, the deceased claimant was struck by a co-worker's vehicle in a public roadway, as she was crossing the street to reach the employer's parking lot after her shift had ended. The co-worker was exiting the parking lot as claimant approached it. However, the Referee found and we agree, that claimant was not required by her employer to park in that particular parking lot, or in any other particular location. Nor was claimant required by the employer or by circumstances to cross the street in the particular location she chose, thereby encountering the risk of being struck by a vehicle exiting the parking lot. Nor did the employer exercise any control over street traffic. Accordingly, we agree with the Referee's conclusion that claimant was not exposed to a greater, employer-created hazard than was the common, traveling public. Therefore, we find that claimant was not injured in the course and scope of her employment, and the claim is not compensable.[1]

ORDER

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

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[1] The present case is also distinguishable from our recent decision in Ramon M. Marin, 45 Van Natta 1606 (1993), in which we found the claimant's injury was compensable. In Marin, the claimant was injured in the employer's parking lot after work; therefore, we did not face the question of whether the employer exercised control over the area where the claimant was injured. Instead, we had to determine whether the claimant was on a personal mission when he attempted to jump start his dead battery in order to complete his intended departure from work. In Marin, we held that a sufficient work relationship was established, because the claimant's injury occurred in an employer-controlled parking lot while the claimant was attempting to leave work. In the present case, however, we have found that claimant failed to prove a sufficient work relationship, because she failed to prove that the employer exercised control over the area where she was injured.

In the Matter of the Compensation of
LELA K. MEAD-JOHNSON, Claimant
WCB Case No. 92-04457
ORDER ON REVIEW
David C. Force, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Livesley's order that: (1) directed it to pay temporary total disability benefits awarded by an earlier referee's order; and (2) assessed a penalty for an allegedly unreasonable failure to pay the aforementioned benefits. In its brief, SAIF contends that the Referee improperly addressed the temporary disability and penalty and fee issues since it contends that these issues were not raised in claimant's request for hearing. On review, the issues are the scope of review, claim processing and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant was compensably injured in 1979. The claim was closed by Determination Orders dated February 15, 1980 and September 19, 1983, with an award of 10 percent unscheduled permanent disability. The claim was reopened for an aggravation and was reclosed by a March 24, 1989 Determination Order which awarded an additional 17 percent unscheduled permanent disability. By a June 11, 1991 Opinion and Order, Referee T. Lavere Johnson set aside the March 24, 1989 Determination Order as prematurely closed. SAIF requested review of Referee Johnson's order.

The claim was reclosed by a December 17, 1991 Determination Order which awarded no increased permanent disability. Claimant requested reconsideration of the December 17, 1991 Determination Order and a March 13, 1992 Order on Reconsideration increased claimant's unscheduled permanent disability award to 24 percent.

SAIF did not pay temporary disability compensation which accrued after Referee Johnson's June 11, 1991 order. In an order dated January 10, 1992, Referee Mongrain directed SAIF to pay the temporary disability benefits accruing from the date of Johnson's order, but declined to assess penalties and attorney fees against SAIF for its failure to pay the benefits. SAIF requested review of Referee Mongrain's order and did not pay the temporary disability benefits.

On March 31, 1992, we reversed Referee Johnson's order and reinstated the March 24, 1989 Determination Order. Lela K. Mead, 44 Van Natta 535 (1992). SAIF withdrew its request for review of Referee Mongrain's order and the request for review was dismissed by the Board on April 3, 1992. Referee Mongrain's order has become final.

On April 13, 1992, SAIF paid temporary disability benefits from June 11, 1991 (the date of Referee T. Lavere Johnson's order) up to August 2, 1991 (claimant's medically stationary date as determined by the December 1991 Determination Order).

CONCLUSIONS OF LAW AND OPINION

The Referee directed SAIF to pay temporary disability benefits from June 11, 1991 (the date of Referee Johnson's order) until the claim was closed by a December 17, 1991 Determination Order. The Referee also concluded that SAIF's failure to pay the temporary disability compensation ordered by Referee Johnson and enforced by Referee Mongrain's order was unreasonable. Therefore, the Referee assessed a penalty against SAIF for unreasonably refusing to pay compensation.

Scope of Review

On review, SAIF first contends that the temporary disability and penalty and fee issues were not raised by claimant's request for hearing and were not properly before the Referee for consideration. We disagree.

OAR 438-06-031 allows for the raising of issues throughout the course of a hearing, provided that the evidence supports the issue not previously raised. The referee may also continue the hearing upon motion of the other party if the party is surprised and prejudiced by the additional issue. Id. Whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the referee's discretion. Susan D. Troxell, 42 Van Natta 1300 (1990).

Claimant's request for hearing raised only the issue of the extent of permanent disability. No hearing was held and the parties presented their respective positions to the Referee through written arguments. In her written argument, claimant presented the issues as: (1) "whether subsequent developments in the claim, and/or ORS 656.313(1), authorized SAIF Corporation to refuse to comply with Referee Mongrain's order;" and (2) penalties and attorney fees for SAIF's allegedly unreasonable failure to comply with Referee Mongrain's order. SAIF responded to these issues and did not object to the issues or assert that it was surprised or prejudiced by them. SAIF did object to other issues raised in the body of claimant's argument (e.g., entitlement to permanent disability and rate of scheduled disability) and the Referee declined to address those issues.

Inasmuch as SAIF did not object to the claim processing, penalty and attorney fee issues raised in claimant's written argument at the hearing level, we conclude that the Referee properly exercised his discretion in allowing those issues to be raised. Accordingly, we reject SAIF's contention that issues were not properly before the Referee.

Res Judicata

SAIF contends that claimant is barred by res judicata from raising the temporary disability and penalty and attorney fee issues. Specifically, SAIF contends that the temporary disability and penalty/fee issues are the identical issues litigated before Referee Mongrain. We disagree.

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

The present case involves a proceeding initiated by claimant to enforce Referee Mongrain's order. Whether Referee Mongrain's order should be enforced is necessarily not the same issue raised in the prior litigation. See Glen D. Roles, 45 Van Natta 282 on recon 45 Van Natta 488, 489 (1993) (Holding that each enforcement proceeding involves a separate and distinct act of noncompliance). In addition, the factual transaction at issue here (the issuance of Referee Mongrain's order enforcing Referee Johnson's temporary disability award and SAIF's actions in response to that order) could not have been in existence at the time of the earlier proceeding. Therefore, neither issue nor claim preclusion are applicable.

Temporary Disability

The Referee concluded that SAIF was statutorily obligated to pay the temporary disability granted by Referee Johnson's order (and enforced by Referee Mongrain's order) payable from the date of Referee Johnson's order, June 11, 1991, until claim closure, December 17, 1991. The Referee reasoned that SAIF was not entitled to stay payment of this "prospective" compensation granted by Referee Johnson's order under ORS 656.313. We agree.

Pursuant to ORS 656.313(1)(a):

> "Filing by an employer or the insurer of a * * * request for Board review * * * stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs." (emphasis added).

Here, Referee Johnson's order set aside the March 24, 1989 Determination Order as prematurely issued. SAIF appealed Referee Johnson's order, but did not pay the temporary disability which accrued from the date of his order. Pursuant to ORS 656.313(1)(a), SAIF could not properly stay payment of these benefits, but was required to pay the temporary disability accruing after Referee Johnson's order until closure or until reversal of the order itself, whichever of these events occurred first.

As a result of our March 1992 reversal of Referee Johnson's order, it has subsequently been determined that the 1989 Determination Order properly closed the claim. Lela K. Mead, supra. Nevertheless, our reversal was not the first event to occur following issuance of Referee Johnson's order. To the contrary, the first event was closure by Determination Order on December 17, 1991. In light of such circumstances, SAIF was statutorily required to pay the prospective temporary disability payable pursuant to Referee Johnson's order from June 11, 1991 until the December 17, 1991 Determination Order.

SAIF defends its claim processing decision by asserting that, as a substantive matter, claimant was not entitled to temporary disability which accrued from the date of Referee Johnson's order since that order was ultimately reversed. Therefore, it contends that any amounts due after claimant's medically stationary date constitute a "procedural overpayment." Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), SAIF argues that the Board has no authority to impose a procedural entitlement.

We have previously considered and rejected this argument. In John R. Heath, we distinguished Seiber and held that ORS 656.313(1)(a)(A) does not create a "procedural overpayment." Rather, it creates a statutory obligation to pay temporary disability compensation awarded by an appealed order. See John R. Heath, 45 Van Natta 466, on recon 45 Van Natta 840 (1993). Therefore, we conclude that SAIF had a statutory obligation to pay temporary disability that accrued from the date of Referee Johnson's order until claim closure. This obligation was unaffected by the subsequent reversal of Referee Johnson's order. Accordingly, SAIF must pay temporary disability until December 17, 1991, the date of closure. ORS 656.313(1)(a)(A).

Our reasoning is also consistent with Pascual Zaragoza, 45 Van Natta 1221 (1993). In Zaragoza, an Order on Reconsideration set aside a Determination Order as premature. A carrier did not request a hearing for 39 days and did not recommence temporary disability. On review, we affirmed a referee's order that reinstated the Determination Order. Citing Seiber, we declined to order the insurer to pay the "pre-reconsideration order" temporary disability, since we reasoned that to do so would create an "administrative overpayment." Nevertheless, we assessed a penalty for the carrier's unreasonable refusal to timely pay the "pre-reconsideration order" temporary disability. Finally, relying on ORS 656.313(1)(a)(A) and John R. Heath, supra, we concluded that the insurer was required to pay the temporary disability benefits which accrued from the date of the Order on Reconsideration (the prospective temporary disability) until that order was reversed by the referee.

Zaragoza provides support for SAIF's entitlement to stay the "retroactive" temporary disability granted as a result of Referee Johnson's order (which SAIF appealed). However, also consistent with the Zaragoza rationale, we find that SAIF must pay the benefits which accrued from the date of the order appealed (Referee Johnson's June 11, 1991 Opinion and Order) until, in the present case, claim closure. See ORS 656.313(1)(a)(A).

Inasmuch as SAIF has paid temporary disability benefits from the date of Referee Johnson's order until August 2, 1991, SAIF is directed to pay temporary disability from the period August 3, 1991 until the December 17, 1991 Determination Order.

Penalties and attorney Fees

We agree with the Referee's conclusion that SAIF unreasonably failed to pay the temporary disability awarded by Referee Johnson's order (and enforced by Referee Mongrain's order). We base our decision on the following reasoning.

In this proceeding, claimant seeks to enforce Referee Mongrain's order which ordered SAIF to pay temporary disability awarded by Referee Johnson's order. In determining whether SAIF was

unreasonable in failing to comply with Referee Mongrain's order, the question is whether SAIF had a legitimate doubt as to its liability to pay the "prospective" temporary disability ordered by Referee Johnson pending its appeal of that order. See Glen D. Roles, supra. As we earlier stated, pursuant to ORS 656.313(1)(a), SAIF could not properly stay payment of the temporary disability benefits accruing from the date of Johnson's order, but rather had a "statutory obligation" to pay them until closure or until reversal of the order itself, whichever of these events occurred first. Although SAIF paid the temporary disability owing from June 11, 1991 to claimant's medically stationary date (August 2, 1991); it did not pay for the period from August 3, 1991 until claim closure.

In light of the clear statutory directive in ORS 656.313(1)(a), we conclude that SAIF did not have a legitimate doubt as to its liability for payment of the temporary disability granted by Referee Johnson's order as enforced by Referee Mongrain's order. SAIF's appeal of Referee Mongrain's order did not absolve SAIF from its obligation to pay "prospective" temporary disability arising form Referee Johnson's order. In other words, SAIF's appeal of Referee Mongrain's order "stayed" its responsibility to pay the penalty assessment. However, the appeal did not countermand SAIF's statutory mandate to pay the "post-order" temporary disability granted by Referee Johnson's order pending its appeal. Consequently, we hold that SAIF's conduct was unreasonable. Accordingly, we affirm the Referee's penalty assessment.

Assessed attorney fees

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 $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We note that 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 December 14, 1992 is affirmed. For services on review, claimant's attorney is awarded $1,000 payable by SAIF.

September 20, 1993 Cite as 45 Van Natta 1757 (1993)

In the Matter of the Compensation of
CORALEE J. PUCKETT, Claimant
WCB Case No. 93-04001
ORDER OF DISMISSAL
Vance D. Day, Claimant Attorney
Schwabe, et al., Defense Attorneys

Claimant, pro se, has requested Board review of Referee Garaventa's June 21, 1993 order. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

On July 21, 1993, the Referee issued her Opinion and Order. The order contained a statement explaining how and when to appeal the Referee's decision; i.e., by mailing a request for review of the order to the Board within 30 days of the Referee's order. The order was mailed to claimant at the address given in her hearing request. The record does not contain a notification from claimant indicating that her mailing address had changed.

On September 1, 1993, claimant mailed, by certified mail, her request for Board review of the Referee's July 21, 1993 order. In the request, claimant stated that the owner of the property where she

had previously resided had not forwarded her mail. Consequently, claimant had not received the Referee's July 21, 1993 order until August 17, 1993. Aware of the need to appeal the Referee's order within 30 days of its issuance, claimant asserts that her late receipt of the order did not provide her with "enough time to set up for a review." Therefore, claimant seeks a "30-day extension."

CONCLUSIONS OF LAW AND OPINION

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

Here, the 30th day after the Referee's July 21, 1993 order was August 20, 1993. Claimant's request for review was filed on September 1, 1993, the day she mailed the request by certified mail to the Board. See OAR 438-05-046(1)(b). Inasmuch as September 1, 1993 is more than 30 days after the Referee's July 21, 1993 order, it is untimely. Consequently, we lack authority to review the order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. In addition, we acknowledge claimant's explanation for the untimeliness of her appeal; i.e., that the owner of the property did not forward her mail.

However, the determinative issue is not when claimant received her copy of the Referee's order, but rather when the order was mailed. See Joyce E. Mitts, 42 Van Natta 972 (1990) (Where current address of a party provided to the Hearings Division in another case, but not to the Board in the case in question, and a copy of the Board's order, which was mailed to that party at address provided to the Board, was not returned as undeliverable, the order had been mailed to all parties and was final). Moreover, there is no notification in the record prior to issuance of the Referee's order that claimant's correct mailing address was something other than the address previously given in her hearing request. Under such circumstances, we have consistently held that an order was properly mailed to a party. Ernest L. Vaughn, 40 Van Natta 1574 (1988); Douglas Meuler, 40 Van Natta 989 (1988); compare Mary J. Gates, 42 Van Natta 1813 (1990) (Where claimant had provided Board with her new address prior to issuance of Board order and did not receive notice of the order, the Board held that the order had not been mailed to claimant and was not final).

In any event, as acknowledged in claimant's request, she received the Referee's order some three days prior to expiration of the 30-day statutory appeal period and was aware of that deadline. Thus, claimant clearly understood the instructions for timely requesting Board review, which were clearly stated in the Referee's order.

Finally, regardless of claimant's explanation for the failure to timely appeal within the 30-day appeal period, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. Alfred F. Puglisi, 39 Van Natta 310 (1987).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFF HEATON, Claimant
WCB Case No. CV-91011
FINDINGS OF FACT, CONCLUSIONS AND FINAL ORDER (CRIME VICTIM ACT)
Diane Brissenden, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on July 23, 1993 at Salem, Oregon. Applicant, Jeff Heaton, appeared by way of a speaker telephone.[1] The Department of Justice Crime Victims' Compensation Program ("Department") was present and represented by Diane Brissenden, Assistant Attorney General. Jason Barber, claims examiner, was also present on behalf of the Department. The court reporter was Dorothy Frank. Exhibits 1 through 75 were received and admitted into evidence. The record was closed July 23, 1993.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order dated October 9, 1990, as amended and reconsidered December 27, 1990, June 13, 1991, August 15, 1991, and November 14, 1991. By its order, the Department awarded applicant 33 percent of his lost earnings, as well as hospital, medical and counseling expenses. ORS 147.035(1)(a)(A), (B); ORS 147.125; OAR 137-76-025.

FINDINGS OF FACT

On January 12, 1990, applicant filed an application for benefits with the Department. He claimed that he had been the victim of an assault, burglary, and robbery on March 23, 1989. This incident occurred when applicant accepted a ride with his assailant, who "held [applicant] against his will; verbally assaulted, 'terrorized' [applicant], robbed [him] of personal property; placed [applicant] in fear of imminent death." Applicant further reported that the assault had severely aggravated a preexisting epilepsy condition and later precipitated "suicidal ideation, resulting in involuntary commitment to Holladay Park Hospital for 4 days; post-traumatic stress disorder." Applicant sought reimbursement for lost earnings and medical expenses.

Thereafter, the Department obtained reports from the Portland Police Bureau. These reports confirmed that a number of applicant's personal possessions had been taken from his apartment by two men and a woman accomplice. These individuals were charged with Kidnapping II, Robbery II, and Burglary I.

In February 1990, Dr. Rich, neurologist, responded to the Department's request for information. Diagnosing anxiety, depression, and exacerbation of a seizure disorder, Dr. Rich stated that applicant's problems were "in part" the direct result of the crime.

In March 1990, the Department received a March 1989 report from Drs. Tinker and Colistro, psychologists. Noting a history of stress-induced seizures dating back to childhood, the examiners diagnosed a "major thought disorder with affective disturbance." They also reported "panic attacks, symptoms of a Post-traumatic Stress Disorder and a complex partial disorder." The examiners attributed the recent symptoms from the stress disorder to applicant's assault and a scheduled trial. Concluding that applicant was not capable of gainful employment, the examiners recommended that he apply for social security disability.

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[1] Prior to the hearing, applicant requested permission to appear by means of telephone. Uncomfortable with attending the hearing in person, applicant asserted that his appearance via telephone would be more convenient for him. The Department did not oppose the request. Although the Board's "crime victim appeal" rules did not expressly permit a "telephonic" appearance, I noted that the Board's "workers' compensation" rules did provide for such an appearance. See OAR 438-82-035; 438-82-040; 438-07-022. Reasoning that I was required to conduct the hearing in a manner "reasonably calculated to achieve substantial justice," I ruled that, considering the parties' respective positions, applicant's appearance by means of telephone would satisfy that requirement. See ORS 147.155(5); OAR 438-82-040(2). Consequently, applicant's request was granted. Prior to proceeding with the hearing, the parties acknowledged that their positions concerning applicant's "telephonic" appearance had not changed.

In April 1990, applicant submitted a "Verification of Employment" from a temporary employment service. The report listed net earnings for 1988 - 89 of $6,561.24. In June 1990, the employment service further reported that applicant's last assignment prior to the March 1989 assault had been January 16 - 18, 1989. Applicant's gross income for that period was $120, while his net income was $110.57. The employment service's records further indicated that applicant had worked on a relatively consistent basis from March 10, 1989 through September 8, 1989 for weekly hours ranging from 8 to 40.

On October 12, 1990, the Department issued its Findings of Fact and Order. Applicant was awarded compensation for hospital, medical and counseling expenses. In conjunction with that order, the Department asked Dr. Rich to submit an opinion explaining what portion of applicant's medical condition was related to the March 1989 criminal incident. Similar requests were forwarded to Dr. Paltrow, applicant's attending psychiatrist.

On October 25, 1990, applicant requested reconsideration of the Department's decision. Specifically, applicant sought reimbursement for lost wages and an itemization of which conditions / bills the Department was accepting for payment.

In December 1990, Dr. Paltrow responded to the Department's request for further information. Attributing "perhaps 1/3 of the total bill" to the March 1989 criminal incident, Dr. Paltrow predicted that applicant "would probably reach a pre-crime status around March, 1991."

On December 24, 1990, Dr. Rich contacted the Department by means of telephone. Noting that he had not seen applicant for "quite some time," Dr. Rich concluded that the crime had contributed one-half to applicant's present condition.

On December 27, 1990, the Department issued an Amended Findings of Fact and Order. Averaging applicant's past 7 months of net pay, the Department concluded that he had a monthly net wage of $560. Relying on Dr. Paltrow's "verbal report over the telephone dated December 24, 1990," the Department further reasoned that applicant was disabled from work from September 8, 1989 to November 30, 1990. Consequently, the Department awarded applicant 33 percent of his lost earnings during that period ($686.26). In addition, applicant was granted 33 percent of his hospital, medical, and counseling expenses which were directly related to the crime.

Thereafter, applicant sought further reconsideration. Specifically, applicant objected to the reduction of his benefits.

On January 25, 1991, Dr. Paltrow submitted another medical report. Stating that he "now believe[s] 100% of [applicant's] current situation resulted from the victimization," Dr. Paltrow recommended that applicant receive comprehensive medical treatment, vocational rehabilitation, and lost earnings. Finally, noting that applicant had not worked in 2 years, Dr. Paltrow reported that it was "currently indefinite as to when [applicant] would become stationary."

On February 25, 1991, Dr. Rich responded to applicant's request for clarification regarding the information Rich had supplied to the Department. Describing the "seven-month disability" period referred to by the Department as an estimate of the time that applicant was "fully disabled in relationship to his unfortunate assault," Dr. Rich opined that (as of his "last formal follow-up [exam] on March 13, 1990) applicant continued to be disabled. Dr. Rich attributed "approximately 50 percent" of applicant's medical condition to the criminal incident. Finally, Dr. Rich recommended that additional information concerning applicant's present condition and prognosis should be addressed to applicant's current physician.

On April 12, 1991, the Department notified applicant that an independent medical examination had been scheduled. The examination was designed to evaluate his condition in light of his request for further compensation.

On April 19, 1991, Dr. Paltrow provided another report to the Department. Considering applicant's unresolved personality traits and disorders stemming from childhood, Dr. Paltrow "lean[ed] toward" attributing 1/3 of applicant's problem to the criminal incident.

On May 22, 1991, the Western Medical Consultants issued their psychiatric evaluation. Concluding that applicant had significant, preexisting difficulties, the Consultants opined that applicant's current psychiatric difficulties were unrelated to the March 1989 criminal incident. Determining that his condition had returned to its "pre-crime status," the Consultants found that the major contributing factor in applicant's psychiatric symptomatology was his preexisting illness.

On June 13, 1991, the Department issued an Order on Reconsideration. Based on the Western Medical Consultants' opinion, the Department found that applicant's current need for treatment, vocational assistance request, and loss of earnings were unrelated to the March 1989 criminal incident. Consequently, the Department declined to modify its prior decision.

On June 14, 1991 and August 9, 1991, applicant submitted offers to the Department seeking settlement of his dispute. Specifically, applicant sought $600 to fund an "Alcohol and Drug Counselor" training program. Subsequently, applicant requested $5,000 in satisfaction of his claim.

On August 15, 1991, the Department issued another Order on Reconsideration. Finding no basis for reversing its original order, the Department adhered to its decision.

On October 14, 1991, applicant requested further consideration of the Department's decision. Submitting additional information regarding his wages, applicant sought increased benefits.

On November 14, 1991, the Department issued an Amended Findings of Fact and Order. Based on the wage information, the Department recalculated applicant's average weekly net income from its previous figure ($129.24) to $183.81. In light of this modification, the Department increased applicant's compensation for lost earnings to $1,068.43.

Thereafter, applicant requested Board review of the Department's decision. He seeks additional compensation in the form of reimbursed medical and vocational expenses (in addition to further reimbursement for lost wages) until such time as he reaches a "pre-crime status."

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).

As a victim of a crime, applicant is entitled to benefits which result from his injury. ORS 147.015(1); 147.035(1). In accordance with its statutory duty concerning the amount of applicant's compensation, the Department shall determine the amount of applicant's loss resulting from the injury. ORS 147.125(2).

Here, applicant sustained an injury to preexisting psychological and neurological conditions. In light of his extensive pre-injury medical history and the variety/complexity of his diagnoses, I look to the medical evidence to determine the degree of applicant's loss which is attributable to the criminal incident.

In reaching this conclusion, I by no means disregard the testimony offered by applicant. He testified in an articulate and passionate manner. Based on the tone and tenor of his voice, I judged him to be a credible witness. Nevertheless, considering that the issue before me is the degree of contribution from the criminal incident on his preexisting conditions, I give great weight to the opinions authored by medical experts to resolve this complex matter.

Three medical experts have addressed this issue. Dr. Rich has attributed one-half of applicant's disability to the criminal incident. Before and after issuing opinions relating one-third of applicant's problems to the incident, Dr. Paltrow has related all of applicant's disability to the crime. Finally, the Western Medical Consultants concluded that applicant's condition had returned to its "pre-crime status" and that the major contributing cause of applicant's disability was his preexisting illness.

Applicant contends that I should rely on the "100 percent" opinion authored by Dr. Paltrow, as well as on Dr. Rich's opinion. For the following reasons, I cannot agree with applicant's assertion.

Dr. Paltrow does render a conclusion that all of applicant's disability is the result of his victimization. However, in doing so, Dr. Paltrow does not explain why he had previously concluded that one-third of applicant's expenses were due to the criminal incident. Moreover, Dr. Paltrow subsequently essentially recanted his "100 percent" opinion, when he reported that he "lean[ed] toward" attributing one-third of applicant's problem to the crime. Considering the unexplained disparities between Dr. Paltrow's several opinions, I am not inclined to accord them much weight. Yet, even if I did, I would conclude that, at best, Dr. Paltrow supports the Department's determination that one-third of applicant's expenses are related to the criminal incident.

Dr. Rich relates 50 percent of applicant's problem to the crime. Nevertheless, that opinion was rendered in December 1990 some nine months after his last examination (March 1990). Furthermore, in rendering this conclusory opinion, Dr. Rich recommended that additional information regarding applicant's disability be obtained from physicians familiar with his current condition. Considering the significant lapse of time since Dr. Rich had last examined applicant, I do not find Dr. Rich's opinion regarding applicant's disability to be particularly persuasive. I draw additional support for this conclusion from Dr. Rich's suggestion that further inquiries be directed to more current physicians.

The Western Medical Consultants have also offered a medical opinion. After conducting a detailed review of applicant's medical history and performing an in-person examination, the Consultants issued an extensive opinion regarding his current condition and its relationship to the criminal incident. Concluding that applicant's condition had returned to its "pre-crime status," the Consultants determined that the only treatment applicant would need was psychiatric in nature and that his preexisting illness was the major contributing factor in his psychiatric symptomatology.

I find the Consultants' opinion to be both well-documented, as well as thoroughly explained. Therefore, I find their conclusions persuasive. Consequently, I rely on their conclusion that applicant's condition has returned to its "pre-crime status." Moreover, in light of this opinion, I am not persuaded that the extent of applicant's lost earnings and medical expenses attributable to the criminal incident exceeds the 33 1/3 percent award granted by the Department. Accordingly, I recommend that the Department's order be affirmed.

In reaching this conclusion, I recognize the profound physical, emotional, and financial trauma applicant has experienced as a result of this criminal attack. I further acknowledge applicant's desire to receive further compensation in order to advance his future educational, vocational, and economic options; i.e., improve applicant's "quality of life."[2] In response to these concerns, I can only offer the following comments.

Without question, the unprovoked violent act perpetrated on applicant is deplorable. Nonetheless, the issue for my resolution is not whether the incident occurred. To the contrary, the existence of this unfortunate criminal episode is undisputed. Rather, my statutory duty is to determine what portion of applicant's lost wages and medical expenses have resulted from that criminal incident. Based on my review of the medical opinions, I have concluded that applicant's condition has returned to its "pre-crime status" and that one-third of his lost earnings and medical expenses during the period of time in question are attributable to the attack.

ORDER

I recommend that the Department's Findings of Fact, Conclusions and Order dated October 9, 1990, as amended and reconsidered December 27, 1990, June 13, 1991, August 15, 1991, and November 14, 1991 be affirmed.

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[2] Applicant emphasized during his testimony that, despite the severity of his condition and the dire financial circumstances confronting him, he held neither grudges nor malice toward anyone. To the contrary, it was his fervent desire that Jason Barber, the Department's claim examiner, receive a written commendation for his tireless efforts throughout the processing of applicant's claim.

In the Matter of the Compensation of
NANCY L. COOK, Claimant
WCB Case No. 92-04610
ORDER DENYING RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration of the Board's May 28, 1993 Order on Review (Remanding), as reconsidered June 25, 1993. Concluding that the Referee erred in dismissing claimant's hearing request without requiring the parties to present evidence, the Board remanded for the completion of a reviewable record. The employer seeks further consideration of the Board's decision, contending that the present record is sufficiently developed to conclude that the employer's denial should be upheld.

In support of its contention, the employer reiterates its prior assertions that it was prepared to offer the testimony of "many witnesses" in support of its denial and that claimant failed to appear at hearing. In light of such circumstances, the employer argues that there is no justification for the additional private and public expense which will result from a rehearing, particularly when it considers the present record legally sufficient.

We acknowledge that further costs to the workers' compensation system will undoubtedly be incurred if another hearing is convened. Nevertheless, the likelihood of such added expenses cannot allow us to overlook the Board's statutory obligations. For the reasons expressed in the Board's prior orders, we consider the record as presently developed insufficient to determine whether the employer's denial was based on "later obtained" evidence and whether the employer has proven by clear and convincing evidence that the claim is not compensable. See ORS 656.262(6); CNA Insurance Companies v. Magnuson, 119 Or App 282 (1993). In reaching this conclusion, we further note that an attorney's unsworn representations do not constitute evidence. See SAIF v. Cruz, 120 Or App 65 (1993).

Consequently, the employer's request for reconsideration is denied. The Referee shall continue to proceed in accordance with the instructions contained in the Board's prior orders.

IT IS SO ORDERED.

In the Matter of the Compensation of
PENNY N. KESTER, Claimant
WCB Case No. 92-03744
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of those portions of Referee Peterson's order that: (1) found that her right shoulder claim had not been prematurely closed; and (2) declined to assess a penalty for the self-insured employer's allegedly unreasonable failure to authorize a diagnostic test. In its brief, the employer contends that the Referee should have found that it had established an entitlement to an offset. On review, the issues are premature closure, penalties and offset. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last two sentences in that section.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's conclusions on the issue of premature closure, and we add the following supplementation.

On review, claimant argues that, at the time of closure, Drs. Fuller and Reimer, the independent medical examiners, had recommended further non-invasive investigation of her right shoulder. Claimant contends that, until an MRI is performed, it will be impossible to determine whether further medical treatment will materially improve her condition.

We have previously held that a recommendation for further diagnostic services does not preclude a finding that a claimant was medically stationary at the time of closure. Linda F. Wright, 42 Van Natta 2570 (1990). Moreover, in this case, Dr. Kaesche, claimant's attending physician, recommended an MRI only if Dr. Fuller and the employer authorized the repeat test. As noted by the Referee, neither of those conditions occurred. Finally, we agree with the Referee's conclusion that the only medical evidence in the record regarding claimant's medically stationary status was provided by Drs. Fuller and Reimer who found claimant medically stationary on March 16, 1992. Consequently, we affirm the Referee on the issue of premature claim closure.

Penalties

We adopt the Referee's conclusion that claimant is not entitled to a penalty for the employer's allegedly unreasonable failure to authorize the MRI recommended by Dr. Kaesche.

Offset

As a preliminary matter, we note that claimant has argued that the employer should not be permitted to raise the issue of offset, as it did not timely cross-request review of the Referee's order. Although the employer did not formally cross-request review of the offset issue, we have previously held that, as part of our de novo review, we have the authority to consider issues that are raised other than by a formal cross-request for review. Syndee S. West, 44 Van Natta 968 (1992). Also see Destael v. Nicolai Company, 80 Or App 596 (1986). Accordingly, because the offset issue was decided by the Referee, we proceed to consider the issue on review.

The Referee concluded that the employer's termination of claimant (for failing to appear at work) was not justified and the employer had failed to establish that it was entitled to an offset of overpaid temporary disability benefits. On review, the employer argues that it is not relevant whether claimant's termination was justified. The employer contends that the only issue is whether claimant was released for regular work and was then terminated for reasons other than the compensable shoulder injury. We agree.

In Stone v. Whittier Wood Products, 116 Or App 427 (1992), the court held that the Board was not required to first determine whether a termination was unlawful before a claimant's entitlement to workers' compensation benefits could be determined. Rather, the court held that the reasons a worker was terminated, so long as they were not related to the compensable injury, were not relevant to the issue of entitlement to temporary disability benefits. Stone, supra; Henry L. Studer, 45 Van Natta 214 (1993).

Here, claimant does not contend that her termination was due to her injury. Moreover, she does not contest the amount of the employer's asserted overpayment. Rather, she argues that the employer is not entitled to an offset by virtue of its "unjustified" termination.

Under such circumstances, we conclude that claimant was released for work and was then terminated for reasons other than the compensable shoulder injury. Pursuant to the Stone case, we find that it is not relevant whether or not claimant's termination was "unjustified." Finally, because claimant has not contested the existence or the amount of the overpayment, we conclude that the employer is entitled to its asserted offset. Accordingly, that portion of the Referee's order is reversed.

ORDER

The Referee's order dated November 12, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that declined to award an offset is reversed. The self-insured employer is authorized to offset temporary disability benefits paid after August 14, 1991 against future awards of permanent disability. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
TERESA A. OLSON, Claimant
WCB Case No. 92-11404
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Schultz' order that upheld the self-insured employer's denial of claimant's aggravation claim for her cervical and right shoulder condition. Alternatively, claimant contends that the employer "de facto" denied a claim for a cervicodorsal strain that occurred at the time of the original injury. On review, the issues are aggravation and compensability. We affirm.

FINDINGS OF FACT

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

Claimant sought treatment on March 6, 1991 with Dr. Brown, not Dr. Brenner.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's opinion on this issue.

Compensability

We adopt the Referee's opinion on this issue, with the following supplementation.

Claimant contends that the employer de facto denied a claim for cervicodorsal strain made by the report of Dr. Bald on September 28, 1988. (Ex. 10). We disagree.

On January 14, 1988, claimant sought emergency room treatment. Dr. Brenner reported the following history: "[Claimant] lifted trash 2 days ago, felt something "pull" in right neck but had no real pain at time. Yesterday had mild discomfort, greater today." He found the neck to be nontender, the right trapezius tender. He diagnosed a right trapezius strain. (Exs. 3 and 4). The employer accepted the claim for the trapezius strain.

On September 28, 1988, claimant sought treatment for right neck and upper back pain which she attributed to the same injury. Dr. Bald found a mild spasm in the right trapezius and paraspinous muscles adjacent to the shoulder blade. He found no specific point tenderness in the neck and no limitations in neck range of motion. He diagnosed a mild, chronic, cervicodorsal strain. (Ex. 10). The symptoms for which claimant sought treatment were the same on both occasions. Despite the different medical terminology used by each doctor, there is no medical opinion stating that claimant sought treatment for a new or different condition than the one accepted by the employer.

ORDER

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

In the Matter of the Compensation of
JAMES M. REEVES, Claimant
WCB Case No. 92-11503
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The self-insured employer requests review of Referee Neal's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral hearing loss; and (2) awarded an assessed fee of $2,300. On review, the issues are compensability and attorney fees. We reverse in part, affirm in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant seeks compensation for bilateral hearing loss. Claimant filed previous claims for bilateral hearing loss in 1985 and 1989. Both claims were denied. Claimant did not appeal either of the denials.

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. Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563-64 (1989), rev den 309 Or 645 (1990). A worsening of the denied condition is considered a "changed" condition. See Kepford v. Weyerhaeuser, 77 Or App 363, 365, rev den 300 Or 722 (1986). Therefore, claimant is not barred from proving that a condition has worsened, even though that condition was the subject of an unappealed denial.

Here, the record contains two medical opinions regarding claimant's ear condition since the 1989 unappealed denial. Dr. Kaplan, otolaryngologist and claimant's treating physician, reported that, based on a review of past audiograms, claimant sustained a "significant drop in hearing on the left side between 1989 and 1990." (Ex. 32). He related the hearing loss in major part to claimant's occupational noise exposure. (Id.) However, he also stated that "significant hearing loss on the right side is unchanged since 1989." (Id.)

Claimant also was examined by Dr. Mettler, ENT specialist, for an independent medical examination. Dr. Mettler also reviewed previous audiograms, concluding that claimant had "slowly gotten better over the years" and that, since 1989, he had not "had any increase in his hearing loss." (Ex. 33).

Dr. Kaplan disputed Dr. Mettler's conclusion, stating that "noise related hearing loss is well known not to show an improvement with time" and that the most recent audiogram obtained in his office "documents a greater degree of hearing loss than noted on [the] 1989 audiogram." (Ex. 34). He further questioned the validity of Dr. Mettler's testing, stating that his audiogram "confirms the progression of the hearing loss noted in 1989." (Id.)

Absent persuasive reasons to the contrary, we give greater weight to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). We agree with the Referee that Dr. Kaplan's opinion is entitled to greater weight in this case. Dr. Kaplan's opinion is well-reasoned and based on a review of prior audiograms as well as an accurate history. Therefore, even assuming that Dr. Mettler's opinion is based on an accurate audiogram, we consider Dr. Kaplan's opinion to be more persuasive.

Based on Dr. Kaplan's opinion, claimant proved that the hearing loss in his left ear has worsened. Consequently, claimant is entitled to litigate compensability of the left ear. Because, according to Dr. Kaplan, the worsened hearing loss was, in major part, caused by claimant's employment, we conclude that he proved compensability of the hearing loss in the left ear. See ORS 656.802(2). However, Dr. Kaplan also indicated that the hearing loss in the right ear had not worsened. Accordingly, claimant is prevented from litigating compensability of the right ear condition since it was the subject of the unappealed 1989 denial. See Liberty Northwest Corp. v. Bird, supra.

Therefore, we reverse that portion of the Referee's order insofar as claimant's right ear hearing loss was found compensable. We affirm that portion of the Referee's order insofar as claimant's left ear hearing loss was found compensable.

Attorney Fees

Having found that claimant proved only the compensability of his left ear condition, we reduce the assessed attorney fee awarded by the Referee, which was based on claimant proving that he had compensable hearing loss in both ears. Furthermore, claimant's attorney is entitled to an assessed fee for services on review for prevailing against the employer's request for review regarding the compensability of claimant's left ear hearing loss. See ORS 656.382(2).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review with regard to the compensability of claimant's left ear hearing loss is $2,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issue and the value of interest involved.

ORDER

The Referee's order dated January 14, 1993 is reversed in part, affirmed in part and modified in part. That portion of the order setting aside the employer's denial insofar as it pertained to claimant's right ear hearing loss is reversed. The employer's denial insofar as it pertained to the right ear condition is reinstated and upheld. The Referee's assessed attorney fee award is modified. In lieu of the Referee's attorney fee award, for services at hearing and on review with regard to the compensability of claimant's left ear hearing loss, claimant's attorney is awarded an assessed fee of $2,500. The remainder of the order is affirmed.

In the Matter of the Compensation of
THOMAS L. ABEL, Claimant
Own Motion No. 91-0386M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant contends that the SAIF Corporation has failed to comply with our May 28, 1992 Own Motion Order and requests that we issue an order directing SAIF to comply with our earlier order and awarding claimant penalties and attorney fees for SAIF's alleged unreasonable resistance to payment of compensation. In response, SAIF argues that it has fully complied with our May 28, 1992 order.

Temporary Disability Compensation

In our May 28, 1992 order, we found that claimant's compensable injury worsened as of May 27, 1982, the date he was hospitalized and treated for a grand mal epileptic seizure. Thomas L. Abel, 44 Van Natta 1039 (1992). Furthermore, we concluded that claimant was in the work force at the time he was hospitalized in 1982. In that regard, we found that claimant "continued to seek work but was unable to find or keep work because of his seizure disorder and related depression." We authorized the "reopening of claimant's claim for the payment of temporary disability compensation beginning May 27, 1982, the date claimant was initially hospitalized for the accepted seizure condition." We ordered that, when appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

We also concluded that SAIF's delay of almost two years in submitting a recommendation to the Board constituted an unreasonable resistance to the payment of compensation. Because no compensation is due a claimant on an own motion claim until an order is issued reopening the claim, we found that there were no amounts "then due" upon which to base a penalty pursuant to ORS 656.262(10)(a). However, we assessed a penalty-related attorney fee of $3,000 for SAIF's unreasonable resistance to the payment of compensation. ORS 656.382(1).

SAIF requested reconsideration of our May 28, 1992 order, contending that we were without authority to award a penalty-related attorney fee under our own motion authority. SAIF did not request reconsideration of our conclusions regarding the temporary disability issue. On reconsideration, we adhered to and republished our prior order. Thomas L. Abel, on recon 44 Van Natta 1189 (1992).

SAIF then sought review of our decision by the Court of Appeals, again raising only the issue of the penalty-related attorney fee. However, SAIF subsequently withdrew its request for review. As a result, on February 18, 1993, the Court of Appeals issued an order of dismissal. Thus, our May 28, 1992 order, as reconsidered, is final.

When SAIF failed to pay temporary disability benefits for the entire period from May 27, 1982, claimant sought enforcement of our May 28, 1992 Own Motion Order through the Hearings Division. On July 12, 1993, Referee Neal issued an order which ordered SAIF to pay temporary disability benefits for the unpaid periods from May 27, 1982 and awarded penalties for SAIF's failure to pay these benefits and for its failure to timely pay other periods of temporary disability benefits. SAIF requested reconsideration of that order, contending that the Hearings Division did not have jurisdiction to enforce an order issued under the Board's own motion authority. On reconsideration, claimant agreed with SAIF's contention and the Referee withdrew her prior order.

We agree that the Hearings Division does not have jurisdiction to enforce an own motion order; instead, the Board in its own motion authority has sole jurisdiction to enforce its own motion orders. Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986).

Here, claimant requests that we enforce our May 28, 1992 order, contending that SAIF has failed to comply with that order in that: (1) SAIF has not paid temporary disability compensation for the periods from June 2, 1982 through May 30, 1985 and from July 2, 1985 through March 16, 1987; and (2) SAIF failed to timely pay other periods of temporary disability benefits.

SAIF requests that we refer this matter to the Hearings Division for a fact finding hearing, requesting "an opportunity to be heard." However, a fact finding hearing is not necessary in this case because the record is sufficiently developed to determine whether SAIF has complied with our former order. In any event, SAIF had its opportunity to be heard in the prior proceeding. If SAIF disagreed with our decisions regarding claimant's entitlement to temporary disability benefits, it should have requested reconsideration or appealed that issue to the court at that time. As discussed above, it did not do so.

Our May 28, 1992 order ordered SAIF to pay temporary disability benefits beginning May 27, 1982. When appropriate, the claim was to be closed pursuant to OAR 438-12-055. SAIF does not argue that claim closure is appropriate, nor does it argue that the temporary disability benefits accruing from the date of our order may be terminated pursuant to any provision of a statute or rule. In fact, SAIF continues to pay temporary disability benefits as they accrue.

Instead, SAIF argues that it has fully complied with our May 28, 1992 order and paid all temporary disability benefits due. In support of its argument, SAIF submits a schedule of payments made to claimant and a July 8, 1993 letter from Dr. Grossman, claimant's treating physician. The schedule of payments shows that SAIF has paid temporary disability payments to claimant for the period from May 27, 1982 to August 6, 1993, excluding the periods from June 2, 1982 through May 30, 1985 and from July 2, 1985 through March 16, 1987. SAIF essentially argues that Dr. Grossman's letter establishes that temporary disability benefits are not due during these excluded periods because claimant was not disabled during those periods.

SAIF's argument is against the law of the case. Our prior order found that claimant: (1) was disabled as of May 27, 1982; (2) was in the work force as of that date; and (3) continued to seek work but was unable to find or keep work due to his compensable condition. As discussed above, that order is final. SAIF may not now argue that claimant was not disabled during that time period. SAIF is not arguing that claimant's condition has changed and he is now able to work or he is now medically stationary. Instead, SAIF is arguing that claimant was not disabled during a time in which our prior order determined that he was disabled.

However, SAIF chose not to contest our findings regarding claimant's entitlement to temporary disability benefits within the appropriate time period. It may not do so now. 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).

Accordingly, SAIF is ordered to pay claimant temporary disability compensation for the periods from June 2, 1982 through May 30, 1985, and from July 2, 1985 through March 16, 1987.

Penalties and Attorney Fees

Claimant requests that we award penalties and attorney fees for the late payment and nonpayment of temporary disability benefits. We agree that SAIF's violations warrant penalties and attorney fees.

Late Payment of Temporary Disability Benefits Accruing from the Date of Our Order

OAR 436-60-150(4)(f) provides that, in order to be timely, payment of temporary disability benefits accruing from the date of the order shall begin no later than the 14th day after the order is issued. Id.

Our order was issued on May 28, 1992; however, it was withdrawn, reconsidered, supplemented, and republished on June 22, 1992. In addition, the parties' rights of appeal were extended to run from the date of our June 22, 1992 Own Motion Order on Reconsideration. Therefore, the date of our reconsideration order is the date from which we calculate the timely payment of the temporary disability benefits accruing from the date of our order. Thus, payment of temporary disability benefits accruing from the 14th day after June 22, 1992 should have begun on July 6, 1992.

Furthermore, OAR 436-60-150(5) provides, in relevant part, that "[t]emporary disability shall be paid to within seven (7) days of the date of payment at least once each 14 days." Therefore, SAIF's first payment of accruing temporary disability benefits should have been made on July 6, 1992, for the period from June 22, 1992 through June 28, 1992. However, SAIF made its first payment of temporary disability on July 14, 1992, for the period from June 22, 1992 to July 10, 1992. Thus, the payment for the period from June 22, 1992 through June 28, 1992 was late. SAIF offers no reason for this late payment. Consequently, we find its conduct to be unreasonable and base the penalty on that amount. Helen M. Chase, 42 Van Natta 1850, 1853 (1990); Catherine A. Medina, 38 Van Natta 384 (1987).

For SAIF's violation, we assess a penalty of 25 percent of the temporary disability benefits paid for the period from June 22, 1992 through June 28, 1992. Half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee for this violation. ORS 656.262(10).

Late Payment of Retroactively Awarded Temporary Disability Benefits

ORS 656.313(1)(a) provides, in relevant part, that "[f]iling by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed[.]" (emphasis added). As discussed above, although SAIF initially appealed our decision regarding the penalty-related attorney fee, it did not appeal our award of temporary disability compensation. The clear language of the statute allows a carrier to stay payment only of the compensation appealed. Here, because SAIF did not appeal the temporary disability compensation, it is not permitted to stay payment of that compensation. See Linda J. Huges-Smith, 44 Van Natta 1801 (1992).

OAR 436-60-150(4)(f) provides that, in order to be timely, payment of temporary disability benefits must be made no later than the 14th day after the date any litigation authorizing retroactive temporary disability becomes final. Here, because SAIF did not appeal the temporary disability compensation award, the litigation involving that award became final on July 22, 1992, 30 days from the date of our June 22, 1992 order on reconsideration. Therefore, payment of the retroactively awarded temporary disability compensation was due no later than 14 days from that date, or on August 5, 1992.

On October 2, 1992, SAIF made payments for retroactively awarded temporary disability compensation for the period from March 17, 1987 to June 22, 1992. On July 12, 1993, SAIF made payments for retroactively awarded temporary disability compensation for the periods from May 27, 1982 to June 1, 1982 and from May 31, 1985 to July 1, 1985. These payments were late, and SAIF offers no reason for these untimely payments.

We conclude that these unexplained late payments constitute an unreasonable delay in the payment of compensation. ORS 656.262(10). For this violation, we assess a penalty of 25 percent of the temporary disability benefits paid for the following periods: (1) from March 17, 1987 to June 22, 1992; (2) from May 27, 1982 to June 1, 1982; and (3) from May 31, 1985 to July 1, 1985. Half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee for this violation. ORS 656.262(10).

Nonpayment of Retroactively Awarded Temporary Disability Benefits

Following the same legal reasoning discussed in the "Late Payment of Retroactively Awarded Temporary Disability Benefits" section, we conclude that all of the retroactively awarded temporary disability compensation was due on August 5, 1992. SAIF has not yet paid temporary disability benefits for the periods from June 2, 1982 through May 30, 1985 and from July 2, 1985 through March 16, 1987.

As discussed above, SAIF contends that these amounts are not owed claimant because, it argues, claimant was not disabled during those periods. As concluded above, this contention is against the law of the case. Furthermore, we find it unreasonable for SAIF to rely on such a contention. If SAIF disagreed with our temporary disability award, its option was to appeal that award. SAIF does not have the option of failing to pay the award and attempting to relitigate the issue.

We conclude that SAIF's failure to pay all of the retroactive temporary disability compensation awarded by our prior order represents an unreasonable delay in the payment of compensation. ORS 656.262(10). For this violation, we assess a penalty of 25 percent of the unpaid temporary disability benefits for the periods from June 2, 1982 through May 30, 1985 and from July 2, 1985 through March 16, 1987. Half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee for this violation. ORS 656.262(10).

In summary, we assess the following penalties for SAIF's unreasonable delay in paying compensation and failure to pay compensation: (1) 25 percent of the temporary disability benefits paid for the period from June 22, 1992 through June 28, 1992; (2) 25 percent of the temporary disability benefits paid for the periods from May 27, 1982 to June 1, 1982, from May 31, 1985 to July 1, 1985, and from March 17, 1987 to June 22, 1992; and (3) 25 percent of the unpaid temporary disability benefits for the periods from June 2, 1982 through May 30, 1985 and from July 2, 1985 through March 16, 1987. Half of these penalty amounts shall be paid to claimant's attorney in lieu of an attorney fee. ORS 656.262(10).

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS L. BARNETT, Claimant
Own Motion No. 93-0215M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our August 6, 1993 Own Motion Order in which we declined to reopen his claim for own motion relief on the ground that he had not established that he was in the work force at the time of disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our August 6, 1993 order and granted the SAIF Corporation an opportunity to respond to the motion. SAIF's response has been received. After further consideration, we issue the following order.

In our August 6, 1993 Own Motion Order, we concluded that claimant had established that: (1) on May 15, 1990, his compensable cervical spine condition worsened requiring surgery; (2) in January 1990, his compensable injury made it futile for him to make any reasonable work search efforts; and (3) therefore, at the time of disability, his compensable condition made any reasonable job search futile. We continue to adhere to the reasoning and conclusions in our prior order concerning the above issues. However, in our prior order we also found that claimant had not proved that, but for the compensable injury, he would have been willing to work. Based on the parties' additional arguments and submissions, we reconsider our conclusion regarding claimant's willingness to work.

In order to prove that he was in the work force at the time of disability, claimant must prove that he is willing to work, even if efforts to find work would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant submits an August 23, 1993 affidavit in which he states that he worked as a timber faller for seven months out of the 1989 calendar year and was laid off during the winter months when work became less available. He also states that, while he was laid off, his condition worsened leading to a release from work followed by a request for surgery on May 14, 1990. Finally, claimant states that, but for his industrial injury, he would have taken available work in the woods when the weather permitted.

On this record, we find that claimant has proved that he remained willing to work, but for his compensable injury. As noted above, the record establishes that, in January 1990, any reasonable work search was made futile by the compensable injury. Therefore, we conclude that claimant has proved that he was in the work force at the time of disability. Dawkins v. Pacific Motor Trucking, supra.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning April 29, 1993, the date he was hospitalized for surgery. ORS 656.278(1)(a). 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 the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTO C. BAROCIO, Claimant
WCB Case No. 92-08451
ORDER ON REVIEW
Max Rae, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Howell's order that declined to assess a penalty and related attorney fee for the self-insured employer's allegedly unreasonable denial of his injury claim. Claimant also argues that the Referee erred in purporting to limit the nature and extent of compensation for the compensable injury, and he requests that this matter be remanded for further evidence taking. The employer cross-requests review of those portions of the Referee's order that: (1) set aside its denial of claimant's injury claim for a right rib fracture; and (2) awarded claimant an assessed attorney fee of $1,700 for his counsel's services at hearing. On review, the issues are compensability, remand, penalties and attorney fees.

We deny the motion for remand, and affirm and adopt the Referee's order with the following supplementation.

Compensability

We disagree with claimant's contention that the Referee "decided" whether his claim was disabling or nondisabling, or which medical services are compensable. The Referee's order set aside the employer's denial and remanded the claim "for acceptance of a compensable right twelfth rib fracture and the payment of any compensation due." The order does not purport either to classify the claim as disabling or nondisabling or to limit the amount of compensation due as a result of the rib fracture. Indeed, those issues were not actually litigated before the Referee.

The central issue actually litigated before the Referee was whether claimant had proved a compensable injury. In deciding that issue, it was essential for the Referee to determine that the work-related injury resulted in disability or required medical services. See ORS 656.005(7)(a). The Referee determined that claimant's injury required medical services, and thus concluded that claimant had proved a compensable injury. The determination of the extent of disability resulting from the injury, as well as the medical services required by the injury, must necessarily await processing of the claim. See Hanes v. Washington County Community Action, 107 Or App 304, 308, rev den 312 Or 234 (1991). Inasmuch as the extent of compensation due for the injury was not actually litigated before the Referee, the Referee's order has no preclusive effect on future litigation relating to the extent of such compensation. See Drews v. EBI Companies, 310 Or 134, 139 (1990).

We also disagree with claimant's contention that the Referee erred in "defin[ing] the scope of the conditions resulting from the injurious event." (See App. Br. at 3). Given the unreliability of claimant's complaints, the Referee found that claimant's only compensable injury is the rib fracture. The Referee's finding is consistent with the statutory requirement that a compensable injury be established by medical evidence supported by objective findings. ORS 656.005(7)(a). Here, the Referee correctly found that only the rib fracture is established by medical evidence supported by objective findings.

Remand

Finally, we disagree with claimant's contention that the record is insufficiently developed and must be supplemented with additional evidence on remand. Under ORS 656.295(5), we may remand

the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, we must find that the additional evidence: (1) was not obtainable at the time of hearing; and (2) 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).

We find that claimant had an opportunity to present evidence at hearing establishing the compensability of his injury claim. We also find that the additional medical reports submitted with claimant's appellate brief, though dated after the hearing, could have been obtained with due diligence prior to the hearing. Further, even were we to consider those reports, we are not persuaded that they are reasonably likely to affect the outcome of this case.

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as attorney fees are not compensation, claimant is not entitled to an assessed fee for defending the Referee's attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 6, 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
MIGUEL A. CARDONA, Claimant
WCB Case No. 91-17381
ORDER ON REVIEW
Royce, Swanson, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Crumme's order that: (1) declined to assess penalties for the SAIF Corporation's allegedly unreasonable denial of claimant's back injury claim; and (2) awarded claimant's counsel an assessed attorney fee of $2,500 for services concerning SAIF's denial. SAIF initially requested review, but subsequently withdrew that request. We previously dismissed that request for review. In response to SAIF's action, claimant requests an assessed attorney fee for services on Board review concerning SAIF's withdrawal of its appeal and an assessed attorney fee for SAIF's allegedly unreasonable request for review. On review, the issues are penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Penalties

The Referee concluded that SAIF's denial was not unreasonable and therefore declined to assess a penalty. We disagree.

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. If the carrier based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). The carrier'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).

Mr. Lowe, the employer's owner and president, testified that he received a phone call on November 8, 1991 during which he was informed that claimant had sustained a back injury at work the previous day. (Tr. 72, 73). Thereafter, Mr. Lowe prepared an 801 form reporting the injury. (Ex. 1). In the employer section of the 801 form, Mr. Lowe indicated that claimant "left the building without notifying supervisor. The next day I was notified that the injury occurred. Other workers in [claimant's] department were not aware of injury." (Ex. 1). Mr. Lowe sent the 801 form to SAIF on November 13, 1991.

A November 8, 1991 emergency room report indicated that claimant had injured his low back at work in a lifting incident. (Ex. 1B). A November 14, 1991 treatment form also indicated that claimant had sustained a work injury. (Ex. 1A). However, on November 21, 1991, SAIF issued its denial of claimant's low back injury on the basis of insufficient evidence. (Ex. 2).

SAIF issued its denial approximately eight days after the employer sent it the 801 form. While claimant did not immediately report the incident when it happened, he promptly reported it the following day. Nothing on the 801 form indicates that the injury was not work-related. Under such circumstances, the mere fact that the incident was unwitnessed is not enough to give SAIF a legitimate doubt as to its liability absent further corroborating evidence. Moreover, the emergency room report also indicated that the injury was work-related. Finally, the November 14, 1991 treatment form also indicated that claimant's injury was work-related. In short, SAIF performed no investigation prior to issuing its denial.

Under these circumstances, we conclude that SAIF did not have a legitimate doubt as to its liability and therefore its denial was unreasonable. Kenneth A. Foster, supra. Accordingly, we assess a penalty based on all amounts due at the time of the hearing as a result of the Referee's compensability decision, to be paid in equal shares to claimant and his attorney. ORS 656.262(10)(a).

Attorney Fees

Board Level

Claimant's counsel contends that he is entitled to an attorney fee for services rendered before this forum prior to SAIF's withdrawal of it appeal. We disagree.

When a request for Board review is dismissed without a decision on the merits, we are without authority to award attorney fees under ORS 656.382(2). Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1991). Therefore, claimant request for an attorney fee on this basis is denied.

Hearings Level

Alternatively, claimant contends he is entitled to an increased attorney fee pursuant to ORS 656.386(1) for finally prevailing against SAIF's denial. As noted above, claimant is not entitled to an assessed attorney fee for services rendered before this forum. However, claimant did prevail against SAIF's denial at hearing. The Referee awarded claimant's counsel a $2,500 assessed attorney fee for services rendered at hearing in connection with SAIF's denial.

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 $2,500 assessed attorney fee reasonably compensates claimant's counsel for efforts at the hearings level. In reaching this conclusion, we have particularly considered the time

devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved. [1]

Unreasonable Appeal

Finally, claimant's counsel contends he is entitled to an attorney fee under ORS 656.382(1) on the basis that SAIF's appeal was unreasonable. However, we have previously held that the Board does not have the authority to assess a penalty or related attorney fee for a vexatious, unreasonable or frivolous appeal. See Verl E. Smith, 43 Van Natta 1107 (1991); Donald G. Messer, 42 Van Natta 2085 (1990). Consequently, even assuming that SAIF's appeal had been unreasonable, we would be without authority to grant claimant's request.

ORDER

The Referee's order dated December 18, 1992 is reversed in part and affirmed in part. That portion which declined to assess a penalty for SAIF's unreasonable denial is reversed. The SAIF Corporation is assessed a penalty based on all amounts of compensation due at the time of hearing as a result of the Referee's compensability decision, to be paid in equal shares to claimant and his attorney. The remainder of the order is affirmed.

[1] SAIF requested remand to further develop the record on this attorney fee issue. Inasmuch as we do not consider the present record to be incompletely, improperly, or insufficiently developed, that request is denied. ORS 656.295(5).

September 22, 1993 Cite as 45 Van Natta 1775 (1993)

In the Matter of the Compensation of
CINDY D. CLARK, Claimant
WCB Case Nos. 92-10208 & 92-08923
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Barber's order that found that claimant's back claim should be processed as an aggravation, rather than a new injury. On review, the issue is claims processing. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's back claim constituted an aggravation, rather than a new injury. On review, claimant asserts that her claim should be processed as a new injury occurring on June 29, 1992.

In Peggy Holmes, 45 Van Natta 278 (1993), which was issued subsequent to the Referee's order, we noted that under the law in effect prior to the 1990 legislative changes, the test for determining whether a claim should be processed as an aggravation or a new injury/disease was the same test applied in subsequent employer situations. See Teresa L. Walker, 41 Van Natta 2283 (1989). In other words, prior to the 1990 changes, we had determined that a claimant did not establish entitlement to compensation for a new injury -- as opposed to an aggravation -- unless she proved that her subsequent injury or work exposure independently contributed to a worsening of her prior underlying condition. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986); Teresa L. Walker, supra.

In Holmes, we conformed the test for distinguishing new injuries from aggravations, in cases involving the same employer/insurer, to current responsibility law. See ORS 656.308(1); Peggy Holmes, supra. Consequently, we concluded that a new injury is established by proof that the later injury is a material contributing cause of the disability and/or need for treatment and a new occupational disease is established with proof that the later work exposure is the major contributing cause of a worker's current condition. See Duane R. Dickey, 45 Van Natta 1663 (1993). Therefore, in the present case, in order to establish a "new injury," claimant must show that the June 29, 1992 incident was a material contributing cause of her disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

Here, claimant testified that she never completely recovered from her May 11, 1990 injury and that she has had problems off and on since then. (Tr. 7). Claimant also testified that since the 1990 injury, she has periodically experienced sharp pains lifting at work or at home. (Tr. 13).

On June 30, 1992, claimant was treated in the emergency room by Dr. Anderson who diagnosed an aggravation of chronic back strain. In July 1992, claimant saw Dr. Langdon whose chart notes indicate that claimant was moving boxes of glassware when she aggravated her previous back injury. Dr. Langdon referred claimant to Dr. Franks, who saw claimant on August 12, 1992. Dr. Franks reported that claimant "reinjured" herself on June 29, 1992 when she was moving boxes of glassware. Prior to the June 1992 incident, claimant had been receiving ongoing treatment for the effects of the 1990 compensable back injury from Dr. Day, chiropractor.

Based on the preponderance of the evidence in the record, we agree with the Referee that claimant's back condition was a continuation of her 1990 compensable injury rather than a new injury. Accordingly, we conclude that claimant's claim should be processed as an aggravation claim.

ORDER

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

In the Matter of the Compensation of
MICHAEL A. DIPOLITO, Claimant
WCB Case No. 92-04390
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Jaime Goldberg (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Neal's order that awarded a $100 assessed attorney fee for claimant's counsel's services in setting aside the SAIF Corporation's "de facto" denial of a medical bill. On review, the issue is attorney fees.

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

Claimant contends that the Referee's attorney fee award was unreasonably low and seeks a fee of $750 to $1,000.

This matter arose when SAIF was mistakenly billed for a nonexistent CT scan. After a hospital audit, an unpaid $90 x-ray bill was discovered and paid. SAIF paid the bill as a result of its claims examiner's investigation of the CT bill with the hospital. SAIF's examiner had no contact with claimant's counsel and the claims examiner did not know what claimant's hearing request was about. The efforts of claimant's attorney in this case consisted of filing a hearing request. Claimant's attorney offers no proof of the amount of time he spent on this matter, and aside from representations concerning his office overhead, does not address the factors set forth in OAR 438-15-010(4). Based on this record, and having considered the factors set forth in OAR 438-15-010(4), we conclude that the Referee's attorney fee award is reasonable in light of claimant's counsel's efforts in filing a hearing request and securing payment of the $90 x-ray bill.

ORDER

The Referee's order dated November 30, 1992 is affirmed.

In the Matter of the Compensation of
WILLIAM J. EMERY, Claimant
WCB Case Nos. 92-10927 & 92-06427
ORDER ON RECONSIDERATION
Susan D. Isaacs, Claimant Attorney
Lundeen, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Liberty Northwest Insurance Corporation requests reconsideration of those portions of our July 29, 1993 Order on Review that: (1) directed that the Referee's assessed attorney fee award be paid by Liberty Northwest, rather than Kemper Insurance Company (Kemper); and (2) awarded claimant an assessed attorney fee, payable by Liberty Northwest, for claimant's counsel's services on Board review. In order to allow sufficient time for consideration of Liberty Northwest's motion, we abated our order on August 26, 1993. Claimant has timely responded to Liberty Northwest's motion. Inasmuch as the time to submit further responses has expired, we proceed with our reconsideration.

At hearing, claimant's right to compensation was at risk due to Kemper's assertion that claimant's request for hearing of its denial was untimely. That assertion justifiably prompted claimant's active participation at hearing to protect his right to compensation. Liberty's denial stated it was denying claimant's claim for aggravation on the basis that, although claimant's current condition was compensable, work activities with his subsequent employer (Kemper's insured) were responsible. Therefore, Liberty did not place claimant's compensation at risk. Since Kemper created the need for claimant to establish the compensability of his claim, Kemper remains responsible for the Referee's $2,000 attorney fee for services at the hearing level. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod on recon 119 Or App 447 (1993); SAIF v. Bates, 94 Or App 666 (1989).

Furthermore, due to our de novo review authority, claimant's compensation was also at risk on Board review due to Kemper's appeal. Dennis Uniform Manufacturing v. Teresi, supra. Because claimant's compensation was at risk of disallowance as a result of Kemper's appeal, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, also payable by Kemper. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

In his response, claimant requests an assessed fee for services rendered in responding to Liberty Northwest's motion. Inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for counsel's services on reconsideration for defending against the attorney fee issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, the Referee's $2,000 assessed attorney fee award shall be paid by Kemper. The $500 assessed fee for claimant's counsel's services on review shall also be payable by Kemper. On reconsideration, as modified and supplemented herein, we adhere to our July 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
MYCHAEL K. FOSS, Claimant
WCB Case No. 92-12017
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Galton's order that: (1) dismissed claimant's request for hearing; and (2) did not set aside the SAIF Corporation's partial denial of claimant's claim for seizures. On review, the issues are propriety of the dismissal and, if the dismissal was improper, compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact," except we do not find that claimant abandoned his request for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee granted SAIF's motion to dismiss claimant's hearing request, because he found that claimant abandoned his hearing request and that, in failing to attend a scheduled independent medical examination, claimant engaged in conduct that resulted in unjustified delay of the hearing. See OAR 438-06-071; Ring v. Paper Distribution Services, 90 Or App 148 (1988); see also David M. Foote, 45 Van Natta 270 (1993) (Where the claimant's failure to attend IMEs prevented the employer from obtaining evidence to support its denial, remand appropriate to direct referee to: (1) issue an interim order to attend IME; and (2) if the claimant refuses to attend, consider dismissal of claimant's hearing request for unjustified delay). We agree that claimant's failure to attend the IME prevented SAIF from preparing its case and thus caused unjustified delay of the hearing on the merits. Accordingly, dismissal was proper.

However, in reaching this result, we do not find that claimant abandoned his hearing request, based on his failure to appear at hearing. See Williams v. SAIF, 99 Or App 367 (1989) (Neither OAR 438-06-071 nor ORS 656.283(7) requires claimant to personally attend a hearing); Mario Miranda, 42 Van Natta 405 (1990) (A hearing should not be dismissed simply because claimant failed to attend).

ORDER

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

In the Matter of the Compensation of
KEVIN E. SAHLFELD, Claimant
WCB Case No. C3-02277
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On August 27, 1993, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The proposed agreement states that claimant has received the Department's informational enclosure, and that it is attached and incorporated by reference. (Page 4, Lines 18 - 23). Notwithstanding this statement, the informational enclosure has not been attached to the agreement, nor is it present in the file.

Without such an "incorporated" attachment, the proposed agreement is considered incomplete for purposes of review. Additionally, the agreement is deficient for our review because it fails to provide the date of first claim closure. See OAR 436-60-145(4)(b).

Finally, the proposed agreement provides that the remaining unpaid balance of claimant's permanent disability award, due from an Order on Reconsideration, "shall be accelerated and paid at the same time as the sums due under this CDA." (Page 3, Lines 3 - 7). For the following reasons, we are unable to approve a CDA containing such language.

The CDA identifies its consideration as $21,000 (less a $3,975 attorney fee). Nevertheless, the agreement further provides that the remaining balance of claimant's permanent disability shall be accelerated and paid along with the CDA. The acceleration of permanent disability awards is an action which is expressly within the Director's discretion. ORS 656.230; Erven Simril, 43 Van Natta 629 (1991). Thus, we are without authority to authorize such an action.

Parenthetically, it appears that it is the parties' intentions to achieve the following result. One, claimant should receive the unspecified remaining balance of his permanent disability award. In addition, claimant should receive $21,000 (less a $3,975 attorney fee).

In the interest of assisting the parties to eventually achieve their mutually desired objective in an efficient manner and in compliance with Board authority, we offer the following comments. We would not object to a CDA which settled the amount of the remaining balance of claimant's permanent disability award, as long as the amount of that award is specifically identified and added to the other CDA proceeds. Thus, the consideration listed in the CDA would be increased by the amount of the remaining balance of claimant's permanent disability awards. (Since the award would not have been entirely paid and the pending CDA was releasing claimant's right to past, present and future rights to permanent disability, this "remaining balance" increase would constitute consideration.)[1]

[1] We find this approach to be consistent with our prior decisions holding that overpayments and an insurer's forebearance of its right to pursue an offset cannot serve as consideration for a claimant's release of certain rights. See e.g. Raymond E. Clonkey, 43 Van Natta 1778 (1991). In the cases concerning offset, we found that the disability payment had already been paid and the carrier presumably had a legal duty to make such payments. Timonthy W. Moore, 44 Van Natta 2060 (1992). In the present case, however, SAIF was under no duty to pay more than the required monthly permanent disability payments, claimant's permanent disability award had not been completely paid, and once the CDA was submitted, SAIF was entitled to stay payments of permanent disability, pending approval of the CDA. ORS 656.236(3). Accordingly, the CDA provision detailing payment of the remaining balance constitutes consideration.

Furthermore, where the parties did not intend for claimant's counsel to receive an attorney fee from the "accelerated" permanent disability award, the CDA attorney fee would remain unchanged. Finally, in submitting such a CDA, claimant would include a letter requesting dismissal of his hearing request regarding the permanent disability issue once the CDA was approved.

In conclusion, because the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we hold that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1991). 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 SAIF Corporation shall recommence payment of any temporary or permanent disability that was stayed by the 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
ESTHER M. ANDERSON, Claimant
Own Motion No. 93-0245M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested the Board reconsider our July 1, 1993 Own Motion Order, as reconsidered on July 30, 1993, in which we declined to reopen her claim for own motion relief on the ground that she had not established she was in the work force at the time of her disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we withdrew our July 1, 1993 order, as reconsidered on July 30, 1993, and granted the SAIF Corporation an opportunity to respond to the motion. SAIF's response has been received. After further consideration, we issue the following order.

In our prior orders, we concluded that claimant's condition worsened requiring surgery in March 1993. Therefore, we found that, in order to establish entitlement to temporary disability benefits, claimant had to prove that she was in the work force as of March 1993. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). In addition, we found that the work injury made it futile for claimant to make a job search at the time of her March 1993 worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). We continue to adhere to the reasoning and conclusions in our prior orders concerning the above issues.

However, in our prior orders, we also found that claimant had not proved that, but for the compensable injury, she was willing to work. Without proof of that essential element, we concluded that claimant failed to establish that she was in the work force. Based on the parties' additional arguments and submissions, we reconsider our conclusion regarding claimant's willingness to work.

Claimant submitted an August 23, 1993 affidavit, in which she attests that she has not worked since a prior surgery in 1990, but has been willing to work since then and through the date of the affidavit. She also stated that she has been unable to meet the demands of employment and the requirements of her job with Franklin Capital, Inc. Also, in a letter dated August 20, 1993, Ms. McKay-Anderson, Vice President of Operations for Franklin Capital, Inc., stated that claimant "has expressed a desire to return, and was doing so at the time of and up to her surgery in March 1993."

SAIF argues that the letter from Franklin Capital, Inc. is not persuasive evidence of the work force issue because there is no indication that claimant was ever employed by Franklin Capital, Inc. We disagree. We find that Ms. McKay-Anderson's statements establish that claimant previously worked at

Franklin Capital and continued to express a desire to do so until her March 1993 surgery. Furthermore, Ms. McKay-Anderson also stated that the firm would have rehired claimant if she had been physically able to do the job.

On this record, we find claimant was willing to work at the time of disability, although her compensable injury made futile any reasonable efforts to return to work. Thus, we find that claimant was in the work force at the time of disability. Weyerhaeuser v. Kepford, supra; Dawkins v. Pacific Motor Trucking, supra.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning March 2, 1993, the date she was hospitalized for 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. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANTHONY FOSTER, Claimant
WCB Case No. 92-06071
ORDER OF ABATEMENT
Coons, Cole & Cary, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our August 26, 1993 Order on Review that awarded an assessed attorney fee in the amount of $10,000 for claimant's counsel's services at hearing and on review concerning the compensability issue. In order to further consider this matter, we withdraw our prior order. After completion of our reconsideration, we shall issue our decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD A. MURPHY, Claimant
WCB Case No. C3-01937
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Royce, Swanson, et al., Claimant Attorneys
Liberty Northwest, Insurance Carrier

Reviewed by Board Members Neidig and Gunn.

On July 20, 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 disapprove the proposed agreement.

Here, the wording of the proposed agreement contains certain language which the Board has concluded may limit claimant's accepted condition(s) and/or medical treatment for those accepted conditions. Specifically the agreement states:

> "The accepted conditions which are the subject of this disposition are all compensable conditions arising out of the injurious exposure * * * and include the

following: cervical strain, right shoulder strain and discectomy with fusion at C5-6. Such conditions may be limited by other proceedings on this claim. This disposition does not limit reasonable and necessary medical treatment related to such compensable conditions attributable to this claim. (Emphasis added).

The Director's rules provide that a proposed claim disposition agreement must identify the accepted conditions that are the subject of the disposition. OAR 436-60-145(4)(a). See Karen I. Vega, 43 Van Natta 176 (1991). Here, the first sentence quoted above suggests that additional conditions may have been accepted, but only three conditions are specifically identified.

Furthermore, although the second sentence quoted above may be provided for informational purposes only, the Board has routinely held that CDA's may dispose of only accepted conditions. See Frederick M. Peterson, 43 Van Natta 1069 (1991). Thus, any language which could be construed to refer to a denial is objectionable.

Finally, the third sentence refers to reasonable and necessary medical services related to the compensable condition. We have previously held that such language could be interpreted to limit a claimant's right to medical services. See Kenneth D. McDonald, 42 Van Natta 2307 (1990).

Consequently, by letter of July 29, 1993, we requested an addendum to clarify the accepted conditions and delete or clarify the abovementioned language in the agreement. 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 return it to the parties.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAY PITMAN, Claimant
WCB Case No. 92-09201
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Crumme's order that: (1) declined to award claimant temporary disability compensation; and (2) declined to assess penalties or attorney fees for an allegedly unreasonable failure to pay temporary disability. On review, the issues are temporary disability and penalties and attorney fees. We vacate.

PRELIMINARY MATTERS

Subsequent to the filing of the briefs, the employer submitted a memorandum of supplemental authorities. 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 (1986). Accordingly, we allow the employer's submission, but consider it only to the extent that it advises us of recent developments in the law.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary disability

Claimant was injured in December 1991. The claim was accepted as a nondisabling injury. However, beginning in April 1992, claimant experienced disabling symptoms. On June 12, 1992, Dr. Serrurier reported to the employer that the claimant was unable to work. (Ex. 4B). The employer did not commence payment of temporary disability. However, on June 30, 1992, the employer requested the Department to issue a Determination Order regarding claimant's disabling/nondisabling claim status. (Ex. 5). Thereafter, the claimant filed a request for hearing seeking temporary disability from April 1992 through the date of hearing. At the time of the October 6, 1992 hearing, the Department had not issued a Determination Order resolving the matter.

The Referee found he had jurisdiction to decide claimant's entitlement to procedural temporary disability on a claim where the employer had requested the Department to make a determination on whether claimant's claim was disabling or nondisabling. Despite this favorable jurisdiction ruling, the Referee nonetheless concluded that because the claim was presently classified as nondisabling, claimant was not entitled to an award of temporary compensation.

ORS 656.268(11) provides that upon receipt of a request made pursuant to ORS 656.262 or ORS 656.277, the Department of Insurance and Finance shall determine whether the claim is disabling or nondisabling. Thus, the Board does not have original jurisdiction to determine whether claimant's claim has become disabling. Rather, jurisdiction lies with the Director. See Christine A. Degrauw, 44 Van Natta 91 (1992), rev'd on other grounds, DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993). Nor does the Board have jurisdiction to determine substantive entitlement to temporary disability. That determination will also be made by the Department at the time of claim closure.

We have previously decided that under certain circumstances, we have jurisdiction over matters pertaining to procedural entitlement to temporary disability. See Ralph E. Fritz, 44 Van Natta 1168 (1992); Steven V. Bischof, 44 Van Natta 255, on recon 44 Van Natta 433 (1992). Although these cases are instructive, we conclude those decisions are not applicable here.

In Bischof, the claim was classified as disabling. The employer, upon receiving medical verification of disability, began making temporary disability payments. After an investigation, however, the employer issued a denial denying the claim was disabling. Temporary disability payments were terminated. The claimant requested reclassification by the Department. Prior to the Department's decision, the claimant requested a hearing for unlawful termination of temporary disability. We held that the Board had limited jurisdiction to decide claimant's entitlement to procedural temporary disability where the employer had unilaterally terminated temporary disability benefits in contravention of ORS 656.268(3). In so holding, the Board did not reach the disabling/nondisabling status issue, nor the substantive entitlement issue. See Steven V. Bischof, supra.

In Fritz, the claim had been initially classified as nondisabling. A Notice of Closure closed the claim. Thereafter, the claimant requested a hearing seeking interim compensation. We held that we did not have jurisdiction over issues pertaining to the Notice of Closure, but that we did have jurisdiction to consider the claimant's entitlement to interim compensation in accordance with ORS 656.262(4). We asserted jurisdiction over the interim compensation issue because we found that the actual issue was the claimant's procedural entitlement. The order emphasized that the issues of disabling/nondisabling status and substantive entitlement were not before the Board. See Ralph E. Fritz, supra.

Implicit in the Fritz and Bischof decisions is the underlying policy that the function of ORS 656.262 and ORS 656.268 is to provide for the orderly processing of claims, i.e., the carrier's procedural obligations. See Doris A. Pace, 43 Van Natta 2526 (1991); Soledad Flores, 43 Van Natta 2504 (1991). In these matters the Board has jurisdiction to enforce compliance with statutes which expressly pertain to the obligation to begin the payment of interim compensation or which authorizes termination of temporary disability. This case, however, does not pertain to either of these specific statutory obligations and entitlements. Interim compensation is not at issue. Nor is any alleged unlawful termination of temporary disability an issue. Thus, we are not concerned with the question of whether or not the carrier has failed to fulfill its procedural obligations with regard to this claim.

Rather, we find that the "actual issue" here is whether or not the compensable injury, which was accepted as nondisabling, has become disabling within one year of the injury. At the time of hearing, this precise question of claim status was pending before the Director for resolution. In any event, the statutory scheme clearly contemplates that the Director will review, in the first instance, a claim that a nondisabling injury has become disabling. See ORS 656.262, ORS 656.268(11); ORS 656.277. Because claimant's entitlement to temporary disability depends on whether the compensable condition has become disabling, were we to assert jurisdiction, we would necessarily decide the issue that is specifically given to the Director, a fact which distinguishes this case from Bischof and Fritz.

If the Director determines that the claim has become disabling, the insurer would have the duty to commence payment of temporary disability benefits. Should the insurer fail to comply with its statutory obligation to pay temporary disability awarded by the Director, claimant could seek enforcement of the order by requesting a hearing with the Board. Alternatively, any party that disagrees with the Director's "reclassification" determination may request a hearing under ORS 656.283. See Walter T. Driscoll, 45 Van Natta 391 (1993).

Penalty and attorney fee

Claimant seeks entitlement to a penalty and/or assessed fee on the grounds that the employer unreasonably failed to pay temporary disability. Inasmuch as we have found no jurisdiction over the temporary disability issue, it therefore follows we do not have jurisdiction over this issue as well. ORS 656.262(10)(a).

ORDER

The Referee's order dated November 4, 1992 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

In the Matter of the Compensation of
DAVID J. ROWLEY, Claimant
WCB Case No. 90-20805
ORDER OF ABATEMENT
Peter O. Hansen, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Claimant requests reconsideration of those portions of our August 26, 1993 Order on Review which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a bilateral trigger finger condition; and (2) reversed the Referee's attorney fee award. Regarding his aggravation claim, claimant argues that our holding is inconsistent with prior case law holding that a claimant who has not received a prior award of permanent disability is not required to prove that his alleged worsened condition exceeds any disability for which he was previously compensated. Claimant also contends that his attorney is entitled to an assessed fee for prevailing against SAIF's compensability denial.

In order to further consider this matter, we withdraw our prior order. SAIF is granted an opportunity to respond to claimant's motion. 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
KAREN L. TAYLOR, Claimant
WCB Case No. 92-12387
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Barber's order that: (1) declined to consider a medical report; and (2) affirmed an Order on Reconsideration awarding no permanent disability. On review, the issues are evidence and extent of permanent disability.

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

In January 1990, claimant compensably injured her back and right hip. In June 1992, the SAIF Corporation issued a Notice of Closure awarding no permanent disability. A September 11, 1992 Order on Reconsideration affirmed the Notice of Closure.

At the hearing, claimant offered Exhibit 16A (an August 10, 1992 letter from Dr. Noyes, claimant's treating physician, which provided claimant's range of motion findings) and Exhibit 19 (an October 19, 1992 letter from Dr. Noyes clarifying that the range of motion findings contained in Exhibit 16A were based on a July 23, 1992 examination). Although admitting Exhibit 16A, the Referee refused to admit Exhibit 19 because it was not submitted or considered during the reconsideration proceeding. Claimant challenges this ruling, asserting that the report is admissible under ORS 656.268(5) because it corrects and clarifies Exhibit 16A, which was considered on reconsideration and admitted at hearing.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court considered the admissibility of documents at hearing in view of ORS 656.268(5). That statute limits the evidence that may be submitted at the reconsideration proceeding to that which corrects erroneous information and medical evidence that should have been submitted by the attending physician at the time of claim closure. Finding that ORS 656.283(7), which pertains to the presentation of evidence at hearing, contained no similar limitation, the court held that the Referee may consider evidence that could not have been submitted to the Director on reconsideration. Id.

We recently applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7); 656.283(7)) were applicable. Id.

Here, Exhibit 19 was not considered by the Referee because it was not within the limitations imposed by ORS 656.268(5). However, pursuant to Smith and Luciani, ORS 656.268(5) is not applicable to evidence submitted at hearing. Since there is no other basis for preventing the admission of this attending physician's report, and because it is already in the record, we admit it into evidence and proceed with our review. See Warren G. Kucera, 43 Van Natta 2782 (1991).

After considering Exhibit 19, however, we conclude that claimant did not prove any permanent impairment. We agree with the Referee that Dr. Noyes provided inconsistent opinions regarding claimant's condition. Dr. Noyes initially reported that claimant had "no physical objective findings to lead to an impairment status." (Ex. 14). However, Dr. Noyes subsequently reported that claimant exhibited "a considerable loss of range of motion" and recommended against a return to her regular work. (Exs. 16A, 19). We find no support for claimant's assertion that Dr. Noyes' reports are not inconsistent because his reference in the first report to the absence of "physical objective findings" did not take into account work restrictions and decreased range of motion. Rather, we find that Dr. Noyes' first report is most reasonably construed as finding that claimant demonstrated no permanent impairment.

Consequently, having found that Dr. Noyes provided inconsistent opinions, we find that his opinion is entitled to no weight. The record contains no other evidence showing that claimant has permanent impairment. Therefore, we agree with Referee that claimant failed to prove entitlement to permanent disability.

ORDER

The Referee's order dated January 19, 1993 is affirmed.

In the Matter of the Compensation of
DONNA L. ARMSTRONG, Claimant
WCB Case No. 90-21929
ORDER ON REVIEW
Howser & Munsell, Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mongrain's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a psychological condition, and (2) declined to assess penalties or attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT AND ULTIMATE FACT

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

We do not adopt the Referee's finding of ultimate fact (4).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's psychological condition is not compensable. He reasoned that the evidence did not clearly and convincingly demonstrate that conditions not generally inherent in every working situation were the major contributing cause of that condition. We disagree.

To establish the compensability of a mental disorder as an occupational disease under ORS 656.802(1)(b), claimant must prove that her work activities were the major contributing cause of her condition or the worsening of her underlying condition and must establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Elizabeth A. Hallyburton, 44 Van Natta 852 (1992). Moreover, she must prove that: (1) the employment conditions that produced the mental disorder exist in a real and objective sense; (2) those conditions are not generally inherent in every working situation and are not the result of reasonable disciplinary or corrective actions; and (3) her condition has been diagnosed as a mental or emotional disorder that is generally recognized in the medical or psychological community. ORS 656.802(3)(a)-(d). Finally, the evidence must clearly and convincingly show that the mental disorder arose out of and in the course of employment. Penny L. Wilson, 44 Van Natta 85, 86 (1992).

Diagnosable Mental Disorder

Claimant filed her claim on May 25, 1990, contending that employment conditions from February 1990 to May 1990 had caused her mental disorder. The only medical reports that purport to diagnose claimant's mental disorder at that time are provided by a consulting psychiatrist, Dr. Saville, M.D., and by two independent medical examiners, Dr. Turco, M.D., and Dr. Holland, M.D.

Dr. Saville diagnosed claimant as suffering from major depression with melancholia. Dr. Holland diagnosed a dysthymic reaction. He explained that dysthymia and major depression are essentially different degrees of the same disorder, and that both are generally recognized psychological conditions. (Tr 4-99).

Dr. Turco diagnosed claimant's condition as substance abuse habituation on prescribed medications. (Tr 3-129). However, we find that he based his diagnosis on inaccurate and unreliable history. He believed that claimant had been taking the prescribed medications for approximately 10-15 years, had been taking up to 500 Fiorinal pills per year, and had received 7 doses of Demoral in 1991. (Tr 3-129, 162)

The record reflects that claimant had been prescribed a small quantity of narcotics and barbiturates in 1974 and 1975, but there is no evidence that she ever took those medications. (Tr 3-178). Dr. Turco admitted on cross-examination that those facts did not suggest a long-term drug addiction. He further admitted that he was unaware of claimant's daily drug usage. (Tr 3-234). The record also reflects that claimant began taking approximately 30 Fiorinal per month in December 1987, not the 500 per-year assumed by Dr. Turco. Dr. Sullivan, M.D., a consulting neurologist, stated that that dosage and duration did not indicate a drug addiction. (Ex 65, 13, 15). Dr. Saville examined claimant in December 1990, and also concluded that claimant is not a substance abuser.

Other portions of the record raise questions regarding whether Dr. Turco had an accurate history. For example, he opined that claimant's concern about her husband's health was a major stressor. However, he subsequently admitted that he was aware that claimant's husband had no health problems until after claimant's physician advised her to stop working. (Tr 3-212). He also testified that claimant failed to inform him about her drug use or marital problems, but subsequently admitted that that was not true. (Tr 3-167).

Given Dr. Turco's inaccurate and unreliable history, we conclude that his diagnosis of claimant's condition is not persuasive. We rely, instead, on the diagnosis provided by Dr. Saville, as confirmed by Dr. Holland, and conclude that claimant suffers from a mental disorder that is generally recognized in the psychological community as major depression.

Causation

To evaluate the numerous reports on the causation of claimant's condition specifically, it is helpful to understand the general etiology of her condition. The most thorough explanation of that is provided by Dr. Holland. He stated that claimant has an underlying dysthymic disorder that preexisted her current psychological condition. (Tr 4-22). He explained that when that condition goes into a more severe phase, then it is classified as a major depression. (Tr 4-24). Dr. Holland testified that stress can cause a dysthymic disorder to aggravate and become a major depression. (Tr 4-36, 67). Consequently, the determination of whether work-related stressors were the major contributing cause of claimant's condition is a matter of finding "the total number of stressors that were in [claimant's] life, the relative weight of each stressor, and the preponderance of the stressors as to whether or not they were vocationally or non-vocationally related." (Ex 54).

Claimant was subjected to numerous job and non-job related stressors, each of which existed in a real and objective sense, prior to filing her claim. The job-related stressors primarily resulted from the reorganization of her employer in the spring of 1990.

The record reflects that, between February and May of 1990, the employer implemented an operational reorganization and computer conversion. As part of the reorganization, lines of authority were changed and new positions were created. However, it was unclear to many people in the organization who had authority over what and what their responsibilities were. In effect, the employer placed the employees in positions without job descriptions, training or supervision. Claimant, in particular, was unsure as to who she was to supervise, who she was to answer to and who was responsible for certain decisions that needed to be made. She complained of being unable to obtain answers that she needed to be responsive to the customers.

The computer conversion was also confusing, because of the lack of immediate training or the provision of employer-defined user guides. Although the system was designed for businesses such as the employer's, the instructions provided with the system did not relate the new commands and functions to the old commands and functions. During the reorganization and conversion, there was a high turnover of employees and staff shortages, and other employees were exhausted by their work demands.

During that same period of time, claimant encountered numerous non-work stressors. She was having marital problems, one of her sons was having academic problems, her other son was despondent over the break-up of a relationship, and she was trying to refinance her house and needed to borrow money from a friend to succeed with that endeavor.

Claimant contends that of all of the stressors, the work-related stressors were the major contributing cause of her mental disorder. We agree.

Because of the various possible causes of claimant's psychological condition, including work and non-work stressors, 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). The record contains numerous reports concerning causation, including those of Dr. Turco. However, inasmuch as we have concluded that his reports are based on inadequate analysis, an inaccurate history and a diagnosis that we have rejected, we conclude that his opinion regarding causation is not persuasive.

Dr. Holland initially opined that claimant's work-related stressors were the major cause of her mental disorder. (Ex 26-24). He subsequently changed his opinion, stating that "nonvocational stressors were greater than the vocational ones at the time of the aggravation of [claimant's] disorder." (Tr 4-102). He stated that his change of opinion was based on new information that work-related stressors were not the only stressors in claimant's life. (Tr 4-88). However, he did not specify what new stressors he learned of, singly or in combination, that changed his opinion. Therefore, we do not find his opinion to be persuasive.

Dr. Davol, Ph.D., claimant's treating psychologist since 1986, opined that the events at claimant's work precipitated her depressive reaction. He explained that claimant is an individual who takes her job home and is prone to worry. (Ex 55). It was his impression that claimant reacted with anxiety, distress and depression when her job security was threatened. (Ex 55). He made that assertion being fully aware of claimant's prior psychological problems, her non-work stressors and her drug use.

Dr. Bonazzola, claimant's treating physician since 1986, also opined that claimant's work activities were the major contributing cause of her symptoms. (Ex 45). He also was fully aware of claimant's prior psychological problems, non-work stressors and drug use. He stated:

> "I have known [claimant] for approximately 5 years. I have found her to be an intelligent, conscientious and dutiful worker and mother whose primary interests have been in caring for her sons and performing her work responsibilities to the best of her ability. I saw her at regular intervals throughout 1989 and 1990 as her work situation, mental situation and physical health deteriorated. There is no question in my mind that her symptoms were completely or almost completely the result of job-related stress." (Ex 45).

Dr. Saville initially opined that claimant's mental disorder began because of work-related stress. (Ex 33). Although she subsequently indicated that it is difficult to determine the weight of the causal factors, she never expressly changed her opinion. (Ex 57).

Where the medical evidence is divided, we generally give greater weight to the treating physician's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, with full knowledge of claimant's complete history, claimant's treating physician and psychologist both opined that the major contributing cause of claimant's condition was work-related stress. Their opinions are buttressed by those of the consulting psychiatrist, Dr. Saville. Moreover, their opinions are supported by claimant's social worker and other lay evidence. See, e.g., Terry K. Davis, 44 Van Natta 786, 789 (1992).

It is uncontroverted that claimant suffered ongoing stress, from work and non-work stressors, for many years. It is also undisputed that she has a chronic underlying psychological condition that is aggravated by stress. Nevertheless, the record shows that she was able to manage that stress and perform her job in an exemplary fashion. Her employment evaluation in February 1990 noted that she exceeded company standards or did outstanding work in all but one category. (Ex 34). She did not perform below standard in any category. Her ability to perform her work suffered only after the employer implemented the reorganization.

The record also reflects that claimant's overriding concern in life was her job. Claimant's former husband testified that work was "number one in her entire life. That's all she ever talked about." (Tr 1-72). He also indicated that claimant's non-work stressors, including their marital problems, her sons' problems and the loan, did not appear to affect claimant very much. Claimant's testimony confirmed

Dr. Holland's opinion does not persuade us to reject the opinions of the treating physician and psychologist. As we explained above, Dr. Holland's opinion is not persuasive because he did not explain his change of opinion concerning causation.

Claimant apparently suffered from dysthymia for many years prior to the spring of 1990. The medical evidence establishes, however, that her underlying dysthymia worsened to become a major depression after the employer commenced its reorganization and computer conversion. The medical evidence further establishes that the condition was caused by stress. The medical and lay evidence persuasively establish that the major source of stress in claimant's life at the time of the worsening was the reorganization and computer conversion. Consequently, we conclude that work stressors were the major contributing cause of claimant's mental disorder. ORS 656.802(1), & (3); see Charlene Newman, 43 Van Natta 368, 372 (1991).

Conditions Generally Inherent in Every Working Situation

Conditions "generally inherent in every working situation" are conditions that are common to all employments, not merely the specific occupation involved. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We are authorized to determine what "conditions [are] generally inherent in every working situation" on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

The Referee concluded that an employer's reorganization and changes in lines of authority are conditions common to all employments. We agree. Nevertheless, we find that claimant's stress resulted from circumstances of the employer's reorganization that are not common to all employments. The employer's reorganization left claimant with no defined job description, no clear supervision and indefinite scope of responsibility. Further, the employer did not offer claimant the assistance needed to deal with those uncertainties. In short, claimant was placed in a position without proper training or supervision. We conclude that those circumstances are not conditions generally inherent in every working situation.

Clear and Convincing

To establish compensability, there must be clear and convincing evidence that claimant's mental disorder arose out of and in the course of her employment. To be clear and convincing, evidence must establish that the truth of the asserted fact is highly probable. Riley Hill General Contractor, Inc. v.Tandy Corp., 303 Or 390, 402 (1987). Based on the totality of the evidence, and in the light of our prior reasoning analyzing the respective persuasiveness of each portion of that evidence, we find it highly probable that the employer's lack of training, supervision, job definition and support surrounding the reorganization were the major contributing cause of claimant's mental disorder. Consequently, we conclude that claimant's mental disorder is compensable as an occupational disease.

Penalties and Attorney Fees

Claimant requested penalties and attorney fees for SAIF's allegedly unreasonable denial of her psychological condition claim. 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).

Although we have found claimant's claim compensable, when it denied the claim, SAIF had received reports that indicated that claimant had encountered numerous, objectively severe, non-work stressors, including family and financial problems. There was also evidence of prior psychological problems, as evidenced by her prior psychiatric hospitalization counseling, and use of habit forming controlled substances. Moreover, Dr. Turco's report indicated that claimant did not have a diagnosable mental disorder, let alone a work-related mental disorder. Although Dr. Turco subsequently abandoned that report at the hearing, we conclude that, based on all of the information available to it, SAIF had a legitimate doubt about its liability. Consequently, claimant is not entitled to a penalty or attorney fees for SAIF's allegedly unreasonable denial. See Elizabeth E. Heller, 45 Van Natta 272, 277 (1993).

Claimant is entitled to an assessed attorney fee for finally prevailing on Board review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed 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 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, the value of the interest involved and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated September 10, 1992, as amended on September 18, 1992, is affirmed in part and reversed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial is reversed. The denial is set aside and the claim remanded to SAIF for processing according to 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 SAIF Corporation.

In the Matter of the Compensation of
CHARLES A. BOSTON, Claimant
WCB Case No. TP-93009
THIRD PARTY DISTRIBUTION ORDER
Jolles, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Safeco Insurance Company, as a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of third party settlement proceeds stemming from a malpractice action. See ORS 656.593(3). Contending that the record does not support a conclusion that Safeco incurred additional expenses as a result of the malpractice, claimant asserts that Safeco is not entitled to a share of the settlement proceeds. We agree with claimant.

FINDINGS OF FACT

On April 21, 1990, claimant was compensably injured in a work-related motor vehicle accident. Claimant's car ran off the road and he sustained serious injuries to his left leg. Following the accident, claimant had to walk for approximately 30 to 40 minutes through a corn field in order to obtain help.

Claimant was transported by ambulance which arrived to pick him up approximately one hour after the accident. The ambulance delivered him to Tuality Community Hospital fifty minutes later.

At Tuality, claimant was treated by Drs. O'Neill and Neitling. Claimant's injured foot was dressed and splinted. He was advised to ice his foot and to keep it elevated. Claimant was also given antibiotics and was told to stay off work over the weekend.

The next day, claimant reported to Kaiser Permanente, where he was treated by Dr. Loch. Dr. Loch diagnosed an open comminuted fracture of the left ankle. Claimant underwent surgical exploration and debridement of the wound. He subsequently developed an infection in the fractured ankle.

On March 24, 1992, claimant filed a complaint alleging medical malpractice on the part of Tuality Hospital and Drs. O'Neill and Neitling. Claimant alleged that he had sustained personal injuries and had incurred medical bills, lost time from work and sustained loss of earning capacity. Claimant sought $250,000 in damages.

Claimant settled the third party case, with the approval of Safeco, for $7,500.

On June 25, 1992, Safeco reported to claimant that its total claim costs equalled $48,828.50. Safeco's total claim costs are comprised of $25,732.87 in medical bills, $15,899.11 in temporary disability benefits and $671.52 in vocational assistance.

On September 14, 1992, Dr. Loch reported that it was problematic to state that claimant's infection would not have occurred had the debridement been performed at the outset. Dr. Loch stated that in cases in which the surgery was performed earlier, infections still did occur. Dr. Loch also reported that, because claimant had walked an extended distance through the corn field, it became even more difficult to say that there would have been a substantial reduction in the risk of developing an infection if claimant had undergone wound debridement at Tuality.

When claimant refused Safeco's request for a share of the settlement proceeds, Safeco petitioned the Board for resolution of the dispute.

CONCLUSIONS OF LAW AND OPINION

A paying agency is entitled to the recovery of its claim costs from a third party settlement for malpractice, to the extent that the agency is receiving reimbursement for additional expenses incurred as a result of the malpractice. Ray F. Littlefield, 41 Van Natta 1781 (1989); John Galanopoulos, 34 Van Natta 615, 616 (1982). The burden of proof is upon the paying agency to establish the extent of its expenditures attributable to the malpractice. Id.

Here, Safeco contends that it is entitled to recover from the third party settlement its expenses that are due to the malpractice. Safeco argues that claimant sustained a wound infection as a result of the compensable injury. Safeco contends that bone grafting of the ankle fracture was delayed, due in part, to premature closure of the wound during the initial treatment at Tuality.

The record does not establish that, but for Tuality's allegedly negligent treatment, claimant would not have otherwise incurred the subsequent medical treatment and temporary disability. Consequently, Safeco has not established its entitlement to a share of the third party settlement. We base this conclusion on the following reasoning.

In Diane T. Dawes, 44 Van Natta 75 (1992), the claimant settled a lawsuit against a chiropractor for unnecessary adjustments to her low back. The paying agency contended that it was entitled to recover from the third party settlement its costs incurred in paying temporary disability benefits and chiropractic bills for improper treatments. Specifically, the paying agency argued that the chiropractor's improper treatments prejudiced it by requiring it to pay additional time loss and medical services for "care" which physically and mentally damaged the claimant.

In Dawes, we concluded that the record did not establish that the compensation for which the paying agency was seeking reimbursement would not have been incurred but for the malpractice. Rather, the record showed that the chiropractor's bills pertained to the claimant's compensable condition and her condition remained disabling, notwithstanding the improper treatments, during the time for which the paying agency sought reimbursement. Dawes, supra.

Similarly, in the present case, we are unable to find that the compensation for which Safeco is seeking reimbursement would not have been incurred but for the malpractice. In his initial surgery report, Dr. Loch, claimant's treating orthopedic surgeon, reported that due to the potential contamination of the fracture site as a result of the delayed cleansing of the wound and premature closure of the wound with the initial treatment, bone grafting of the fracture site would best be delayed.

Although Dr. Loch's report provides that the bone graft was delayed, there is no evidence that the graft could have been avoided if there had been no delay. In other words, Safeco has not shown that the delayed bone graft caused additional expense due to extra medical bills or temporary disability payments. Moreover, Dr. Loch later reported that it was "problematic to state that an infection would not have occurred," even if there had been no delay. Dr. Loch noted that, given that claimant had to walk an extended distance through a field, it was even more difficult to say that there would have been a substantial reduction in the risk of developing an infection had claimant's wound debridement been carried out sooner.

Finally, Dr. Hoff, M.D., also reviewed claimant's medical records and reported that, with regard to the seven to eight hour delay, he did not think such a delay was of great significance in worsening claimant's condition. Dr. Hoff noted that, often, six to eight hours would be common in waiting for an operating room, and would make no material change in the final outcome. Dr. Hoff reported that the problems that claimant incurred would have more than likely been experienced had the same thing (wound debridement and irrigation) been done at the time of claimant's initial treatment at Tuality.

Accordingly, we conclude that the record does not establish that Safeco's payment of claimant's medical bills or temporary disability benefits during the time in question, were incurred as a result of the delay in treatment caused by Tuality. Rather, the record establishes that, more likely than not, claimant's subsequent medical bills (including surgery and further treatment for his infection) and ensuing temporary disability would have been incurred in any event, as a result of the compensable injury.

Consequently, Safeco has failed to establish that the compensation for which it seeks reimbursement was incurred as a result of the alleged malpractice. Accordingly, we hold that Safeco is not entitled to a share of third party settlement proceeds stemming from claimant's malpractice action against Tuality. ORS 656.593(3).

IT IS SO ORDERED.

In the Matter of the Compensation of
RACHEL J. DRESSLER-IESALNIEKS, Claimant
WCB Case Nos. 92-04993 & 91-14444
ORDER ON REVIEW
William G. Whitney, Claimant Attorney
David O. Horne, Defense Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Freightliner Corporation (Freightliner) requests review of those portions of Referee McCullough's order that: (1) set aside its partial denial of claimant's right arm epicondylitis condition; (2) upheld Wausau Insurance Companies' (Wausau) denial of claimant occupational disease claim for the same condition; and (3) awarded claimant's counsel an assessed attorney fee, payable by Freightliner, for services at hearing. On review, the issues are compensability, responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

We adopt the conclusions and reasoning as set forth in the Referee's order with the following supplementation.

Freightliner contends that Wausau is precluded from arguing that Freightliner is responsible for claimant's condition because it did not comply with the notification provisions of ORS 656.308(2). ORS 656.308(2) requires a carrier to provide written notification of its intent to disclaim responsibility for a claim on the basis that the worker's injury resulted from exposure with another employer. Failure to follow the requirements of ORS 656.308(2) precludes a carrier from arguing that an earlier employment exposure caused a claimant's need for medical services. Byron E. Bayer, 44 Van Natta 1686, 1687 (1992).

However, the fact that Wausau may be precluded from arguing that Freightliner is responsible for claimant's condition does not change the result in this case. In addition to denying responsibility for claimant's condition, Wausau denied compensability of the condition. The standard for compensability of claimant's condition and the standard for shifting responsibility for claimant's condition in this case are the same. That is, to establish compensability, claimant must show that the work activities at Wausau's insured were the major contributing cause of a pathological worsening of his condition. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Similarly, in order to shift responsibility, Freightliner must establish that claimant's work activities for Wausau's insured were the major contributing cause of a pathological worsening of claimant's condition. See Donald Moon, 43 Van Natta 2594 (1991).

We agree with the Referee that the record fails to establish that claimant's work at Wausau's insured caused a pathological worsening of his underlying condition. Therefore, claimant did not establish a compensable occupational disease against Wausau. Accordingly, Wausau's denial is upheld on this basis, notwithstanding Wausau's noncompliance with ORS 656.308(2).

Attorney Fees

We adopt the conclusions and reasoning as set forth in the Referee's order with the following supplementation.

Freightliner contends that Wausau should be responsible for the $1,500 attorney fee awarded by the Referee, for services at hearing, on the basis that Freightliner did not deny compensability. We disagree.

Freightliner's October 1, 1991 denial is captioned "Notice of Intent to Disclaim Responsibility and Deny Compensation." (Ex. 63) (Emphasis supplied). While the denial mentioned the possibility of the issuance of a ".307" order, it ends by reiterating that it is a disclaimer of responsibility and a denial of compensation. It was not until the hearing that Freightliner clearly indicated that it was denying responsibility only. (Tr. 3). Accordingly, we agree with the Referee that the assessed attorney fee for services at hearing should by paid by Freightliner.

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 $100, to be paid by Freightliner. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 26, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $100, payable by Freightliner.

In the Matter of the Compensation of
WILLIAM G. JONES, Claimant
WCB Case No. 92-04706
ORDER ON REVIEW
Doblie and Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of Referee Crumme's order that set aside its denial of claimant's injury claim for a bilateral avascular necrosis condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

We do not find that claimant's symptoms were probably entirely due to avascular necrosis when claimant first sought treatment on December 30, 1991. (See O&O p. 3; Ex. 28-49-51). Instead, considering the medical record as a whole and claimant's continuing symptoms following his October 16, 1991 work injury, we find that claimant's injury caused his preexisting avascular necrosis condition to become symptomatic such that claimant now requires surgery for his resultant condition. (See Exs. 17; 25A-46; 28-28-29; 28-39-40; 28-59-60).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Discussion of Findings" and "Ultimate Findings of Fact and Conclusions of Law," with the following supplementation.

As a preliminary matter, we acknowledge receipt of the insurer's June 14, 1993 request that a certain Board member recuse himself from consideration of this case. However, because that former member no longer sits on the Board, the insurer's request is moot and we do not address it.

On the merits, we agree with the Referee that the claim for a current bilateral avascular necrosis condition is compensable, because claimant's fall at work caused his preexisting hip condition to become symptomatic and require surgical treatment. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) (If a work injury renders a preexisting condition symptomatic, the current condition is compensable so long as the injury is the major contributing cause of the worker's resultant need for treatment).

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 February 1, 1993 is affirmed. For services on review, claimant's attorney is awarded an attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
PHILLIP A. MULLINS, Claimant
WCB Case No. 92-01786
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests, and claimant cross-requests, review of that portion of Referee Gruber's order that awarded claimant 5 percent (16 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant became medically stationary after July 1, 1990, and he made a request for reconsideration pursuant to ORS 656.268. Therefore, in rating his permanent disability, we apply the disability rating standards in effect on the date of the August 12, 1991 Determination Order. OAR 438-10-010, 436-35-003(2). Those standards are provided in WCD Admin. Order 2-1991. Further, because we are rating claimant's permanent disability after June 17, 1993, the temporary rules in WCD Admin. Order 93-052 also apply. OAR 436-35-003(4); see Melvin E. Schneider Jr., 45 Van Natta 1544 (1993).

We agree with and adopt the Referee's determination that claimant is entitled to a 5 percent award for a chronic condition which renders him unable to repetitively use the thoracolumbar spine for

twisting or lifting over 20 pounds. See former OAR 436-35-320(5). In this regard, we rely on Dr. Becker's reports dated November 14, 1991 and January 2, 1992. (Exs. 13, 15).[1]

The insurer argues that Exhibits 13 and 15 are not persuasive because they were prepared by Dr. Becker's medical assistant, Mr. Deerfield, and were not signed by Dr. Becker, claimant's attending physician. We disagree. Both exhibits are medical reports provided over the typewritten names of Dr. Becker and Mr. Deerfield. We are persuaded, therefore, that the reports were either jointly prepared by Becker and Deerfield or prepared by Deerfield and subsequently ratified by Becker. In either event, the report satisfies the requirement that the impairment findings be made by the attending physician for the purpose of evaluating permanent disability. See ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1992). Our conclusion in this regard is supported by the record, which includes a report that was authored solely by Deerfield and bears only his name. (See Ex. 12). We further note that the Referee is not bound by common law or statutory rules of evidence. See ORS 656.283(7).

Turning to the non-medical factors in rating claimant's permanent disability, we find that claimant's age of 27 years is assigned no value. See OAR 436-35-290(2). He has earned a high school diploma and attained an SVP level of 2 as a green chain offbearer (DOT #663.686-018). There is no indication in the record that he has attained a higher SVP level. Therefore, claimant is assigned a value of 4 for the education factor. See OAR 436-35-300(3)(e).

Regarding the adaptability factor, we find that claimant's job at injury as a green chain offbearer required medium strength demands. There is insufficient evidence to establish that claimant has performed any job with greater than medium strength demands during the 10 years preceding the time of determination. See OAR 436-35-310(1). Currently, Dr. Becker indicates that claimant is permanently limited to light/medium work. (Ex. 15). Based on the matrix in OAR 436-35-310(2), we assign a value of 2 for the adaptability factor.

Assembling the factors, we multiply the education value of 4 and the adaptability value of 2 for a product of 8. That product is then added to the impairment value of 5 for a total of 13 percent. See OAR 436-35-280. Claimant is entitled to 13 percent unscheduled permanent disability for the compensable 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 extent of unscheduled permanent disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 4, 1992 is modified in part and affirmed in part. In addition to the Referee's 5 percent (16 degrees) unscheduled permanent disability award, claimant is awarded 8

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[1] We note that Exhibits 13 and 15 were written after issuance of the August 12, 1991 Determination Order but before issuance of the March 26, 1992 Order on Reconsideration. We have previously held that a medical report which is written or ratified by an attending physician after claim closure (and before the reconsideration proceeding) may be considered only if it qualifies under ORS 656.268(5) as a corrective report or is "medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." Kristine M. Trump, 45 Van Natta 1268 (1993); Mark A. Pendell, 45 Van Natta 1040 (1993).

Recently, however, the Court of Appeals has held that, although the evidence that may be submitted on reconsideration before the Department of Insurance and Finance is limited by ORS 656.268(5), under ORS 656.283(7) the evidence that may be submitted at a hearing before a referee is not so limited. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

We applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report from the attending physician, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7); 656.283(7)) were applicable. Id. Here, since we have found that the attending physician either jointly prepared the reports or subsequently ratified them, there is no other basis preventing the admission of Exhibits 13 and 15. Therefore, pursuant to Smith and Luciani, the Referee in this case had the authority to consider those exhibits.

percent (25.6 degrees) unscheduled permanent disability, giving him a total of 13 percent (41.6 degrees) unscheduled permanent disability for the low back injury. Claimant's attorney is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased compensation created by this order, provided that the total of fees awarded by the Referee and the Board does not exceed $3,800. This attorney fee is payable directly to claimant's attorney. Claimant's attorney is also awarded $500 for services on Board review, to be paid by the insurer. The remainder of the order is affirmed.

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

Claimant requested reconsideration of our September 9, 1993 Own Motion Order Reviewing Carrier Closure in which we affirmed SAIF's Notice of Closure of June 3, 1993. With his request for reconsideration, claimant submitted additional information regarding the "medically stationary" issue.

"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 propriety of the closure turns on whether claimant was medically stationary at the time of the June 3, 1993 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). Claimant bears the burden to establish that he was not medically stationary when the claim was closed. 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 a letter dated May 25, 1993, Dr. Antimisiaris, claimant's treating physician, opined, "I think that medically he is in a satisfactory, stable condition. With a low ejection fraction, atrial fibrillation, a prosthetic valve with the need for Coumadin, and his continuing symptoms, I do not think that [claimant] can do very much. I do not think that he will have any further material improvement from medical treatment or the passage of time."

In his letter of July 15, 1993, Dr. Antimisiaris stated that "[w]hile I do believe that [claimant] is stable clinically, his condition is quite poor." He concludes the letter with the statement, "[w]e are doing all we can do medically to help him but we are not having much success because of the very poor cardiac status."

With his request for reconsideration, claimant submits a September 15, 1993 letter from Dr. Antimisiaris in which the doctor stated that "I define [claimant's] condition as stable, disabling and quite symptomatic." Dr. Antimisiaris also stated in the September 15, 1993 letter that upon reflection, his statement in his May 25, 1993 letter that "[claimant's] condition is satisfactory" was erroneous in that "I cannot categorize his condition as satisfactory based on the amount and extent of symptoms he continues to have."

Dr. Antimisiaris' September 15, 1993 statements regarding whether claimant was in satisfactory or unsatisfactory condition at the time of closure do not negate his statement that claimant will not improve with further medical treatment or the passage of time. Furthermore, Dr. Antimisiaris continues to opine that claimant is "stable" and does not indicate there will be improvement with treatment or over time. We are persuaded that Dr. Antimisiaris' statements, including those made in his September 15, 1993 letter, establish that claimant's condition was medically stationary at closure. The record contains no evidence that, at claim closure, it was reasonably expected that claimant's condition would improve with further treatment or the passage of time.

Thus, on this record, we conclude claimant has failed to prove he was not medically stationary at claim closure. Therefore, we adhere to our September 9, 1993 order in which we concluded that SAIF's closure was proper.

We withdraw our September 9, 1993 Own Motion Order Reviewing Carrier Closure. On reconsideration, as supplemented herein, we adhere to our September 9, 1993 order in its entirety. The parties' rights to reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORI E. COLLINS, Claimant
WCB Case No. 92-11230
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

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

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

Claimant argues that two reports (Exhibits 12A and 14B) from Dr. Lewis, her attending physician, establish that she has impairment in the form of a chronic condition. We do not consider Dr. Lewis' observations to be persuasive.

Former OAR 436-35-320(5) provides that "[a] worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition."

Dr. Woolpert performed an independent medical examination. Concluding that claimant had no impairment, Woolpert determined that claimant could return to work without restrictions. (Ex. 6-5). Considering claimant's lack of objective findings, Dr. Woolpert noted that claimant's symptoms might indicate a psychological reaction. (Ex. 6-4).

Dr. Lewis concurred with Woolpert's conclusions. (Ex. 8). Furthermore, Dr. Lewis found claimant medically stationary with no permanent impairment. (Ex. 12).

Thereafter, Dr. Lewis completed a physical capacity evaluation (PCE). Lewis checked boxes on a form indicating that claimant could not bend or crawl at all, and could squat and climb occasionally. (Ex. 12-A). Dr. Lewis also responded by circling "NO" when asked if claimant could use her hands for repetitive action such as pushing and pulling of arm controls, and her feet for pushing and pulling of leg controls.

Dr. Lewis later provided his explanation for his "PCE" findings in a letter to claimant's attorney. Lewis stated that "though my PCE evaluation seems fairly limiting, [claimant] should be able to function in the medium category of work based upon these." (Ex. 14B). Dr. Lewis also concluded that the "basic philosophy of the IME evaluation is still intact and I feel [claimant] is stationary."

When there is a dispute between medical experts, we give the most weight to those opinions that are both well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). We also, absent persuasive reasons otherwise, generally give greater weight to opinions from the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983).

Here, we find persuasive reasons not to defer to the opinion and findings offered by Dr. Lewis. In light of the comprehensive nature of Dr. Woolpert's report, we consider his observations and findings to be both well-reasoned and complete. In any event, we further note that Dr. Lewis initially concurred with Dr. Woolpert's conclusions and even subsequently continued to state that the "basic philosophy of the IME evaluation is still intact." Considering such circumstances, we do not consider Dr. Lewis' "PCE" findings sufficient to support a permanent disability award, particularly when Dr. Lewis does not expressly conclude that claimant suffered permanent impairment as a result of her compensable injury.

ORDER

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

In the Matter of the Compensation of
JOHNNY J. FORREST, Claimant
WCB Case No. 92-08890
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Livesley's order that found that res judicata barred litigation of his right ankle injury claim. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

On June 26, 1991, claimant spent the day cleaning showers for the employer. At the end of the day, both shoes were completely wet and claimant had pain in his right foot. He subsequently received treatment for his right foot pain, which was originally diagnosed as an infection.

On July 5, 1991, claimant was admitted to an emergency room due to persistent pain in his foot. On a First Medical Report dated that same day, claimant's complaints were listed as right ankle pain. The location of the injury was described as right "foot pain/swelling (and) red."

On July 9, 1991, claimant was examined by Dr. Nelson, M.D., who reported that claimant had swelling of his right leg with associated discomfort which initially began in his right ankle. Dr. Nelson diagnosed deep venous thrombosis, and the diagnosis was confirmed by Dr. Schwartz, M.D.

On August 9, 1991, the insurer denied that claimant's "condition of right ankle is the result of either an injury or a disease precipitated by your occupational exposure (with the employer)."

Claimant filed a hearing request from the August 9, 1991 denial on August 13, 1991. In response, the insurer denied that claimant sustained a work-related accidental injury or occupational disease.

On November 22, 1991, claimant withdrew his request for hearing. An Order of Dismissal, issued by Referee Gruber on November 27, 1991, dismissed claimant's hearing request. That order was not appealed.

On March 17, 1992, Dr. Jacobson, M.D., reported that claimant never had thrombophlebitis of the leg, and the condition had been misdiagnosed.

On July 6, 1992, claimant requested a hearing from the insurer's "de facto" denial of compensability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer's August 1991 denial denied the June 26, 1991 injury, regardless of how the injury was classified. He further concluded that the November 27, 1991 Order of Dismissal barred claimant from relitigating the same claim. The Referee, therefore, dismissed claimant's request for hearing.

On review, claimant concedes that, as to his right ankle condition, the denial has become final. However, claimant argues that, because the denial did not refer to pain and swelling in his foot and thigh, and did not specifically deny deep venous thrombosis, those claims are not barred by principles of res judicata. We disagree.

Preclusion by former adjudication, generally referred to as res judicata, is a doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously

entered in a claim. Drews v. EBI Companies, 310 Or 134 (1990). Preclusion by former adjudication includes "issue preclusion" and "claim preclusion."

Here, because the August 9, 1991 denial was not actually litigated to judgment, issue preclusion does not apply. However, claim preclusion precludes a plaintiff who has prosecuted one action against a defendant through to a final judgment from prosecuting another action against the same defendant where the claim in the second action is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews, supra at 140, citing Rennie v. Freeway Transport, 294 Or 319 (1982). Claim preclusion does not require actual litigation.

In the present case, claimant concedes that the insurer's August 9, 1991 denial of his right ankle has become final, pursuant to claimant's withdrawal of his request for hearing and the Referee's Order of Dismissal. Accordingly, claimant must show that his condition has changed, so as to create a new set of operative facts that previously could not have been litigated.

In Carol D. Goss, 43 Van Natta 821 (1991), aff'd 110 Or App 151 (1991), we found that, because a claimant chose not to request a hearing from a denial of her aggravation claim, she was required to show that her current low back and left hip condition was changed from her condition at the time of the denial. Because the claimant's claim was merely a different characterization of the identical conditions which led to the aggravation denial, and there were no conditions present that did not already exist when the aggravation denial was issued, we concluded that the claim was precluded. Citing Million v. SAIF, 45 Or App 1097 rev den 289 Or 337 (1980), we concluded that the fact that the claimant asserted her claim by another legal theory did not alter the preclusive effect of the denial. Goss, supra.

Similarly, in the present case, claimant has not shown that his current leg condition is changed from his condition at the time of the August 9, 1991 denial. Although claimant has submitted a report from Dr. Jacobson, M.D., which states that claimant's condition was "misdiagnosed" as thrombophlebitis of the leg, Dr. Jacobson has stated that claimant did have definitive findings. There is no evidence that claimant's condition has changed or that conditions now present did not exist at the time of the 1991 denial. Moreover, Dr. Nelson, who originally treated claimant, rebutted Dr. Jacobson's statement that claimant's condition was misdiagnosed. Dr. Nelson reported that claimant had a number of ultrasound studies, all read by a specialist, which provided evidence of claimant's thrombosis.

Under the circumstances, we conclude that claimant has not shown that his current leg condition is changed from his condition at the time of the August 9, 1991 denial. Furthermore, although claimant has asserted his claim under another legal theory, we conclude that such an approach does not alter the preclusive effect of the denial, which became final through operation of law. Accordingly, we find that under the doctrine of claim preclusion, claimant is barred from litigating the compensability of his present right leg condition.

Finally, in the alternative, we conclude that, even if claimant's claim was not barred by claim preclusion, it would fail on the merits. Dr. Nelson reported that he could not say with any degree of medical probability that claimant's exposure to chemicals would have resulted in a deep venous thrombosis. Dr. Ballman, M.D., who saw claimant twice in followup in July 1991, reported that it was very unlikely that the work exposure described would be the cause of claimant's thrombosis.

Furthermore, although Dr. Jacobson reported that claimant's condition was work-related, we are not persuaded by his opinion. Dr. Jacobson reported that he did not know "precisely what this patient had." Dr. Jacobson also stated that there was no question that a clear-cut relationship existed between "whatever happened at (the employer's work place) and the progression of events with this individual." We find Dr. Jacobson's opinion to be unpersuasive, as he has not explained the causal connection between claimant's condition and his work exposure. Moreover, Dr. Jacobson has not responded to Dr. Nelson's report stating that three diagnostic tests have provided objective evidence of the thrombosis condition, which Dr. Nelson and the other physicians have been unable to relate to claimant's work exposure. Under the circumstances, we decline to rely upon Dr. Jacobson's opinion.

Accordingly, we affirm the Referee's order.

ORDER

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

In the Matter of the Compensation of
WAYNE D. HELGERSON, Claimant
WCB Case No. 92-12597
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of Referee Myzak's order that set aside its denial of claimant's occupational disease claim for bilateral hearing loss. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

On July 24, 1992, claimant was seen by Dr. Hodgson, otologist, for an independent medical evaluation of his hearing loss. Dr. Hodgson reported that claimant had worked in various saw mills without using ear protection from 1960 until 1968, when he began working in the employer's paper mill. (Ex. 4). These sawmills were in Oregon and were identified on claimant's employment application. (Tr 6). Hodgson opined that the majority of claimant's hearing loss occurred prior to 1972, and that the major cause of his hearing loss prior to that date was caused by his work in the saw mills. Hodgson also opined that the progression of claimant's hearing loss over the last 20 years, while he worked at the employer, was greater than that normally expected as a result of aging and was probably due to the fact that claimant did not wear hearing protection all of the time when he began working at the employer's paper mill. (Ex. 4).

The employer received this report on August 17, 1992, and a typewritten claim, listing Dr. Hodgson as an attending physician, was filed the same day. (Ex. 5).

On September 8, 1992, claimant was independently examined by Dr. Hiatt, an ear, nose and throat specialist. Hiatt reviewed claimant's hearing records and Dr. Hodgson's report. He concluded that the change in claimant's hearing since 1972 was not due to on-the-job noise and that no substantial portion of the hearing loss noted in 1972 was due to noise exposure at this employer because of the history of prior heavy noise exposure without ear protection. (Ex. 6).

On September 16, 1992, the employer denied the compensability of claimant's claim. It stated:

> "Our denial is based on the fact it does not appear that you have sustained any hearing loss that is a result of your employment with [the employer]. The information received indicates that your condition was not worsened by nor arose out of and in the course and scope of your employment, either by accident or occupational disease, within the meaning of the Oregon Workers' Compensation Law."

CONCLUSIONS OF LAW AND OPINION

The Referee applied Garcia v. Boise Cascade Corporation, 103 Or App 508 (1990), for the proposition that, because claimant has chosen to file against only one employer, he must prove actual causation against this employer. The Referee concluded that claimant proved that his bilateral hearing loss was compensable by proving his work activities at this employer were the major contributing cause of the worsening of his preexisting hearing loss.

We affirm the Referee's opinion that claimant's hearing loss is compensable, but for different reasons.

At the time it issued its denial, the employer had in its possession uncontroverted medical evidence that the major contributing cause of claimant's hearing loss condition was due to Oregon employment. Nevertheless, it declined to issue a disclaimer of responsibility pursuant to ORS 656.308(2). Instead, it characterized claimant's hearing loss as a "preexisting condition," which requires claimant to prove that work activities at this employer were the major contributing cause of the worsening of that condition.

Where, as here, the evidence shows that the major contributing cause of claimant's occupational disease is his work in noisy conditions for a number of years with various employers, and the employer fails to follow the notice requirements of ORS 656.308 and contests compensability at hearing, claimant is not required to prove that employment during the employer's exposure is the major contributing cause of his condition. See Rene G. Gonzalez, 44 Van Natta 2483 (1992).

Furthermore, the characterization of claimant's condition as a preexisting condition is inappropriate. Only if the employer disclaims responsibility on the basis that claimant's earlier employment with other Oregon employers is the major contributing cause of his condition, notifies claimant that he has 60 days in which to file a claim against any prior employer, and claimant fails to file a claim against the other employer, will claimant's prior symptoms while working at the earlier employers be analyzed as a preexisting condition. See Kevin G. Eller, 45 Van Natta 1 n. 1 (1993).

Moreover, as we concluded in Rene G. Gonzalez, supra, the application of Garcia v. Boise Cascade Corp., supra, is inapposite where the claimant has no obligation to join any prior employers or insurers, because the employer waived any argument that responsibility should be assigned to some previous employer or insurer. As we noted in Gonzalez, ORS 656.308(2) provides that any carrier which intends to disclaim responsibility on the basis of an exposure with another carrier must specify in its disclaimer of responsibility which carrier is allegedly responsible; and only then must the claimant file a claim with such other insurer. Here, as a result of the employer's failure to disclaim responsibility, and contrary to the Referee's conclusion that claimant had chosen to file against only one employer, claimant was not required by ORS 656.308(2) to file a claim with another employer or insurer.

Turning to the merits, the medical evidence indicates that claimant's employment both before and after the employer came on the risk was the major contributing cause of claimant's condition. Both Dr. Hodgson and Dr. Hiatt agree that the major contributing cause of claimant's hearing loss prior to his employment at the current employer was his work at sawmills prior to 1968. In addition, we are more persuaded by Dr. Hodgson's opinion that the major contributing cause of the increase in claimant's hearing loss since that time was noise-induced damage that occurred while claimant was not wearing hearing protection during his work at the current employer. Somers v. SAIF, 77 Or App 259, 263 (1986).

Furthermore, the employer was both the last employer whose exposure did or could have caused the disease, and who was on the risk at the time claimant sought medical treatment for his symptoms. We thus conclude that the employer is liable for claimant's hearing loss condition. See Oregon Boiler Works v. Lott, 115 Or App 70 (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 compensability issue is $1,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 7, 1993 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
RANDALL E. HUG, Claimant
WCB Case No. 92-11787
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Scott H. Terrall & Associtates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Podnar's order that dismissed his request for hearing on the ground that claimant failed to appear. On review, the issue is the propriety of the Referee's dismissal order. We remand.

FINDINGS OF FACT

On September 10, 1992, claimant requested a hearing from the self-insured employer's denial. A hearing was scheduled for December 8, 1992.

On the date scheduled for hearing, claimant's attorney appeared but claimant was not present. Claimant's counsel requested a continuance and, alternatively, requested to proceed on the record.

The employer opposed claimant's request to proceed on the record and moved to have the hearing request dismissed.

Ruling from the bench, the Referee concluded that the employer's motion would be granted and the matter dismissed. The Referee informed the parties that if claimant appeared within 30 days and showed good cause for his failure to appear, he would reinstate the request for hearing.

The Referee's Order of Dismissal issued December 11, 1992.

On January 4, 1993, claimant wrote to the Referee to request that his case be placed back on the docket. Claimant stated that he was not at the hearing on the scheduled date because he was working long hours and had forgotten about the hearing.

In a January 6, 1993 letter, the Referee notified claimant that his motion was denied as he had not shown good cause for his failure to appear.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing on the ground that claimant did not appear at hearing. We disagree.

We have previously held that, where a worker's attorney appears on his behalf at a hearing, dismissal of the worker's request for hearing is not appropriate. Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). Also see Williams v. SAIF, 99 Or App 367 (1989). Here, claimant's counsel appeared and was ready to proceed on the record without claimant. Accordingly, we find that the Referee was without authority to dismiss.

We therefore proceed to consider claimant's counsel's request for reinstatement of the hearing request, which we construe as a motion for postponement. The Referee considered claimant's counsel's motion and found that claimant had failed to establish "good cause" which would justify a postponement. Under former OAR 438-06-081, in order to obtain a postponement, claimant must demonstrate that extraordinary circumstances beyond his control existed that prevented his appearance at hearing.

Here, claimant contends that he was working long hours six days a week prior to the hearing. Claimant contends that the hearing "slipped his mind." However, as noted by the Referee, there was no evidence that claimant did not receive the Notice of Hearing. Furthermore, claimant was the party who requested a hearing and he has not contended that he was unaware that a hearing had been scheduled. Under the circumstances, we conclude that claimant has failed to establish extraordinary circumstances beyond his control which would justify postponement. Therefore, the motion to postpone was properly denied. Additionally, because claimant failed to appear at the first hearing, he has waived his right to appear at a subsequent hearing. Denette D. Dale, 41 Van Natta 2179 (1989).

We remand this matter to Referee Podnar for a hearing on the merits. At hearing, the Referee shall determine what evidence may be received, however, no exhibits shall be received which were not submitted in connection with the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available and planning on testifying at the prior hearing or under subpoena to testify at that hearing. See Rebecca Marks, 45 Van Natta 802 (1993); Mario Miranda, 42 Van Natta 405, 406 (1990).

ORDER

The Referee's Order of Dismissal dated December 11, 1992 is vacated and the case is remanded to Referee Podnar for further proceedings consistent with this order.

In the Matter of the Compensation of
RONNIE D. MAYNARD, Claimant
WCB Case No. 92-13042
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
Burt, Swanson, et al., Defense Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The noncomplying employer (William Smith & Associates) requests review of Referee Brown's order that: (1) dismissed its request for hearing concerning an Order on Reconsideration award of temporary total disability benefits; and (2) awarded claimant an assessed attorney fee of $2,800 for services at hearing. On review, the issues are jurisdiction, temporary disability benefits and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that he did not have jurisdiction over the noncomplying employer's request for hearing, as the noncomplying employer (Smith) was not the person who contracted to pay claimant. We disagree.

Here, as the Referee noted, claimant was not actually paid by Smith, the general contractor. Rather, claimant was paid by the subcontractor, Burns. However, neither Smith nor Burns obtained workers' compensation coverage. ORS 656.029(1) provides that the responsibility for providing workers' compensation coverage is placed upon the person who awards a contract involving the performance of labor, unless the individual providing the labor under the contract provides such coverage before the contract commences. If the person responsible for providing coverage does not do so, that person is treated as a noncomplying employer. ORS 656.029(1).

Accordingly, pursuant to the statute, because Burns did not provide coverage for claimant before the contract commenced, Smith, the general contractor, was the person responsible for providing coverage. Because Burns did not do so, the Department properly held that Smith was a noncomplying employer. See Nelander v. DIF, 112 Or App 419 (1992).

Thus, Smith is not technically an "employer" in the sense that he did not directly pay claimant or control claimant's work. Nevertheless, pursuant to the statutory scheme, in light of Smith's failure to ensure that Burns was providing workers' compensation coverage, as well as his own failure to retain such coverage, Smith is deemed to be a noncomplying employer for purposes of workers' compensation law. As a "party," Smith is entitled to challenge ensuing claims processing decisions arising from the "noncomplying" determination. See ORS 656.005(20). To do otherwise would prevent Smith from contesting decisions for which he would be held ultimately responsible for claim costs. See ORS 656.054(3).

Accordingly, as a result of the Department's determination that Smith must be treated as a noncomplying employer under the provisions of ORS 656.029(1), Smith is a "party" as defined by ORS 656.005(20) and had the right to request reconsideration and a hearing contesting the Determination Order. Therefore, Smith's request for hearing is reinstated. Inasmuch as a hearing was held and the record is sufficiently developed, we may consider the merits of the employer's challenge to claimant's award of temporary disability benefits. ORS 656.295(5).

Temporary Total Disability

The Referee alternatively concluded that, if he had jurisdiction over this matter, claimant had established entitlement to temporary disability benefits from February 5, 1991 to August 30, 1991. We agree with the Referee, and we adopt his Conclusions of Law and Opinion on that issue.

Attorney Fees - Hearing Level

On review, the noncomplying employer contends that the Referee's attorney fee award of $2,800 was excessive, as the case was not complex and was submitted to the Referee on the record with closing arguments conducted over the telephone. In his reply brief, claimant submits that an attorney fee of $1,500 "might be a reasonable alternative." (Emphasis in original).[1]

After reviewing the record and the factors set forth in OAR 438-15-010(4), we conclude that $1,500 is a reasonable attorney fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by the hearing record, the complexity of the issue and the value of the interest involved. The Referee's order is modified accordingly.

Attorney Fees - Board Level

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of entitlement to temporary disability benefits, to be paid by the SAIF Corporation on behalf of the noncomplying employer. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $750 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated January 29, 1993 is modified in part and affirmed in part. The noncomplying employer's request for hearing is reinstated. In lieu of the Referee's attorney fee award of $2,800, claimant's counsel is awarded $1,500 for services at hearing, to be paid by the SAIF Corporation on behalf of the noncomplying employer. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, also to be paid by SAIF on the noncomplying employer's behalf.

[1] We appreciate the significance of claimant's counsel's "submission" in that it essentially represents a "statement against interest." The candor demonstrated by such an action will not go unrecognized should we be called upon to make future attorney fee determinations based on counsel's representations.

In the Matter of the Compensation of
EILEEN M. WINFREE, Claimant
WCB Case No. 92-09400
ORDER ON REVIEW
Russell E. Vause, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

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

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions of law and opinion, with the following supplementation and modification.

The Referee analyzed claimant's claim for a cervical condition as an injury claim. On review, the insurer contends that the claim should have been analyzed as an occupational disease. We disagree.

An occupational disease is distinguished from an injury in two ways: (1) a disease is not unexpected inasmuch as it is recognized as an inherent hazard of continued exposure to conditions of the particular employment; and (2) it is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1980); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). The court has construed the phrase "sudden in onset" to mean occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, 56 Or App 184, 188 (1982).

A preponderance of the evidence in the record establishes that claimant's cervical condition arose unexpectedly and during a short, discrete period of time. Claimant testified that on March 25, 1992, while lifting and emptying a garbage can at work, she felt a sensation down her back and ringing in her ears. (Tr. 10). She did not feel any pain immediately and continued to work. During the next two days, however, she developed gradual neck pain. (Tr. 11). By March 27, 1992, she was complaining of severe headaches, tightness in the entire spine and numbness in both hands. (Ex. 10). Dr. Krisciunas ordered an MRI scan which revealed advanced degenerative disc changes at C5-6 with prominent disc bulging and considerable spinal stenosis. (Ex. 14). Claimant was released from work and referred for a neurosurgical consultation. In late April 1992, she underwent surgery for cervical discectomy with interbody fusion at C5-6.

Thus, claimant's condition was precipitated by an identifiable incident and progressed during a two-day period, a short period of time. Those facts support an injury analysis. Claimant's statement to the insurer also supports an injury analysis. She stated that she was injured when she lifted the garbage can and "felt it then." She added that her symptoms did not occur immediately, but "came on gradually." (Ex. 21A-2). Although claimant characterized her condition as an occupational disease, and indeed filed an occupational disease claim, we are not bound by her characterization because it is not supported by law. Contrary to claimant's belief (at that time), her condition is analyzed as an injury if it developed over a short, discrete period of time. See Donald Drake Co. v. Lundmark, supra.

An injury analysis is also consistent with the medical evidence. Dr. Rosenbaum found that claimant's complaints were most compatible with a cervical strain. (Exs. 31-1, 35-2). Dr. Berkeley identified the "lifting injury" as the initiating factor in producing claimant's symptoms. (Ex. 34).

For these reasons, we agree with the Referee that claimant's cervical condition should be analyzed as an injury. The Referee's injury analysis followed the two-step compensability analysis we first applied in Bahman M. Nazari, 43 Van Natta 2368 (1991). The Referee found that claimant had proved a compensable injury under the material contributing cause standard. He also found that claimant's preexisting degenerative cervical condition combined with the injury to cause disability or need for treatment. Applying ORS 656.005(7)(a)(B), the Referee found that the compensable injury is the major contributing cause of disability or need for treatment. See id. We modify the Referee's analysis as follows.

Subsequent to the Referee's order, the Court of Appeals rejected our two-step analysis. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993). The court stated that if, in an initial injury 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. On the other hand, the court stated that, if the disability or need for treatment 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, it is undisputed that claimant has a preexisting, noncompensable degenerative condition in the cervical spine (cervical spondylosis). Based on Dr. Berkeley's opinion, (see Exs. 25-2, 34), we find that the degenerative condition combined with the work-related cervical injury to cause disability and the need for treatment. Therefore, in order to establish a compensable injury claim under ORS 656.005(7)(a)(B), claimant must prove by a preponderance of the evidence that the injury is the major contributing cause of her resultant condition. See id.

Claimant relies on the opinion of neurosurgeon Dr. Berkeley. While acknowledging claimant's preexisting degenerative condition, Dr. Berkeley opined:

> "[T]he injury that [claimant] sustained at work has been the initiating factor in producing the symptoms that [claimant] complained of and it appears that the lifting episodes at work, lifting garbage cans weighing between 100 to 200 pounds, has been the main contributing factor." (Ex. 34).

Although Dr. Berkeley does not expressly state that the work injury itself is the major contributing cause of her condition, such "magic words" are not required. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). We are persuaded that the doctor's opinion, when viewed as a whole, supports a finding that the injury is the major contributing cause of the condition.

A contrary opinion was submitted by neurosurgeon Dr. Rosenbaum. He did not believe that claimant's cervical spondylosis is contributing to her condition. He opined, instead, that claimant's symptoms "can potentially virtually entirely be secondary to stress manifest as posterior cervical discomfort and headaches rather than originating from a true musculoskeletal injury." (Ex. 35-2).

After reviewing both opinions, we agree with the Referee that Dr. Berkeley's opinion is more persuasive. His opinion is more consistent with claimant's testimony that she felt the onset of a "sensation" in her back and ringing in her ears during a specific lifting incident and that her symptoms worsened after that incident. (Tr. 10). It is also consistent with claimant's testimony that she developed more severe symptoms after the incident than she had previously experienced. She testified that those new symptoms included pain, weakness and numbness in her arms. (Tr. 36-37). Claimant's testimony is supported by the record, which does not show that she experienced these symptoms prior to the lifting incident. (See Exs. A, 1-7).

On review, the insurer argues that Dr. Berkeley's opinion was based on an inaccurate history because: (1) he was unaware that, prior to the lifting incident, claimant had been seeking treatment for cervical complaints relating to migraines and situational stress; and (2) he mistakenly believed that claimant had been lifting garbage cans weighing between 100 and 200 pounds. Claimant's co-worker testified that the garbage cans actually weighed between 70 and 100 pounds. (Tr. 45).

Notwithstanding those inaccuracies, we remain persuaded by Dr. Berkeley's opinion for two reasons. First, as we stated above, his opinion is supported by claimant's persuasive testimony that she felt the onset of symptoms during a specific lifting incident. Given that testimony, it is largely immaterial whether the garbage can she lifted weighed 70 or 200 pounds. Second, although claimant experienced migraines and cervical spasms due to stress and anxiety prior to the lifting incident, it is uncontroverted that her symptoms following the lifting incident were new and more severe. The severity of those symptoms eventually resulted in disability and the need for surgery. Accordingly, based on Dr. Berkeley's opinion and claimant's testimony, we conclude that claimant has sustained the burden of proving her injury claim.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 16, 1992 is affirmed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
MICHAEL P. EDWARDS, Claimant
WCB Case No. 92-11788
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of Referee Podnar's order that: (1) increased claimant's award of unscheduled permanent disability for a low back injury from 18 percent (57.6 degrees), as awarded by an Order on Reconsideration, to 51 percent (163.2 degrees); and (2) awarded claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right leg whereas the Order on Reconsideration had not awarded any scheduled permanent disability. On review, the issues are extent of unscheduled and scheduled permanent disability.

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

The Referee relied on Exhibit 32A, Dr. Oelke's June 4, 1992 report, to rate claimant's permanent disability. The insurer contends that the Referee erred in relying on Exhibit 32A because it is based on a post-closure examination and therefore inadmissible pursuant to ORS 656.268(5).

Subsequent to the Referee's order, the Court of Appeals issued its decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court considered the admissibility of documents at hearing in view of ORS 656.268(5). That statute limits the evidence that may be submitted at the reconsideration proceeding to that which corrects erroneous information and medical evidence that should have been submitted by the attending physician at the time of claim closure. Finding that ORS 656.283(7), which pertains to the presentation of evidence at hearing, contained no similar limitation, the court held that the Referee may consider evidence that could not have been submitted to the Director on reconsideration. Id.

We recently applied the Smith holding in Cynthia L. Luciani, 45 Van Natta 1734 (1993). In Luciani, we found that a medical report from the attending physician, although not considered by the Appellate Unit pursuant to ORS 656.268(5), could be considered at hearing provided that no other statutory limitations on evidence (ORS 656.245(3)(b)(B), 656.268(7); 656.283(7)) were applicable. Id. Here, there is no other basis preventing the admission of Exhibit 32A. Therefore, pursuant to Smith and Luciani, the Referee in this case properly relied on that exhibit.

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

ORDER

The Referee's order dated December 22, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the insurer.

In the Matter of the Compensation of
JAMES R. PELFREY, Claimant
WCB Case Nos. 89-22751 & 91-14680
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Lipton's order that granted claimant permanent total disability, whereas an Order on Reconsideration had increased claimant's scheduled permanent disability to 44 percent (66 degrees) for a left knee injury. On review, the issue is permanent total disability.

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

We agree that claimant's physical incapacity in conjunction with his nonmedical disabilities renders any attempt by claimant to obtain regular gainful employment futile. Accordingly, claimant is not required to show he has made reasonable efforts to obtain regular gainful employment. However, that does not end the inquiry. In addition, claimant must prove that, "but for the compensable injury, the claimant would have returned to work." This determination is essential concerning claimant's entitlement to permanent total disability. See SAIF v. Stephen, 308 Or 41, 48 (1989).

SAIF argues that claimant is not entitled to permanent total disability because he has failed to demonstrate the necessary "willingness to work." In this regard SAIF points to evidence which suggests that claimant lacked motivation to pursue vocational services because he had "retired." We disagree with this interpretation of the evidence.

We find the evidence persuasive that claimant's decision to decline vocational services was premised on his belief that he was totally disabled. Claimant testified he did not view himself as "retired" but rather as disabled. He explained that it was not in his best interest to be retired inasmuch as he was not yet vested in his pension program, but was in fact four years short from obtaining full benefits. (See Tr. 16-19).

The record supports claimant's testimony. From October 31, 1988 to claimant's medically stationary date, March 25, 1991, claimant was totally disabled. (See Ex. 51-2). Prior to surgery, claimant's attending physician, Dr. Manley, was of the opinion claimant was unable to participate in vocational efforts or to return to work. (See Ex. 39). And, after surgery, while claimant was recovering, Dr. Manley indicated that claimant was unable to return to work. (See Ex. 41). When claimant became medically stationary in March 1991, Dr. Manley continued to express the view claimant was totally disabled. (See Exs. 50, 51).

Based on this evidence, we reach the following conclusions. Despite significant preexisting conditions, claimant has demonstrated a work history of steady employment spanning 28 years as a pipefitter. It is only until the compensable left knee injury occurred that claimant was unable to work. He attempted to go back to work in August 1987, but his knee worsened and he was taken off work by Dr. Manley. (See Ex. 9, Tr. 18). We find the record persuasively shows that claimant's inability to return to work was due to the compensable left knee injury and not because claimant had "retired." Accordingly, we find claimant demonstrated the necessary prerequisite indicating that "but for the compensable injury claimant would be willing to work." See SAIF v. Stephen, supra at page 47.

Inasmuch as claimant's compensation has not been reduced or disallowed on appeal, claimant is entitled to an assessed attorney fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the 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 26, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
SHERRY A. YOUNG, Claimant
WCB Case No. 91-12999
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Quillinan's order that: (1) found that the Director did not have jurisdiction to review the appropriateness of a proposed surgery (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1); (2) set aside the Director's order which found that proposed low back surgery is not appropriate; and (3) directed SAIF to authorize the proposed surgery. On review, the issues are jurisdiction and medical services. We reverse.

FINDINGS OF FACT

We adopt the "FACTS" section of the Referee's order, with the following supplementation.

Subsequent to the Director's August 14, 1991 order disapproving the proposed surgery (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1), the Director received additional medical evidence supporting claimant's need for another low back surgery (discectomy with interbody fusion of L4-5). Based on this additional evidence, on August 6, 1992, the Director issued an order. The Director found that the proposed surgery is appropriate medical treatment for claimant's compensable injury. The order directed SAIF to reimburse claimant for the expenses of the proposed surgery.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Hearings Division, not the Director, had original jurisdiction over this dispute concerning the appropriateness of claimant's proposed back surgery. The Referee reasoned that ORS 656.327 did not apply because the surgery was proposed treatment, rather than treatment claimant was "receiving." We disagree.

Under ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for Director review of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." We have previously held that the Director review procedure in ORS 656.327 applies to disputes concerning proposed medical treatment, as well as treatment already provided. See Keven S. Keller, 44 Van Natta 225 (1992).

If a party or the Director "wishes" for Director review of a medical treatment dispute and files notice of that desire with the Director, exclusive jurisdiction over the dispute rests with the Director under ORS 656.327. Meyers v. Darigold, Inc., 123 Or App 217 (1993). Here, since the insurer "wish[ed]" review of this medical treatment dispute and because the Director's order issued in response to that "wish," original jurisdiction over this dispute rested with the Director. Id.

Accordingly, the Director retained jurisdiction to decide this medical treatment dispute. However, the Referee had jurisdiction to review the Director's order pursuant to ORS 656.327(2). Pursuant to that statute, the Director's order may be modified only if the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). 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).

SAIF objects to the Referee's admission of several exhibits which were not considered by the Director. Asserting that the record for "substantial evidence" review is confined to that developed before the Director, SAIF argues that the record may not be supplemented. See ORS 656.327(2); OAR 438-17-010(2). We need not resolve that issue because even if the additional exhibits were considered, the Director's decision would be supported by substantial evidence.

Dr. Poulson, orthopedic surgeon, recommended bilateral laminotomy, fusion and partial excision of the L4-5 disc for a probable disc herniation and instability. (Ex. 22). Dr. Tsai, orthopedic surgeon, concurred with this recommendation. (Ex. 21).

Dr. Kitchel, orthopedic surgeon, noted that claimant did not experience pain relief from injections and that a number of physical findings were consistent with a non-organic basis for claimant's pain. For those reasons, Kitchel recommended against surgery. Nevertheless, if a lumbar discogram revealed the L4-5 disc space to be grossly abnormal and there was no abnormality seen at the adjacent discs, Dr. Kitchel added that claimant would be more likely to benefit from surgery. (Ex. 32).

Subsequently, Dr. Poulson performed a lumbar discogram which revealed degenerated L4-5 interspace with instability. (Ex. 39-3). A post-discogram CT scan revealed no evidence of disc material within the central spinal canal, and the thecal sac contours were shown to be normal. (Ex. 39-4).

After reviewing the medical record, the Medical Director concurred with Dr. Kitchel's findings and concluded that the proposed treatment was not appropriate for claimant's current condition. Consequently, the Director held that "[a]bsent a material change in the worker's condition, I hereby order that SAIF Corporation is not required to reimburse for bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1 using posterior instrumentation, if rendered to [claimant]."

Following our "substantial evidence" review, we conclude that the record would permit a reasonable person to make a finding that the proposed surgery is not appropriate. Although there is medical evidence supporting the need for surgery, there is also evidence from Dr. Kitchel that claimant is not an appropriate surgical candidate. See Queener v. United Employers Insurance, 113 Or App 364 (1992). We are mindful that the discogram findings appear to support the appropriateness of surgery. Yet, there is no medical report in the record from any physician which discusses the discogram findings and how those findings support the need for surgery. Absent such evidence, we decline to substitute our judgment for that of the medical experts. Accordingly, we affirm the Director's August 14, 1991 order.

In reaching this conclusion, we note that a second dispute regarding the propriety of another low back surgery request has subsequently been resolved by the Director. See Grace B. Simpson, 43 Van Natta 1267 (1991). (Board may take administrative notice of any fact that is capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned). Specifically, on August 6, 1992, the Director issued an order finding that the proposed surgery (discectomy with interbody fusion of L4-5) was appropriate medical treatment. Consequently, SAIF was directed to provide reimbursement for the surgery. In doing so, the Director reasoned that Dr. Kitchel had subsequently agreed with Dr. Poulson that claimant was a candidate for the fusion surgery. No hearing request from that August 6, 1992 order has been filed.

In light of these subsequent events, it would appear that a proposed low back surgical procedure (discectomy with interbody L4-5 fusion) has been found to be appropriate medical treatment. Nevertheless, our review is confined to the Director's August 14, 1991 order and the record developed in this proceeding regarding that particular surgical procedure (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1). See ORS 656.327(2). Moreover, SAIF has appealed the Referee's decision regarding that Director's order and both parties agree that the Director's August 6, 1992 order does not preclude our review of the Director's August 14, 1991 order.

Under such circumstances, we are obligated to conduct our review. Although we have concluded that the Director's August 14, 1991 order concerning that proposed surgical procedure (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1) shall be affirmed, we wish to emphasize that our decision has no effect on the Director's August 6, 1992 order finding that the subsequent surgery request (discectomy with interbody L4-5 fusion) is appropriate medical treatment.

ORDER

The Referee's order dated November 14, 1991 is reversed. The Medical Director's order dated August 14, 1991 is affirmed.

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Cite as 121 Or App 95 (1993) June 9, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Charles W. Tedrow, Claimant.

STONE CONTAINER OF NV, Petitioner,
v.
CHARLES W. **TEDROW**, Respondent.
(WCB 91-09918; CA A76702)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 3, 1993.
A. E. Bud Bailey, Tualatin, argued the cause for petitioner. With him on the brief was Bailey & Associates, Tualatin.
No appearance by respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Affirmed.

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121 Or App 96> Employer seeks review of an order of the Workers' Compensation Board that requires it to pay for medical treatment of claimant's low back condition. We affirm.

The Board found that the condition, a herniated disc at L5-S1, for which claimant sought medical treatment, was a different condition from a back condition that employer had denied in 1990. There is substantial evidence to support that finding, and the Board did not err by holding that claim compensable.

The Board ordered that employer pay for medical treatment beginning on the date of the denial. Although it made no findings about when claimant's need for treatment relating to the L5-S1 condition began, we read the Board's order as requiring payment only for medical treatment related to the changed condition.

Affirmed.

Cite as 121 Or App 142 (1993) June 16, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Vincent B. Sweeney, Claimant.

SAIF CORPORATION and SWEENEY SIDING, Petitioners,
v.
VINCENT B. **SWEENEY**, Respondent.
(90-09754; CA A68897)

Judicial Review from Workers' Compensation Board.
On petitioners' motion for clarification and reconsideration filed November 17, 1992. Opinion filed October 14, 1992. 115 Or App 506, 839 P2d 254 (1992).
Charles S. Crookham, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, for petitioners.
No appearance contra.
Before Richardson, Chief Judge, and Deits and Riggs, Judges.
DEITS, J.
Reconsideration allowed; opinion modified and adhered to as modified.

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121 Or App 144> Employer seeks reconsideration and clarification of our opinion, 115 Or App 506, 839 P2d 254 (1992). We grant the motion, modify our opinion and adhere to it as modified.

In our earlier opinion, we concluded that the amount of unscheduled permanent partial disability (PPD) awarded to claimant by determination order could be reduced after claimant completed his vocational rehabilitation training program. We said:

> "We conclude that, when an employer chooses the alternative of re-evaluation under ORS 656.268(5), rather than submitting the claim for redetermination, it must follow normal procedures for carrier closure. ORS 656.268(3)(b). If a claimant requests reconsideration of the closure award, the employer is obligated to resume payment of the initial award until the claimant's extent of disability is redetermined.
>
> "* * * * *
>
> "Employer was entitled to re-evaluate the extent of disability after claimant completed the program. However, employer was obligated to make payments under the 1989 determination order when claimant completed the rehabilitation program until the re-evaluation process was complete. When employer issued a notice of closure under ORS 656.268(5), it was required to follow the usual procedures for carrier closure. If a claimant does not seek review of an employer's re-evaluation, or a new determination order is issued, only then may an employer pay the adjusted compensation." 115 Or App at 510.

Employer argues that a notice of closure is effective at the time that it is issued and that we were incorrect in holding that a notice of closure is not effective until the time to challenge it expires or until it is replaced by a determination order. We agree that our language to that effect is incorrect and that a notice of closure is effective upon its issuance. Under DIF's administrative rules, permanent disability benefits must be paid no later than the 30th day after the date of an applicable determination order or the notice of closure. OAR 436-60-150(5).

We adhere to that portion of our earlier opinion that holds that an employer may re-evaluate a permanent disability award after the completion of a vocational rehabilitation **<121 Or App 144/145>** training program. ORS 656.268(5); ORS 656.325(3). The question that remains is the effect on this case of our holding that the notice of closure is effective immediately. The initial determination order was issued on July 28, 1989. Under OAR 436-60-150(5), employer had 30 days to begin paying PPD. On July 31, 1989, claimant entered a vocational training program and, under ORS 656.268(5) and OAR 436-60-040, employer's duty to pay the PPD award was suspended. Claimant completed the training program on April 13, 1990. At that time, employer's obligation to pay the PPD award resumed. However, under OAR 436-60-150(5), employer still had 27 days to begin paying, or until May 10, 1990. On April 30, 1990, employer issued its notice of closure that reduced the PPD award from 36 to 17 percent.

We conclude that, because the notice of closure was issued before employer was obligated to begin payment under the original determination order, employer's issuance of its notice of closure effectively reduced the award and excused employer from payment under the original award. Had payment under the original determination order come due, employer would have been obligated to make the lump sum payment required by that award.

Reconsideration allowed; opinion modified and adhered to as modified.

Cite as 121 Or App 217 (1993) June 23, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bertha M. Gray, Claimant.

BERTHA M. **GRAY**, Petitioner,
v.
SAIF CORPORATION and AMERICAN LEGION #45, Respondents.
(90-14568; CA A74858)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 19, 1993.
Dan Steelhammer, Bend, argued the cause for petitioner. With him on the brief was Brothers, Drew & Steelhammer, Bend.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Affirmed.

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121 Or App 219> Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and holding that her current low back condition is not compensable.

Claimant injured her back at work in February, 1989. Employer accepted a claim for the injury, which was diagnosed as "acute lumbosacral strain." She has continued to suffer back pain since the injury. The claim was closed in November, 1989, with no award for permanent disability. In the meantime, claimant had been seeing her treating physician, and he diagnosed a degenerative condition of the low back requiring surgery. He requested authorization for surgery in January, 1990. SAIF denied the claim in June, 1990, on the grounds that the current condition is not related to the compensable strain and the compensable strain is not the major contributing cause of the need for treatment.

The Board found that claimant's current condition is the result of a combination of her compensable strain and preexisting degenerative disc disease, and that the degenerative condition is the major contributing cause of the current symptoms. The Board determined that ORS 656.005(7)(a)(B) is applicable. That subsection provides:

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

The circumstances of this case fall squarely within the statute. Because claimant's preexisting degenerative condition combines with her compensable injury to cause her disability and need for treatment, claimant must show that the compensable injury is the major contributing cause of the disability and need for treatment. The Board's conclusion that she has not met that burden is supported by its findings, and those findings are supported by substantial evidence. Even assuming, as claimant contends, that she has experienced an aggravation of her compensable claim, her condition is not compensable, because she has not satisfied the requirements of ORS 656.005(7)(a)(B). *See Tektronix, Inc. v. Nazari*, **<121 Or App 219/220>** 117 Or App 409, 844 P2d 258 (1992), *on recon* 120 Or App 590, ___ P2d ___ (1993).

Affirmed.

Cite as 121 Or App 260 (1993) June 23, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Fred H. Jacobson, Claimant.

PACIFIC POWER & LIGHT, Petitioner,
v.
FRED H. **JACOBSON**, Respondent.
(90-11363; CA A70655)

Judicial Review from Workers' Compensation Board.
On respondent's petition for reconsideration. Opinion filed December 23, 1992. 117 Or App 280, 844 P2d 223.
William A. McDaniel and Foss, Whitty, Littlefield & McDaniel, Coos Bay, for the petition.
No appearance contra.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P.J.
Reconsideration allowed; opinion withdrawn; affirmed.
De Muniz, J., concurring and dissenting.

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121 Or App 262> Claimant has filed a petition for review of our opinion. 117 Or App 280, 844 P2d 223 (1992). We treat it as a petition for reconsideration, ORAP 9.15, allow it, withdraw our opinion and affirm the Workers' Compensation Board.

Claimant, a lineman representative, travels daily to various locations in his territory. He seeks benefits for an injury he sustained when he fell off a stool while eating his lunch at a restaurant. In a footnote to our opinion, we rejected claimant's contention that he was a travelling employee, reasoning that the travelling employee rule is limited to employees who travel *overnight*. 117 Or App at 284, n 3. Claimant contends that we should not have so limited the application of the rule. Although we have not found an Oregon decision that has applied the travelling employee rule to a case that did not involve overnight travel, we agree that the overnight qualification was not necessary to our decision.

Claimant contends, additionally, that we erred in reversing the Board, because its decision that claimant's injury was an anticipated risk of the employment is supported by substantial evidence. We agree and conclude that the injury is compensable.

In *Slaughter v. SAIF*, 60 Or App 610, 613, 654 P2d 1123 (1982), we quoted from 1 Larson, *Workmen's Compensation Law* 5-172, 25.00 (1972):

> "'Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable.'"

That same statement is in the most recent edition of Larson's treatise. 1A Larson, *Workmen's Compensation Law*, 5-275, 25.00 (1990).

The Supreme Court has stated its own version of the same concept. In *SAIF v. Reel*, 303 Or 210, 216, 735 P2d 364 (1987), the court said that, in the case of an employee who has been directed, as a part of the employee's duties, to go to a **<121 Or App 262/263>** specific place, the ultimate inquiry in deciding whether injuries that occur during personal activities are covered is whether the risk of injury is a necessary incident of the employment:

> "[W]hen the travel is essentially part of the employment, the risk of [injury during activities necessitated by travel] remains an incident to the employment even though the employee may not actually be working at the time of the injury." 303 Or at 216.

Claimant's job necessitated travel on a daily basis. Although he was not required to eat his lunch at the restaurant, it would have been inconvenient for him to drive all the way home for lunch during his one-hour lunch break. Although employer exercised no control over claimant while he was on his lunch break, employer contemplated that claimant would carry out ordinary comfort activities at the location where he was working and thereby anticipated the risk of an injury that might occur in the context of ordinary comfort activities. We conclude that substantial evidence supports the Board's finding that the risk that claimant might be injured while eating his lunch was a risk of the employment.

Reconsideration allowed; opinion withdrawn; affirmed.

DE MUNIZ, J., concurring in part; dissenting in part.

I agree with the majority that reconsideration should be allowed and that the footnote in our original opinion regarding the overnight qualification was not necessary to our decision.

I dissent from the majority's holding on reconsideration that claimant's injury was compensable. Our original opinion holding otherwise was correct, for the reasons stated in that opinion.

Cite as 121 Or App 402 (1993) June 23, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

S-W FLOOR COVER SHOP, Petitioner - Cross-Respondent,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent,
and
SAIF CORPORATION, Respondent - Cross-Petitioner.
(90-10-009; CA A74356)

Judicial Review from Department of Insurance and Finance.

Argued and submitted February 19, 1993.

Bruce D. Smith, Medford, argued the cause and filed the briefs for petitioner - cross-respondent.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondent - cross-petitioner. With him on the brief were Charles Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Leary C. Jones, Portland, waived appearance for respondent National Council on Compensation Insurance.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

On petition, reversed and remanded as to holding that Landrum was an employee for the period January 1, 1990, to June 30, 1990; otherwise affirmed. Affirmed on cross-petition.

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121 Or App 404> S-W Floor Cover Shop petitions for review, and SAIF cross-petitions for review, of an order of the Department of Insurance and Finance (DIF) in a premium audit dispute for the audit period July 1, 1988, to June 30, 1990.

Petitioner sells floor covering. During the audit period it used the services of Allen, Bailes and Landrum as carpet installers. SAIF issued policies for petitioner and mailed final premium audit billings, basing premium assessments on the amounts paid by petitioner to the installers. Petitioner appealed to DIF, claiming that the amounts were not subject to workers' compensation premium assessment, because the installers were independent contractors, not employees.

DIF applied traditional common law tests to determine whether Allen, Bailes and Landrum were employees or independent contractors for that portion of the audit period between July 1, 1988 and October 3, 1989. On October 3, 1989, a statutory test replaced the common law tests. *Former* ORS 701.025 (renumbered ORS 670.600 in 1991). DIF applied the statutory test for the period October 3, 1989 to June 30, 1990.

Petitioner argues that DIF erred by ruling that Allen, Bailes and Landrum were employees during the period before October 3, 1989. DIF first applied the traditional "right to control" test. *See Woody v. Waibel*, 276 Or 189, 196-97, 554 P2d 492 (1976). It found that, even though petitioner did not supervise installations, customers turned to petitioner if they had problems with installations, and that petitioner had the right to control the manner in which the installers did their jobs. Evidence concerning the other elements of the test, however, was inconclusive. DIF therefore applied the "relative nature of the work" test of *Woody, see Premsingh & Assoc. v. Natl. Council on Comp. Ins.*, 111 Or App 624, 826 P2d 120, rev den 313 Or 300 (1992), and concluded that the installers were employees for the following reasons: (1) installation of carpet was a regular and integral part of petitioner's business; (2) the price a customer was charged for floor covering included installation; (3) petitioner **<121 Or App 404/405>** had specific requirements for installations that were communicated to the installers; (4) customer complaints regarding installation were made directly to petitioner; (5) the skills needed to install floor coverings were familiar to petitioner; and (6) petitioner hired only experienced installers and those known to him. Acknowledging that the determination was "close," DIF looked to the policy outlined in Woody and concluded that petitioner was in a better position than the installers to pass on the cost of industrial accidents to consumers. DIF's findings are supported by substantial evidence and its findings support the conclusion that, under the common law analysis, Allen, Bailes and Landrum were employees.

Petitioner argues that, even if the installers were employees, it should have been held to be exempt from paying workers' compensation insurance under *former* ORS 656.027(7) for the audit period before October 3, 1989, because Allen, Bailes and Landrum were sole proprietors. It relies on our holding in *Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 403, 812 P2d 25 (1991). On review of DIF's order on remand, we overruled our first decision. We held that, if a sole proprietor functions in the capacity of an employee of another, the exemption from workers' compensation coverage is inapplicable with respect to that relationship. *Little Donkey Enterprises, Inc. v. SAIF*, 118 Or App 54, 845 P2d 1298 (1993). DIF did not err in holding that Allen, Bailes and Landrum were employees of petitioner for the audit period before October 3, 1989.

Petitioner next argues that DIF erred in concluding that Landrum was not an independent contractor under the statutory scheme that governed the audit period between October 3, 1989 and June 30, 1990. *Former* ORS 701.025 replaced the common law tests with a list of criteria that an individual or business entity must satisfy to qualify as an independent contractor. All eight criteria must be satisfied before a worker can be considered an independent contractor. *Liberty Northwest Ins. Corp. v. Potts*, 119 Or App 252, 850 P2d 1135 (1993).

DIF held that Landrum was an employee under *former* ORS 701.025 because he did not satisfy subsection (7), which requires that:

> *121 Or App 406>* "Federal and state income tax returns in the name of the business or a business Schedule C or farm Schedule F as part of the personal income tax return were filed for the previous year if the individual or business entity performed labor or services as an independent contractor in the previous year[.]"

DIF found evidence that Landrum filed a Schedule C return for 1989, but found that there was no evidence that he filed a Schedule C return for 1988. It held that, because Landrum did not satisfy the requirements of subsection (7) for the entire portion of the audit period governed by *former* ORS 701.025, he should be considered an employee for that entire time.

Petitioner argues that it was error to hold that Landrum was an employee for the period January 1, 1990, to June 30, 1990, because, by filing a Schedule C form for 1989, he satisfied the "previous year" requirement of subsection (7) for 1990. SAIF concedes that if Landrum qualified as an independent contractor under *former* ORS 701.025 for 1990, petitioner was not required to provide workers' compensation insurance for the portion of the audit period between January 1 and June 30, 1990.[1] We

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[1] Petitioner also challenges DIF's holding that subsection (8) requires that an individual performing labor file a business tax return for the year in which the work was performed. Petitioner is correct that DIF misread subsection (8), but that misreading does not affect this case, because both Allen and Bailes filed such returns.

agree. Nothing in the statute requires that the entire audit period be governed by the law in effect at the beginning of the audit period. *See B. King Construction, Inc. v. Natl. Council on Comp. Ins.*, 120 Or App 420, ___ P2d ___ (1993). The Board erred in holding that Landrum was an employee between January 1 and June 30.

SAIF's cross-petition challenges DIF's holding that Allen and Bailes met the requirements of former ORS 701.025(1), which required that:

> "The individual or business entity providing the labor or services is free from direction and control over the means and manner of providing the labor or services, subject only to the right of the person for whom the labor or services are provided to specify the desired results[.]"

121 Or App 407> DIF examined only whether petitioner exercised actual control over the means and manner of the installers' performance of the work, not whether petitioner had the right to do so. *See Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989). It found (1) the installers performed their work without explicit instructions from petitioner; (2) the manner of performing the installation was left to the individual installer; (3) petitioner did review the work of new installers and did have certain oral agreements with the installers about the manner in which work would be billed, but did not exercise any direction and control over the means and manner in which the work was performed; and (4) petitioner was interested only in whether the floor covering was installed properly. DIF therefore held that Allen and Bailes were free from direction and control over the means and manner of providing the labor or services and concluded that they were independent contractors, because they had satisfied all the criteria of *former* ORS 701.025.

SAIF argues that legislative history suggests that there was no intent to abandon the common law standard for determining independent contractor status, and that *former* ORS 701.025(1) "was not intended to bring about a different result from what would have been reached under Oregon case law."

Former ORS 701.025(1) contains no reference to a nature of the work test, nor to a right to control test. *Cf. Castle Homes, Inc. v. Whaite, supra*, 95 Or App at 269. We are not free to read into the statute words that are not there. ORS 174.010. Because *former* ORS 701.025 incorporated most of the factors previously recognized by case law--including the elements of furnishing of equipment, right to fire and method of payment--we conclude that the language of subsection (1) manifests a deliberate legislative policy choice to adopt a test of actual control rather than right to control. DIF did not err in limiting its examination under *former* ORS 701.025(1) to whether petitioner exercised actual control over the means and manner of the installers' performance of the work. Substantial evidence supports its finding that petitioner did not exercise actual control over the installers during the period October 3, 1989, to June 30, 1990.

121 Or App 408> On petition, reversed and remanded as to the holding that Landrum was an employee for the period January 1, 1990, to June 30, 1990; otherwise affirmed. Affirmed on cross-petition.

Cite as 121 Or App 409 (1993) June 23, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

BLACKLEDGE FURNITURE CO., INC., Respondent,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and
SAIF CORPORATION, Petitioner.
(91-02-012; CA A76093)

Judicial Review from Department of Insurance and Finance.

Argued and submitted May 14, 1993.

Michael O. Whitty, Special 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.

Peter L. Barnhisel, Corvallis, argued the cause and filed the brief for respondent.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Portion of order relating to audit period from October 3, 1989, to June 30, 1990, reversed and remanded for reconsideration; otherwise affirmed.

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121 Or App 411> SAIF petitions for judicial review of an order of the Department of Insurance and Finance (DIF). DIF held that Blackledge Furniture Company (Blackledge) could not be assessed workers' compensation insurance premiums based on services provided by four floor covering installers, because they were not "workers" under *former* ORS 656.005(27) (renumbered ORS 656.005(28) in 1990), for the audit periods July 1, 1988, through June 30, 1989, and July 1, 1989, through June 30, 1990.

DIF applied the traditional common law tests to determine whether the installers were workers, *see Castle Homes, Inc., v. Whaite*, 95 Or App 269, 272, 769 P2d 215 (1989), during the entire audit period. It concluded that "application of the control test alone does not give us a clear determination of petitioner's relationship with the installers." It therefore applied the relative nature of the work test and found that the method of operation of the installers was "sufficiently independent as to provide a separate route through which to channel the cost of industrial accident[s]."

SAIF contends that DIF erred in holding that application of the right to control test was inconclusive. It argues that our holding in *Salem Decorating Center, Inc., v. Natl. Council on Comp. Ins.*, 116 Or App 166, 840 P2d 739 (1992), rev den 315 Or 643 (1993), compels the conclusion that the installers were workers under the right to control test. We disagree. In Salem Decorating, there was no written contract specifying the terms of performance. Blackledge had specific written contracts with all of its installers. In *Salem Decorating*, the employer had the right to monitor the progress of the work to see if the installer was doing an adequate job. Blackledge had no contractual right to monitor work. The employer in *Salem Decorating* had the right to terminate an installer before the job was completed and to replace that installer with another. Blackledge had no right to terminate a job in progress. Because of factual differences, we conclude that *Salem Decorating* does not dictate the result in this case. DIF did not err in concluding that the right to control test in this situation was not determinative. SAIF does not argue that DIF erred in its application of the relative nature of the work test.

121 Or App 412> SAIF next argues that DIF erred by failing to apply former ORS 701.025 (renumbered ORS 670.600 in 1991), rather than the common law tests, to that portion of the audit period commencing October 3, 1989. We agree. *S-W Floor Covering Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, ___ P2d ___ (1993). On remand, DIF should determine whether the installers satisfied all eight of the requirements of *former* ORS 701.025 (renumbered ORS 670.600 in 1991) for the relevant portion of the audit period. *Liberty Northwest Ins. Corp. v. Potts*, 119 Or App 252, 850 P2d 1135 (1993).

Portion of order relating to audit period from October 3, 1989, to June 30, 1990, reversed and remanded for reconsideration; otherwise affirmed.

Cite as 121 Or App 413 (1993) June 23, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LAKE OSWEGO HUNT, INC., Respondent,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and
SAIF CORPORATION, Petitioner.
(90-11-001; CA A75468)

Judicial Review from Department of Insurance and Finance.

Argued and submitted April 16, 1993.

Michael O. Whitty, Special 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.

Peter A. Ozanne, Portland, argued the cause for respondent. With him on the brief were William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Portion of order relating to audit period from October 3, 1989, to March 3 reconsideration; otherwise affirmed.

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121 Or App 415> SAIF seeks judicial review of an order of the Department of Insurance and Finance (DIF) finding that four horse trainers who provided services to Lake Oswego Hunt, Inc., during the audit period April 1, 1989, through March 31, 1990, were not "workers" under *former* ORS 656.005(27)(renumbered ORS 656.005(28) in 1990).

DIF applied the four-factor right to control test of *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 769 P2d 215 (1989), for the entire audit period, and concluded that, because Lake Oswego Hunt neither controlled nor retained a right to control the manner and method used to train the students or horses, the trainers were not workers and were not subject to workers' compensation premium assessment. That conclusion follows from DIF's findings, which are supported by substantial evidence.

SAIF contends that DIF erred by not also applying the relative nature of the work test. We disagree. The right to control test enabled DIF to resolve the issues in this case. Therefore, it was unnecessary to apply the relative nature of the work test. *See Premsingh & Assoc. v. Natl. Council on Comp. Ins.*, 111 Or App 624, 627, 826 P2d 120, *rev den* 313 Or 300 (1992).

SAIF also contends that DIF erred by failing to apply *former* ORS 701.025 (renumbered ORS 670.600 in 1991), which sets the standards for independent contractors, for the period from October 3, 1989, to March 31, 1990. We agree. *S-W Floor Covering Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, ___ P2d ___ (1993). We remand for application of the standards under *former* ORS 701.025 for the relevant portion of the audit period.

Portion of order relating to audit period from October 3, 1989, to March 31, 1990, reversed and remanded for reconsideration; otherwise affirmed.

Cite as 121 Or App 443 (1993) July 7, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert A. Cravens, Claimant.

Robert A. **CRAVENS**, *Petitioner,*
v.
SAIF CORPORATION and Ski Ashland, *Respondents.*
(WCB 90-15039; CA A72277)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 29, 1992.
Robert F. Webber, Medford, argued the cause for petitioner. With him on the brief was Black, Chapman & Webber.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
RICHARDSON, C. J.
Affirmed.

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121 Or App 445> Claimant seeks review of an order of the Workers' Compensation Board holding that SAIF was not barred from obtaining an offset against claimant's permanent disability award for overpaid temporary total disability benefits (TTD). Claimant argues that the doctrine of *res judicata,* specifically issue preclusion, prevents SAIF from raising an issue of overpayment. We review pursuant to ORS 656.298 and affirm.

Claimant was injured while working at his part-time job for Ski Ashland. He also worked full time for the City of Medford. SAIF accepted the resulting claim and began paying TTD on the basis of claimant's wages from his part-time employment. Because of the injury, he could not return to work at either job. Claimant requested a hearing, contending that TTD should be calculated on the basis of wages from both jobs. The referee ruled that TTD was properly calculated on the basis of claimant's part-time wages at Ski Ashland. Claimant did not appeal that ruling.

Despite the referee's ruling, SAIF mistakenly began paying TTD on the basis of claimant's combined earnings at both jobs. Claimant then requested a hearing, seeking penalties and attorney fees because of SAIF's late payment of the recalculated TTD. SAIF and claimant reached an agreement that it would pay a penalty of $300. The referee entered an order to that effect and dismissed claimant's hearing request with prejudice.

Approximately one year later, but before the claim was closed, SAIF discovered the error in calculation of TTD and, when it issued its notice of claim closure, it took an offset against the permanent disability award for the overpayment. Claimant requested a hearing to review the permanent disability award that resulted from closure of his claim, and also to contest the offset from the disability award. The referee affirmed the permanent disability award and barred the offset on the ground that SAIF was precluded from litigating the amount of TTD because of "claim preclusion." Both parties appealed to the Board. The Board affirmed the permanent award, but reversed on the issue of the offset, holding **<121 Or App 445/446>** that neither claim preclusion, issue preclusion nor waiver barred the offset.

On review, claimant relies on the doctrine of *res judicata* as his basis for reversal, but argues only that the included concept of issue preclusion is a bar to SAIF's recovery of the overpayment. He contends that SAIF's stipulation to a penalty for late payment of TTD necessarily determined that the amount of TTD was correct. SAIF would not have agreed to a penalty, he argues, if it had contested the amount of TTD. The issue was necessarily determined by the order accepting the stipulation, claimant contends, and SAIF is foreclosed from now litigating the correctness of the TTD payments. He cites *Drews v. EBI Companies,* 310 Or 134, 795 P2d 531 (1990).

Because claimant uses the general term "*res judicata*" and the Board discussed claim and issue preclusion, we address those separate bases for preclusion. TTD is not, by itself, a "claim" that is precluded by former adjudication purposes. *Drews v. EBI Companies, supra.* Rather, it is an issue included in the claim for compensation. Consequently, *claim* preclusion analysis of the *res judicata* doctrine does not apply in these circumstances.

Because the amount of TTD is a factual or legal issue, final adjudication of the amount may preclude relitigation of that issue. In order for relitigation of an issue to be foreclosed by former adjudication, at least two factors must be met. The issue must have been actually litigated and determined in a setting where its determination was necessary to the final decision and a final decision must have been reached. *Drews v. EBI Companies, supra.* Here, claimant has established neither factor.

The amount of TTD was not actually litigated in relation to claimant's request for penalties for late payment. SAIF did not discover its mistake until much later and no issue of the amount was tendered for decision or discussion. The stipulated settlement of the penalty issue provided for a penalty that was related only to the timeliness of the payments and was not dependent on the amount of TTD.

Although the penalty issue for late payment was finally decided, the compensation claim was still open. In fact, **<121 Or App 446/447>** because the claim is still part of this case on review, it has not finally been determined. In that respect, the case is not materially different from *Drews*. There, the claimant sustained a compensable injury and was paid TTD at a mistakenly low rate. The mistake was not discovered or corrected before the claim was finally closed. Later, the claimant filed a claim for aggravation. That claim was denied but the denial was overturned by the referee. The insurer did not seek review and paid TTD at the same incorrect rate. When the aggravation claim was closed, the claimant appealed the permanent award and raised the issue of the incorrect amount of TTD. The insurer argued that the claimant could have raised that issue at the hearing on the denial and, because he did not, he was precluded from litigating it. The Supreme Court held that TTD was not a separate claim and that the rules of preclusion did not apply because the claim for aggravation, of which TTD was a part, had not been finally determined. Consequently, there was not the requisite finality to foreclose the claimant from litigating the amount of previously paid TTD.

Here, as in *Drews*, even if SAIF could and should have raised the issue of the correct TTD rate, there is not the finality of adjudication that is required for either claim or issue preclusion to apply. The amounts of compensation are, under *former* ORS 656.268(10) (renumbered ORS 656.268(13)), subject to adjustment until final closure. *See Drews v. EBI Companies, supra.* It was pursuant to that statute that SAIF made the adjustment in the permanent partial disability award. The statute would have little meaning if the adjustment could be precluded because the correct amount of compensation should have been litigated during the progression of the claim to final closure.

The Board also held that SAIF had not waived its right to the offset by failing to raise the correctness of the TTD when the penalty issue was litigated. We agree. In *Drews*, the court held that, because waiver was the intentional relinquishment of a known right, the claimant, who was unaware that the TTD was incorrect, could not have waived his right to challenge the amount. Here, the Board found that SAIF did not discover its error in calculation until after the hearing on claimant's request for penalties and, **<121 Or App 447/448>** consequently, could not have intentionally and knowingly waived the request for the offset. The Board's legal analysis is correct and its predicate findings are supported by substantial evidence.

Affirmed.

Cite as 121 Or App 513 (1993) July 7, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

HDG ENTERPRISES, INC., dba Modern Floor Covering Co., *Petitioner- Cross-Respondent,*

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, *Respondent,*
and SAIF CORPORATION, *Respondent- Cross-Petitioner.*
(90-10-018; CA A72994)

Judicial Review from Department of Insurance and Finance.

Argued and submitted October 9, 1992.

Inge D. White, Roseburg, argued the cause for petitioner cross-respondent. With her on the briefs was Dole, Coalwell & Clark, P.C., Roseburg.

Leary C. Jones, Salem, waived appearance for respondent National Council on Compensation Insurance.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent - cross-petitioner. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, J.

On petition and cross-petition, reversed and remanded for reconsideration.

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121 Or App 515> Employer is a retailer, primarily in the business of selling floor coverings. SAIF is its workers' compensation insurance carrier. In May, 1990, SAIF conducted a premium audit of employer's payroll for 1989, which resulted in an adjustment to reflect payments made to 13 installers during that time period. Employer requested a hearing before the Department of Insurance and Finance (DIF), arguing that the 13 installers were independent contractors and not employees subject to workers' compensation insurance premium assessments. DIF concluded that all 13 installers were subject workers for the first three quarters of the year, January 1 to October 3, 1989, and that 12 of the 13 were subject workers for the last quarter of 1989. It affirmed the audit with the exception of the premium assessed for one installer in the fourth quarter and ordered SAIF to rebill employer. Employer assigns error to DIF's ruling.

The time period covered by the final premium audit was from January 1, 1989, to December 31,1989. On October 4, 1989, new legislation became effective that defined "independent contractor" for workers' compensation purposes. ORS 670.600.[1] Therefore, we analyze this case in two time **<121 Or App 515/516>** periods the first, from January 1 to October 3, 1989; the second from October 4 to December 31, 1989. S-W *Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, ___ P2d ___ (1993).

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[1] ORS 670.600 provides:

"As used in various provisions of ORS chapters 316, 656, 657 and 701, 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 standards of this section are met:

"(1) The individual or business entity providing the labor or services is free from direction and control over the means and manner of providing the labor or services, subject only to the right of the person for whom the labor or services are provided to specify the desired results;

"(2) The individual or business entity providing labor or services is responsible for obtaining all assumed business registrations or professional occupation licenses required by state law or local government ordinances for the individual or business entity to conduct the business;

"(3) The individual or business entity providing labor or services furnishes the tools or equipment necessary for performance of the contracted labor or services;

"(4) The individual or business entity providing labor or services has the authority to hire and fire employees to perform the labor or services;

For the first time period, we apply the common law right to control test to determine if the installers were subject workers. The elements to be examined are: (1) the right to or the exercise of control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to terminate. We review DIF's findings for substantial evidence and to determine whether the findings support its conclusions as a matter of law. *Salem Decorating v. Natl. Council on Comp. Ins.*, 116 Or App 166, 171, 840 P2d 739 (1992), *rev den* 315 Or 643 (1993); *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 769 P2d 215 (1989).

121 Or App 517> DIF found:

> "In a typical sales transaction, a customer first contacted [employer] to purchase floor covering. Floor coverings were sold to customers by [employer] at a price which included installation. [Employer's] salesperson would assist the customer in selecting the floor covering and would measure the area in which the floor covering was to be installed or otherwise determined the amount of material required. The sales staff usually drew a rough sketch of the room in which the floor covering was to be installed. This rough sketch would contain a suggested position for any seams as well as other details of the installation.
>
> "Once the customer had agreed to purchase floor covering at a specified price, [employer] selected an installer. The selection of a particular installer was determined by ability to do the work, availability to do the work to coincide with the customer's schedule, cleanliness, personality, and the ability to get along with the customer.
>
> "[Employer] had written agreements with the 13 installers at issue in this case, although some of the contracts were signed after work was completed. * * * [Employer] used a form contract which was drafted by its legal counsel. It is unclear whether there was a contract for the prior year in every case, but the majority of the contracts were renewed."

"(5) Payment for the labor or services is made upon completion of the performance of specific portions of the project or is made on the basis of an annual or periodic retainer;

"(6) The individual or business entity providing labor or services is registered under ORS chapter 701, if the individual or business entity provides labor or services for which such registration is required;

"(7) Federal and state income tax returns in the name of the business or a business Schedule C or farm Schedule F as part of the personal income tax return were filed for the previous year if the individual or business entity performed labor or services as an independent contractor in the previous year; and

"(8) The individual or business entity represents to the public that the labor or services are to be provided by an independently established business. Except when an individual or business entity files a Schedule F as part of the personal income tax returns and the individual or business entity performs farm labor or services that are reportable on Schedule C, an individual or business entity is considered to be engaged in an independently established business when four or more of the following circumstances exist:

"(a) The labor or services are primarily carried out at a location that is separate from the residence of an individual who performs the labor or services, or are primarily carried out in a specific portion of the residence, which portion is set aside as the location of the business;

"(b) Commercial advertising or business cards as is customary in operating similar businesses are purchased for the business, or the individual or business entity has a trade association membership;

"(c) Telephone listing and service are used for the business that is separate from the personal residence listing and service used by an individual who performs the labor or services;

"(d) Labor or services are performed only pursuant to written contracts;

"(e) Labor or services are performed for two or more different persons within a period of one year; or

"(f) The individual or business entity assumes financial responsibility for defective workmanship or for service not provided as evidenced by the ownership of performance bonds, warranties, errors and omission insurance or liability insurance relating to the labor or services to be provided."

DIF concluded that employer had a substantial degree of control it could exercise "if it so chose." It also found that, although employer "did not physically supervise the installations, [it] did regulate the quality of the work, and it was [employer] to whom the customer turned if there was a problem with the quality of the installation. " DIF found that the installers purchased and maintained their own equipment, that employer paid its installers twice per month and that employer "believed it had no right to fire an installer unless the installer failed to perform as specified by the written agreement." DIF concluded that the control factor and the right to fire factor were neutral, that the equipment factor indicated independent contractor status and that the method of payment factor indicated an employer-employee relationship. It therefore held that the right to control test was inconclusive. It then applied the relative nature of the work test, *Woody v. Waibel,* 276 Or 189, 197, 554 P2d 492 (1976), and under that test concluded that the 13 installers were subject workers.

121 Or App 518> We review DIF's findings for substantial evidence. However, whether a right to control exists under the facts as found is a question of law for the court. Substantial evidence supports DIF's findings, and we agree with its conclusions on the latter three factors of the right to control test. However, we do not agree with DIF's conclusion that the control factor of that test was neutral. In analyzing this factor under the common law right to control test, the question is not how much control the employer actually exercises, but how much control it has the right to exercise. *Lockard v. The Murphy Co.,* 49 Or App 101, 104, 619 P2d 283 (1980), *rev den* 290 Or 519 (1981).

As DIF's findings reveal, employer had the right to exercise significant control over the installers. DIF stated that the written agreements between employer and the installers provided that each

> "installer was to perform an installation *'at such times and in such places as [employer] shall request'* and that the installer 'will make such installation *in accordance with such work orders, blueprints and specifications as [employer] shall furnish.' "* (Emphasis supplied.)

Moreover, DIF found that

> "[t]he written agreement is replete with references indicating the degree of control [employer] could exercise if it so chose. [Employer] was specific about the nature and quality of the finished product desired. While [employer] did not physically supervise the installations, [employer] did regulate the quality of the work, and it was [employer] to whom the customer turned if there was a problem with the quality of the installation."

We conclude, under the facts found, that employer had the right to exercise control over how the installations were done, and in most cases exercised that control through the use of specifications in the work order. Therefore, the right to control test indicated an employer-employee relationship. *See Salem Decorating v. Natl. Council on Comp. Ins., supra,* 116 Or App at 170. Accordingly, for different reasons, we agree with DIF's conclusion that the 13 installers were subject **<121 Or App 518/519>** workers for the period January 1 to October 3, 1989, and uphold DIF's order to that extent.[2]

Employer also contends that five installers--Kyllo, Palmer (for Palmer Floors), David, Collier and Nelson--were statutorily exempt from assessment for the first three quarters because they were licensed by the Employment Division. It is undisputed that, before October 4, 1989, the installers who were licensed by the Employment Division were conclusively presumed to be independent contractors. *Former* ORS 656.029(3) *(repealed by* Or Laws 1989, ch 762, 5) provided:

> "A person, other than a partnership engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, who submits proof of compliance with ORS 657.042, *is conclusively presumed to be an independent contractor* and is not eligible to receive benefits under this chapter unless the person has obtained coverage for such benefits pursuant to ORS 656.128." (Emphasis supplied.)

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[2] Because we do not agree that the right to control test was inconclusive, it is unnecessary to address the relatlve nature of the work test.

Employer asserts that during some or all of the period from January 1 to October 3, 1989, the five installers listed above were licensed by the Employment Division, and contends that DIF's findings on this issue are inconsistent with the record. It requests a remand for findings on which installers were exempt, under *former* ORS 656.029(3), and for rebilling relating to premiums assessed based on payments made to these installers during that period.

The record shows, however, that SAIF recognized the exception for those workers conclusively classified as independent contractors. In its final premium audit billing, SAIF stated:

> "Charges have not been made for those earnings of subcontractors that were paid prior to October 3,1989 in cases where the subcontractor is known to have met the exception to the subcontractor law and was filed and certified through the Employment Division. Please check this list of names and if any of those charged prior to October 3, 1989, in fact, maintain registration, please forward that information. "

121 Or App 520> SAIF exempted all but the fourth quarter earnings (earnings after October 4, 1989) for the five installers employer lists as having been exempt up to October 3. There is no evidence that employer was improperly billed for the five installers during the first three quarters. Accordingly, there is no need for remand on this issue.

With regard to the time period from October 4 to December 31, 1989, after the enactment of ORS 670.600, the elements of the statute control the determination of independent contractor status. *Blackledge Furniture v. Natl. Council on Comp. Ins.*, 121 Or App 409, ___ P2d ___ (1993). DIF found that the installers met all the criteria in subsections (1) through (6), except for Collier, who failed to meet subsection (6). It concluded that Collier was a subject employee. Under subsection (7), DIF found that "only Shepard was shown to have filed income tax returns" and concluded that Shepard was an independent contractor for that period. It found that no other installers were shown to have filed tax returns and concluded that the remaining 11 installers were employees. DIF made no findings with respect to subsection (8). Because all eight elements of ORS 670.600 must be satisfied before a worker may be considered an independent contractor, DIF should make findings relating to this subsection on remand. *Liberty Northwest Ins. Corp. v. Potts*, 119 Or App 252, 850 P2d 1135 (1993).

Employer assigns error to DIF's findings and conclusions regarding the elements of ORS 670.600. It first asserts that the final premium audit billing in this case alleged only the failure of the installers to meet subsection (1) of ORS 670.600, and that it should not have been required to present evidence on the factors in (2) through (8). Essentially, employer is arguing that it lacked notice of the issues to be determined at the hearing. However, the record demonstrates that employer knew that the status of the installers for the fourth quarter would be determined under ORS 670.600 and that that statute required that the installers meet each subsection ofthe provision. Employer may not now argue that it had no obligation to show compliance with the requirements of that statute.

Employer next argues that DIF's finding that Collier did not meet subsection (6) is not supported by the record. **<121 Or App 520/521>** DIF stated that "there was no evidence presented that he was registered with the [Construction Contractors Board (CCB)] as required by subsection (6)." However, there are several documents admitted as exhibits that show state that Collier had a valid certification number from the CCB. Nonetheless, DIF found that there was *no* evidence of compliance. When the record, viewed as a whole, would permit a reasonable person to make a finding, substantial evidence supports that finding. ORS 183.482(8)(c). Here, the record does not permit a reasonable person to make a finding that there was no evidence of compliance. We remand for reconsideration on this issue. *See Younger v. City of Portland*, 305 Or 346, 752 P2d 262 (1988).

Employer's next argument and SAIF's cross-petition involve the same issue. DIF found that, of the 12 remaining installers after Collier was eliminated, only Shepard had complied with the requirement of ORS 670.600(7) that federal and state income tax returns for the business be filed for the previous year. Employer points to evidence in the record that all of the installers, with the exception of Thomas, were registered with the CCB under ORS 701.035(1) and contends that DIF erred as a matter of law in finding that the installers were not in compliance with subsection (7). Employer reasons that in order to be registered with the CCB, a person must be an independent contractor as defined by ORS 670.600. One of the qualifications under ORS 670.600 is that the person, in the previous year, has

filed state and federal income tax returns for the business. Employer asserts that it follows, as a matter of law, that if the CCB allowed the person to register as an independent contractor, the requirement as to tax returns must have been satisfied. In its cross-petition, SAIF argues that substantial evidence does not support DIF's finding that installer Shepard had complied with subsection (7), because the only evidence that he had filed a tax return for his business in the previous year was his registration with the CCB.[3]

ORS 701.035(1) provides that "[a]n applicant must qualify as an independent contractor, under ORS 670.600, to **<121 Or App 521/522>** register with the board."[4] DIF noted in its conclusion that despite the language of ORS 701.035(1), ORS 701.055(9) states: "Registration under this chapter is prima facie evidence that the registrant conducts a separate, independent business." It held that because ORS 701.055(9) did not use the language "independent contractor," ORS 701.035(1) did not apply as a legal presumption of compliance with ORS 670.600.

We agree with DIF that registration with the CCB is not conclusive proof that the registrant is an independent contractor. Registration is prima facie evidence only of the fact that the registrant "conducts a separate, independent business." Unlike *former* ORS 656.029(3), it does not give rise to a conclusive presumption as a matter of law. Nonetheless, we believe that registration with the CCB is evidence from which DIF may reasonably draw an inference that the person did file tax returns for the business. Accordingly, DIF properly conducted an independent assessment of the elements of ORS 670.600 to determine whether the installers were independent contractors during the fourth quarter. Based on the evidence, it was permissible for DIF to find that Shepard had complied with subsection (7) because of his registration with the CCB. The problem with that finding, however, is that it is inconsistent with DIF's findings regarding the other installers who were also registered with the CCB. Because DIF appears to draw opposite inferences from essentially the same evidence, we remand for its determination of whether, based on the whole record, the installers were in compliance with ORS 670.600.

Finally, employer contends that SAIF is estopped from assessing additional premiums because, in its final **<121 Or App 522/523>** order, DIF allegedly failed to comply with ORS 183.470(2) by not stating findings of fact or conclusions of law with respect to employer's estoppel argument. On February 12, 1992, DIF issued an amended final order in this case. On this issue, DIF stated in its finding of fact that "SAIF made no false representation of any material facts to [employer]." However, it did not state its conclusion of law on this point as it had in the previous order. On remand, DIF should include in its order its conclusion of law concerning employer's estoppel argument.

On petition and cross-petition, reversed and remanded for reconsideration.

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[3] Employer concedes that there is no direct evidence in the record to support the finding that Shepard filed business tax returns.

[4] The remainder of the statute provides:

"(2) The board shall establish two classes of independent contractor registration:

"(a) The nonexempt class is a sole proprietor, partnership or corporation with employees or a partnership without employees.

"(3) If a registrant who qualifies for registration under paragraph (b) of subsection (2) of this section hires one or more employees, the registration is invalid and reapplication shall be made.

"(4) The decision of the board that a registrant is an independent contractor applies only when the registrant is performing work of the nature described in ORS 701.055 and 701.060."

Cite as 121 Or App 529 (1993) July 7, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jerome F. Bischoff, Claimant.

Jerome F. **BISCHOFF**, Petitioner,
v.
BISCHOFF & STROOBAND, P.C. and SAIF Corporation, *Respondents*.
(91-07659; CA A76223)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs January 15, 1993.
Jerome F. Bischoff, Eugene, filed the brief *pro se*.
Charles S. Crookham, Attorney General, Virginia L. Linder, Solicitor General, and Michael O. Whitty, Special Assistant Attorney General, Salem, filed the brief for respondents.
Before Deits, Presiding Judge, and Riggs and Durham, Judges.
RIGGS, J.
Affirmed.

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121 Or App 531> Claimant appeals an order of the Workers' Compensation Board denying attorney fees. In this case of first impression, we affirm.

Claimant is an attorney who sustained a compensable injury. SAIF denied the claim. Claimant represented himself. The referee awarded claimant a 25 percent penalty and an assessed attorney fee for unreasonable denial of the claim under ORS 656.386(1). The Workers' Compensation Board affirmed the penalty award and reversed the award of attorney fees. Claimant assigns error to the reversal of the award of attorney fees.

We review for error of law. ORS 183.482(8)(a). However, we will defer to the Board's interpretation of its rule, so long as that interpretation is not inconsistent with the rule or the policy expressed in the statutes. *Mershon* v. *Oregonian Publishing*, 96 Or App 223,227, 772 P2d 440, *rev den* 308 Or 315 (1989). The Board's ruling is not inconsistent with rules or statutes. Its definition of attorney fees is:

> " 'Attorney fee' means payment for legal services performed by an attorney *on behalf and at the request of* a claimant * * * under ORS Chapter 656." OAR 438-15-005(4). (Emphasis supplied.)

In *Stanley W. Talley*, 38 Van Natta 1553, 1554 (1986), the Board ruled that *pro se* claimants who are not attorneys may not be awarded an attorney fee. Nothing in the statutes suggests that the legislature intended to treat *pro se* attorneys differently from other *pro se* claimants. Claimant is not entitled to attorney fees.

Affirmed.

Cite as 121 Or App 563 (1993) July 14, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Edwin E. Nowak, Claimant.

Edwin E. **NOWAK**, *Petitioner,*
v.
SAIF CORPORATION and Cobra Development, *Respondents.*
(91-14275; CA A77070)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 14, 1993.

Darrell E. Bewley, Salem, argued the cause for petitioner. With him on the brief was Vick and Gutzler, Portland.

Michael Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, 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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121 Or App 565> Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's dismissal of his request for hearing on the ground that it was untimely. We affirm.

By a May, 1989, determination order, claimant received an award for a compensable injury to his neck and right arm. The determination order stated that claimant had become medically stationary on April 11, 1989. He was eligible for vocational assistance, and enrolled in an authorized training program which ended December 14, 1990, when he found suitable employment. The Evaluation Section issued a second determination order on March 29, 1991, reducing claimant's unscheduled award from 16 percent to 12 percent. The order notified claimant in bold type:

> "FOR A PERIOD OF 180 DAYS AFTER THE MAILING DATE OF THIS ORDER YOU HAVE A RIGHT TO REQUEST A RECONSIDERATION OR A HEARING."

The order did not state claimant's medically stationary date.

Before it was amended in 1990, ORS 656.268(4) permitted the claimant to request a redetermination by the Department of Insurance and Finance (DIF). Alternatively, the claimant could seek a hearing. In 1990, the legislature amended ORS 666.268 to *require* that claimants seek reconsideration of the determination order by DIF before requesting a hearing. Subsection (4)(e) provides:

> "If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section."

The amended statute is applicable to workers who become medically stationary on or after July 1, 1990. Or Laws 1990, ch 2, 54. Because claimant became medically stationary on April 11, 1989, he was required to follow the procedures under the former version of ORS 666.268.

Claimant sought reconsideration of the determination order by DIF, sending the request to the Appellate Unit. The Appellate Unit issued an order dismissing the request, on the ground that it lacked jurisdiction, because claimant had become medically stationary before July 1, 1990, and, hence, **<121 Or App 565/566>** was subject to the law in effect before that date, which made no provision for requesting reconsideration *by the Appellate Unit*. Claimant requested a hearing, and the referee dismissed the request on the ground that it had not been made within 180 days from the date of issuance of the determination order. The Board affirmed the dismissal of the request for hearing.

Under both the former and present versions of the statute, claimant was required to request a hearing within 180 days of the notice of closure, not counting the time from the request for redetermination until redetermination. Here, claimant requested a hearing within 182 days from the determination order, not counting the time from the date he requested reconsideration by the Appellate Unit of DIF to the time the Appellate Unit dismissed his request. Thus, assuming, without deciding, that claimant's request for reconsideration to the Appellate Unit would have been proper under the former

version of ORS 656.268, his request for hearing is nonetheless untimely, because it was not filed within 180 days of the determination order.

Claimant contends that, because the determination order failed to advise him of his medically stationary date, he had no basis to know whether the former or the present version of ORS 656.268 was applicable, and, therefore, no means of knowing which appeal process was available to him. He contends, accordingly, that the determination order does not comply with the provisions of ORS 656.270 regarding what is to be contained in a determination order and is a nullity. ORS 656.270 provides that a determination order must contain

> "a notice in capital letters and boldface type that informs the parties of the proper manner in which to proceed if they are dissatisfied with the determination or closure. The notice shall include information on the rights and duties of the parties to obtain recon-sideration and hearing on the determination or closure, the right of the worker to consult with the ombudsman for injured workers and of the right of the worker to be represented by an attorney. The notice also may include such other relevant information as the director prescribes."

121 Or App 567> The determination order correctly advised claimant of his right, under the former version of ORS 656.268, to seek redetermination or to request a hearing. It was not necessary under the statute for the order to advise claimant of his medically stationary date.

Affirmed.

Cite as 121 Or App 568 (1993) July 14, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ray C. Cox, Claimant.

Ray C. **COX**, *Petitioner,*
v.
SAIF CORPORATION and Gregory Forest Products, *Respondents.*
(91-09172; CA A77360)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 23, 1993.
Robert F. Webber, Medford, argued the cause for petitioner. With him on the brief was Black, Chapman & Webber, Medford.
Steven Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P. J.
Reversed and remanded for reconsideration.

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121 Or App 570> Claimant seeks review of an order of the Workers' Compensation Board affirming without opinion the referee's order that claimant's hypertension, diabetes and hyperlipidemia are not compensable. We agree with claimant that the Board erred in determining that the conditions are not compensable, and we reverse and remand for reconsideration.

In an unappealed order of March 29, 1989, a referee held that claimant's hypertension, diabetes and hyperlipidemia are compensable, because they are materially related to a compensable hand injury. The medical evidence showed that the three conditions were consequences of the compensable injury.

In 1990, the legislature enacted ORS 656.005(7) (a)(A), which provides, in part:

> "No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. "

In *Albany General Hospital v. Gasperino,* 113 Or App 411, 415, 833 P2d 1292 (1992), we held that, under ORS 656.005 (7)(a)(A), if a condition or need for treatment is caused by the industrial injury, as opposed to the industrial accident, the major contributing cause standard is applicable.

In 1991, claimant's treating doctor provided an opinion that the major contributing cause of claimant's hypertension and diabetes is an inherited tendency, and that the major contributing cause of claimant's hyperlipidemia is his diabetes and inherited tendencies. SAIF sent claimant a letter denying the compensability of the three conditions, on the ground that work was not the major contributing cause of the conditions.[1] The referee and the Board affirmed the denial, **<121 Or App 570/571>** reasoning that changes in the law permitted relitigation of the compensability of the three consequential conditions. The Board held that claimant had failed to satisfy his burden under ORS 656.005(7)(a)(A) to show that the compensable injury was the major contributing cause of the three conditions.

Claimant seeks review, contending that SAIF may not relitigate the compensability of the three conditions under the new, stricter standard. We agree. The three conditions were finally and conclusively determined to be compensable in 1989. The Board erred in holding that the compensability of the conditions may be relitigated subsequent to a change in the law creating a new standard for compensability. *North Clackamas School Dist. v. White,* 305 Or 48, 750 P2d 485, *mod* 305 Or 468, 752 P2d 1210 (1988).

Although SAIF seeks to affirm the Board's order, it does not contend on review that the compensability of the conditions themselves are subject to relitigation. Rather, it argues that the compensability of *treatment* for the conditions rendered after July 1, 1990, is subject to relitigation under the standard set forth in ORS 656.005(7)(a)(A). The practical effect is nearly the same.

Thorpe v. Seige Logging, 115 Or App 335, 838 P2d 628 (1992), *rev den* 315 Or 313 (1993), on which SAIF relies, is distinguishable. There, the claimant's treatments with Dimethylsulfoxide (DMSO) had been determined to be compensable in 1983. Subsequently, in 1989, the Department of Insurance and Finance (DIF) amended its administrative rules in response to a statutory change, to provide that DMSO treatment was considered to be reasonable and necessary only for a condition that the claimant did not have. SAIF denied payment for the claimant's DMSO treatments rendered after the effective date of the rule. The claimant contended that relitigation of the compensability of DMSO treatment was barred, or in the alternative, that pursuant to ORS 656.202, his claim should be governed by the law in effect at the time of injury, and the statutory and rule amendments were inapplicable. We held that litigation of the compensability of a specific type of treatment after the amendment to the statute and administrative rule was not barred by the 1983 determination of the compensability of **<121 Or App 571/572>** the treatment. Additionally, we held that the statutory and related rule amendments were applicable to the claim. They did not affect the underlying compensability of the claim. Specifically, we relied on Oregon Laws 1987, chapter 884, section 62(1):

> "Notwithstanding ORS 656.202, amendments by this act to ORS 656.245, 656.254, 656.262, 656.278, 656.298, 656.388, 656.538, 656.622,656.794 and sections 17, 18,28, 29,30,31,33 and 41 of the Act become operative January 1, 1988."

We said:

> "By including the language 'notwithstanding ORS 656.202,' the legislature specifically indicated that it intended that ORS 656.245(4)--and, consequently, rules promulgated under its authority--would apply to all claims in existence *on the operative date of the rules,* without regard to the law that was applicable at the time of injury.

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[1] SAIF has characterized the denial as a denial of *treatment* for the three conditions. The denial letter shows that it clearly was a denial of the compensability of the conditions as well:

> "We continue to receive billings for treatment related to hypertension diabetes, and hyperlipidemia. Your physician has recently indicated your industrial injury to your right hand is not the major cause of these current conditions. Therefore, we must respectfully issue this partial denial of compensability and responsibility for your hypertension, diabetes and hyperlipidemia."

> "We recognize the harsh consequences of so applying the legislation, but we are required to interpret statutes as the legislature writes them. Section 62(a) must be read to describe both the operative date of the specified amendments and the applicability of those amendments to particular claims." 115 Or App at 340. (Emphasis in original.)

Here, a provision analogous to Section 62(1) is applicable to the legislative amendments creating ORS 656.005(7)(a)(A). Oregon Laws 1990, chapter 2, section 54(1) provides

> "Except for amendments to ORS 656.207, 656.211, 656.214(2) and 656.790, this 1990 Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section."

SAIF contends that that section makes ORS 656.005(7)(a)(A) applicable to this claim for the purpose of determining the compensability of medical treatment for the three compensable conditions. We conclude, however, that the provisions of section 54(1) do not express an intention to permit the relitigation of claims that have previously been fully and finally litigated under the former statutes. Our conclusion receives support from the fact that, at the same time that it **<121 Or App 572/573>** enacted section 54(1), the legislature enacted Oregon laws 1990, chapter 2, section 54(2), which provides:

> "Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1,1990, shall be determined pursuant to the law in effect before July 1, 1990."

Section 54(2) clearly expresses an intent that cases in litigation at the time of the enactment ofthe 1990 legislation would not be affected by that legislation. It would be contrary to that intent to read section 54(1) to permit relitigation of claims that were finally litigated at the time of enactment of the 1990 legislation.

As we have held, claimant's three conditions are compensable under the material contributing cause standard, as applicable before the 1990 legislative amendments, and that issue is not subject to relitigation under ORS 656.005 (7)(a)(A). We further conclude that medical treatment for those conditions is compensable under the same standard.[2]

Reversed and remanded for reconsideration.

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[2] No party contends that this claim is subject to the provisions of ORS 656.005(7)(a)(B). That subsection provides:

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

In *Tektronix, Inc. v. Nazari*, 117 Or App 409, 844 P2d 258 (1992), *on recon* 120 Or App 590, 594, ___ P2d ___ (1993), we held that, in order to obtain further compensation for disability or a need for treatment that is the result of a combination of a compensable injury and a preexisting, noncompensable condition, the claimant must show that the injury is the major contributing cause of the disability or need for treatment. We did not consider whether that standard was applicable in the context of a claim that had previously been determined to be compensable under pre-1990 law. We note that here, for the purpose of considering the effect of ORS 656.005(7)(a)(B), the question would be whether claimant's compensable hypertension, diabetes and hyperlipidemia are the major contributing cause of his need for treatment.

Cite as 121 Or 643 (1993) July 14, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LITTLE DONKEY ENTERPRISES, INC., *Petitioner,*
v.
STATE ACCIDENT INSURANCE FUND, *Respondent.*
(88-11-01; CA A72333)

Judicial Review from Department of Insurance and Finance.
On petitioner's petition for reconsideration filed May 19, 1993. Opinion filed February 3, 1993. 118 Or App 54,845 P2d 1298.
Montgomery W. Cobb, Portland, for petition.
Before Richardson,* Chief Judge, and DeMuniz and Leeson,** Judges.
De MUNIZ, J.
Reconsideration allowed; opinion modified; reversed and remanded for reconsideration.
* Richardson, C. J., *vice* Buttler, J., retired.
** Leeson, J., *vice* Joseph, C. J., retired.

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121 Or App 645> Petitioner, Little Donkey Enterprises, Inc., has filed a petition for review of our decision affirming an order of the Department of Insurance and Finance (DIF). We held that owner-operators with whom petitioner had contracted to haul loads for petitioner's shipper customers were employees for purpose of workers' compensation and that amounts paid to them are wages to be considered in the calculation of workers' compensation premium assessments. *Little Donkey Enterprises, Inc. v. SAIF,* 118 Or App 54, 845 P2d 1298 (1993) *(Little Donkey II).* We also reconsidered our opinion in *Little Donkey Enterprises, Inc. v. SAIF,* 107 Or App 400, 812 P2d 25 (1991) *(Little Donkey I),* and held that a person may simultaneously function as the sole proprietor of a business and as an employee of another business, and that that person is not barred from workers' compensation coverage while working in the latter capacity. In *Little Donkey II* we adhered to our holding in *Little Donkey I* that substantial evidence supports DIF's determination that the owner-operators are employees rather than independent contractors.

Petitioner is required by Interstate Commerce Commission (ICC) regulations to enter into lease agreements with the owner-operators of trucks hauling loads under petitioner's operating authority. The lease agreements contain terms required by the ICC in 49 CFR 1057.12. Specifically, 49 CFR 1057.12(c) requires that the lease "shall provide that the authorized carrier lessee shall have exclusive possession, control, and use of the equipment for the duration of the lease." In its first order in this case, DIF based its determination that the owner-operators are employees primarily on its construction of the ICC leases between petitioner and the owner-operators. DIF said:

> "Petitioner's basic position is that it did not believe that it had a right to control the owner-operators concerning the manner and means of carrying out the shipping duties. Clearly, petitioner's belief was incorrect. We simply do not believe the characterization of the relationship as presented by petitioner's witnesses. Their understanding of petitioner's right to control is directly contradicted by the lease agreement noted in the Findings of Fact, above. Because oral testimony of petitioner's witnesses is at such variance with **<121 Or App 645/646>** this agreement, that testimony is untrustworthy and thus lacks credibility.
>
> "The contractual right to control is stated directly and indicated in enumerated duties under the contract. The lease agreement states: "Carriers [petitioner] shall ultimately determine the control and transportation service to be performed under this agreement * * *." Beyond this stated and unqualified right to control, this agreement is replete with enumerated rights to control the owner- operators."

Subsequent to DIF's order and to our decision in *Little Donkey I,* the ICC amended its lease regulation. The amendment provides:

> "(4) Nothing in the provisions required by paragraph (c)(1) of this section is intended to affect whether the lessor or driver provided by the lessor is an independent contractor or an employee of the authorized carrier lessee. An independent contractor relationship may exist when a carrier lessee complies with 49 USC 11107 and attendant administrative requirements." 49 CFR 1057.12(c)(4).

The ICC explained that the amendment is intended to express the intent of the regulation:

> "The purpose of the amendment is to give notice to the courts and workers' compensation or other administrative tribunals who have ruled otherwise that, in requiring that a lease provide for a lessee's 'exclusive possession, control, and use' of equipment provided by the lessor, it is not the intention of the Commission's regulations to define or affect the relationship between a motor carrier lessee and an independent owner-operator lessor." 57 Fed Reg 32905 (July 24, 1992).

The amendment was not brought to our attention in *Little Donkey II.* It necessitates a significant reevaluation of the employee/independent contractor question presented by this case. In view of the amendment, we conclude that reconsideration is appropriate. We allow reconsideration of *Little Donkey II,* withdraw that portion of our decision adhering to the holding in *Little Donkey I* that the owner-operators are employees, and remand to DIF for reconsideration.

Reconsideration allowed; opinion modified; reversed and remanded for reconsideration.

Cite as 121 Or App 647 (1993) July 14, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Irwin W. Geer, Claimant.

Irwin W. **GEER**, *Petitioner,*

v.

SAIF CORPORATION, Carla Properties, Ltd., EBI Companies and Jack Johnston Meat Packers, *Respondents.*

(92-01980, 91-17845; CA A76772)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 24, 1993.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were C. Rodney Kirkpatrick and Kirkpatrick & Zeitz, Portland.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Carla Properties, Ltd. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Randy G. Rice, Portland, waived appearance for respondents EBI Companies and Jack Johnston Meat Packers.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Affirmed.

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121 Or App 649> Claimant petitions for review of an order of the Workers' Compensation Board. We affirm.

The Board characterized the procedural history of this case as "confusing." The essential facts are: On May 13, 1992, the referee issued an order affirming in part, and setting aside in part, SAIF's denial of claimant's claims for a lower back injury, and ordering SAIF to pay an assessed attorney fee. On June 11, 1992, the referee signed an order granting claimant's request that the May 13 order be abated. The abatement order was not mailed until June 15, 1992.

SAIF petitioned the Board for review. The Board indicated its agreement with SAIF's contention that an abatement order is not effective until mailed, but dismissed the petition for review on the ground that an abatement order is not appealable because it does not dispose of a claim. The referee subsequently withdrew the abatement order. Claimant petitioned the Board to reconsider whether an abatement order is effective when signed, rather than when mailed. The Board adhered to its position that such an order is effective when mailed. Claimant then filed this petition for review.

A referee's order generally becomes final[1] 30 days after the date on which a copy is mailed to the parties. ORS 656.289(3). However, the order does not become final if, within that period, a party petitions the Board for review, ORS 656.289(3), or the referee abates the order. *Lyday v. Liberty Northwest Ins. Corp.*, 115 Or App 668, 671, 839 P2d 856 (1992).

In this case, the referee signed the abatement order on June 11, 1992, within the 30-day period. However, it was not mailed until June 15, 1992, after the period expired. The sole issue is whether the Board erred in concluding that the effective date of an abatement order is when it is mailed, rather than when it is signed. Other statutes that address specific orders of the referee and Board provide that orders are effective upon mailing. ORS 656.268(6)(a),(b); ORS 656.268(9): ORS 656.289(3); ORS 656.295(8). The Board did **<121 Or App 649/650>** not err in holding that an abatement order becomes effective when mailed.

In this case, the referee's order of May 13, 1992, became final by operation of law on June 12. The order was not abated within 30 days, nor did any party petition the Board for review within that period.

Affirmed.

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[1] An order that has become "final," for purposes of ORS 656.289(3), is one that is no longer appealable.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

State ex rel Jeffrey **BENZINGER**, Sharon Byers, Sandra Collins, Richard Friend, Teddy Moulton, Blain Young, Sharon L. Allen, Annie Barrow, Linda Carpenter, Susan Christensen, Russell H. Fowler, James G. Harris, Richard E. Hayes, Patrick McCallum, Debra Ray-Spuhler, Delbert Smelser, Philip Sterle, Jr., Stephen R. Sundstrom, Bernard E. Torrance, Walter VanHooser and Viola Walters, *Respondents,*

v.

OREGON DEPARTMENT OF INSURANCE AND FINANCE, acting through the Workers' Compensation Division Appellate Unit, agencies of the State of Oregon, and Larry Young, *Appellants.*

(A9102-01201; CA A72945)

Appeal from Circuit Court, Multnomah County.

Harl H. Haas, Judge.

Argued and submitted February 19, 1993.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for appellants. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Kevin Keaney, Portland, argued the cause for respondents. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Reversed.

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122 Or App 18> Respondent Department of Insurance and Finance (DIF)[1] appeals from an award of attorney fees in a proceeding to compel agency action, ORS 183.490, and a subsequent contempt proceeding. We reverse.

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[1] The parties characterize themselves as plaintiff and defendant. However, ORS 183.490 provides that "upon petition," a court may compel an agency to act in prescribed situations. Consequently, we refer to the parties as petitioner and respondent and refer to the pleading that initiates the proceeding as a petition, not a complaint. We acknowledge that we have not always followed that practice in prior cases. *See*, e.g., *Benzinger* v. *Oregon* Dept. of *Ins. and Finance*, 107 Or App 449, 812 P2d 36 (1991),and Wyer v. Dressler, 41 Or App 799, 601 P2d 1268 (1979), *rev den* 288 Or 527 (1980).

When this case was first before us, we affirmed a judgment that the trial court entered in favor of one of several petitioners under ORCP 67B. *Benzinger v. Oregon Dept. of Ins. and Finance, supra* n 1. We held that ORS 656.268(6)(a) *(since amended by* Or Laws 1991, ch 502, 1), required the Workers' Compensation Division to process a request for reconsideration of a claim closure within 15 days.

After that decision, the trial court authorized another petitioner, VanHooser, to represent a class of persons similarly situated in order to continue the proceeding as a class action. ORCP 32C.[2] The court's class determination order provided that notice to the class was neither required under ORCP 32F(1)(a) nor necessary under ORCP 32E(2). However, the court stated that DIF "may prepare a form of notice to be sent to the class at [DIF's] cost but which must either be stipulated to by [petitioners] or approved by the court upon motion and hearing."

Some of the remaining individual petitioners and the class representative filed motions for summary judgment, which were granted.[3] Relying on our first opinion, the trial court ordered DIF to issue reconsideration orders within the time limitation imposed by the statute, "regardless of whether the reconsideration process has been completed." The court entered a final judgment on August 23, 1991.

122 Or App 19> DIF issued reconsideration orders to members of the class in compliance with the judgment. In those orders, DIF explained that it had not completed a substantive review of the requests for reconsideration, but that it was nevertheless denying them, because it was required to process them within 15 days of receipt pursuant to a class action judgment. The orders identified the lawsuit and the law firm representing the class. However, DIF did not obtain the prior approval of either the class representative or the court before sending those orders to members of the class.

The class representative considered the communication to be a contemptuous violation of the notification restrictions that the court had imposed in its class determination order. At petitioners' request, the court held a hearing to determine whether DIF and a responsible official of DIF should be held in contempt of court. *See former* ORS 33.040 *(repealed by* Or Laws 1991, ch 724, 32). In an opinion letter dated October 16, 1991, issued after the show cause hearing, the trial court found that DIF was not in contempt. The court also stated that it was "prepared to receive [a] request for attorney fees."

On November 6, 1991, petitioners filed a petition for attorney fees for services performed on behalf of the class on the merits and for services performed in the contempt proceeding. DIF filed objections, which the court disallowed. On December 4, 1991, the court entered a judgment awarding fees. DIF appeals from that judgment, assigning error to the attorney fee award.

With respect to fees that were incurred to obtain the judgment on the merits on behalf of the class, DIF argues that the fee petition was untimely. We agree. ORCP 68C(4)(a)(i) provided[4] that a party seeking attorney fees was required to serve a verified and detailed statement of the amount of attorney fees sought "not later than 10 days" after entry of judgment. The court entered a final judgment disposing of all claims on August 23, 1991. The petition for attorney fees was not filed until November 6, 1991.[5] Because the attorney fee **<122 Or App 19/20>** petition was filed more than 10 days after

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[2] Several others remained in the proceeding as individual petitioners.

[3] DIF had issued reconsideration orders to some of the remaining individual petitioners during the course of the proceeding. The court dismissed their claims as moot.

[4] The Council on Court Procedures amended ORCP 68C(4) in 1990. The amendment became effective January 1, 1992. See ORS 1.735.

[5] In *Marquez v. Meyers*, 96 Or App 214, 772 P2d 437 (1989), we held that ORCP 15D gives the court authority to extend the time limitation when a party files a supplemental attorney fee petition for postjudgment collection efforts. We review a court's exercise of that authority for abuse of discretion. In the case before us, the court did not grant petitioner an explicit extension of time under ORCP 15D. However, to the extent that its October 16 letter opinion did so implicitly, an extension of time on the facts in the record before us would be an abuse of discretion. Unlike the party in *Marquez* who could not include in his timely attorney fee petition a fee request for work his attorney had not yet performed, the record before us reveals no reason why petitioner could not have filed an attorney fee petition for work performed to obtain a judgment on the merits, on behalf of the class, within the

entry of the final judgment, the court should have dismissed the fee petition on the ground that it was untimely.[6]

With respect to the fees that are related to the contempt proceeding, the court also erred, but for a different reason. In general, an award of attorney fees may be made only when a contract or a statute expressly authorizes them. *Dennehy v. Dept. of Rev.*, 308 Or 423, 781 P2d 346 (1989). Petitioners nevertheless rely on *Deras v. Myers*, 272 Or 47, 66,535 P2d 541 (1975), where the court stated that "courts of equity have the inherent power to award attorney's fees." In *Dennehy v. City of Gresham*, 314 Or 600, 602, 841 P2d 633 (1992), the court explained that fees were appropriate in *Deras* because the plaintiff had "vindicated an important constitutional right applying to all citizens without any gain peculiar to himself."

Petitioners argue that the award of fees for services rendered in the contempt proceeding was a proper exercise of the court's inherent authority.[7] However, in *Deras* and in the case on which it relied, *Gilbert v. Hoisting & Port. Engrs.*, 237 Or 130, 384 P2d 136, 390 P2d 320, *cert den* 376 US 963 (1964), the party receiving the attorney fee *award prevailed* . Although petitioners prevailed in the proceeding to compel agency action, they did not prevail in the contempt proceeding. Nevertheless, the court awarded fees. There is no authority to award attorney fees to a nonprevailing party. *Buchanan* **<122 Or App 20/21>** *v. Wood*, 79 Or App 722, 729-30, 720 P2d 1285, *rev den* 302 Or 158 (1986). *See also Lewis v. Dept. of Rev.*, 294 Or 139, 143, 653 P2d 1265 (1982). The court erred in awarding attorney fees.

Reversed.

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[6] We express no opinion about whether petitioners would have been entitled to attorney fees if the petition had been timely filed.

[7] In 1991, the legislature enacted new contempt laws. ORS 33.105(1)(e) now authorizes a court to require payment of attorney fees "incurred by a party as the result of a contempt of court." Neither party argues that the new legislation authorizes fees in this case.

Cite as 122 Or App 94 (1993) July 28, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pete Topolic, Claimant.

Pete **TOPOLIC**, *Petitioner,*
v.
SAIF CORPORATION and Productive Painting, *Respondents.*
(WCB 90-14609; CA A76488)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 17, 1993.

Thomas C. Howser, Ashland, argued the cause for petitioner. On the brief were Judith H. Uherbelau and Howser & Munsell, P.C., Ashland.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

RIGGS, J.

Scheduled permanent disability award reversed and remanded for reconsideration; otherwise affirmed.

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122 Or App 96> Claimant seeks review of a Workers' Compensation Board (Board) order holding that he did not have an unscheduled disability and was not entitled to permanent total disability. We affirm in part and reverse in part.

Claimant was born in Yugoslavia in 1941 and speaks with a heavy accent. His education is limited to four years of elementary school and four years of trade school in Yugoslavia. He sustained a compensable injury in October, 1988, in a fall from a scaffold. In November 1988, Dr. Gilsdorf, his treating physician, found that claimant could only perform sedentary to light work because of permanent instability in his hip. Claimant was also examined by Dr. Saviers of Rehabilitation Medical Consultants in March, 1991.

Evidence was offered by both parties on whether claimant had a permanent total disability (PTD) due to a combination of physical, social and vocational factors, under the "odd-lot" doctrine. There is strong disagreement among the experts on claimant's vocational skills. All seven experts found that claimant tested below average in manual dexterity, fine motor coordination, and ability to follow directions. His reading and math skills ranged from 1.7 grade level to 3.4 grade level. Several experts concluded that claimant was not competitively employable. In contrast, two experts, Hagle and Stripe, who testified for SAIF, concluded that he was competitively employable. Hagle, a vocational counselor, found claimant's test results were not consistent with his work history, that claimant was strongly motivated and was not a candidate for PTD. Stripe, a vocational consultant, found that claimant could be employed in a broad array of light and sedentary occupations which require little, if any, reading.

On January 23, 1990, a determination order issued awarding claimant temporary total disability and a total scheduled award of 18 degrees for 12 percent loss of the use of his left leg. Claimant requested a hearing. The referee determined that claimant did not have an unscheduled disability and was not entitled to PTD, but increased claimant's total scheduled award. The opinion was amended twice to finally award claimant scheduled permanent partial disability of 45 **<122 Or App 96/97>** degrees. Claimant appealed the referee's order. The Board affirmed the referee's findings and order. Claimant seeks review of the Board's order.

We review the Board's findings for substantial evidence and errors of law. ORS 183.482(8)(a),(c). Substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 294, 787 P2d 884 (1990); ORS 183.482(8)(c).

Claimant first assigns error to the Board's finding that he did not have an unscheduled disability. Any disability not listed in ORS 656.214(2) to (4) is considered unscheduled. ORS 656.214(1)(b).[1] Based on his review of a Board opinion which discusses scheduled and unscheduled hip injuries, Gilsdorf found claimant's injuries to be both scheduled and unscheduled. The Board did not rely on Gilsdorf's analysis because of its concern that he had given a legal opinion.

> "In cases where evidence is rejected or disregarded by the [Board], and such action purports to be based on facts, it is appropriate for the reviewing court to examine whether the [Board's] decision to disregard or discount evidence in the record is supported by substantial evidence. " *Garcia v. Boise Cascade Corp., supra, 309* Or at 296.

Here, the Board, in support of its decision to disregard Gilsdorf's opinion, indicated that it was hesitant to defer to Gilsdorf when he may not have fully understood the legal meaning of a prior Board order. It also distinguished its prior decision from the present case. Based on past Board decisions and claimant's medical records, the Board found that his injury was to the "leg," which is a scheduled body part. It rendered a reasoned opinion on the basis of explicit findings of fact. Based on the whole record, a reasonable person could find that the claimant does not have an unscheduled injury. *Garcia v. Boise Cascade Corp., supra, 309* Or at 294.

122 Or App 98> Claimant next assigns error to the Board's finding that he is not PTD. ORS 656.206(1)(a) provides:

> " 'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation."

PTD may be established through evidence of physical incapacity alone, or by showing that physical incapacity, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot" doctrine. *Welch v. Banister Pipeline,* 70 Or App 699, 701, 690 P2d 1080 (1984), *rev den* 298 Or 470 (1985).

Claimant argues that, based on a combination of his physical condition, age, and limited reading, math, dexteriy and mental skills, he falls within the "odd-lot" doctrine. Claimant underwent seven vocational evaluations which resulted in conclusions as varied as claimant would not be able to find suitable work to claimant was definitely not PTD. The Board found the reports by employer's witnesses, Hagle and Stripe, who concluded that claimant was employable, to be the most credible. The Board placed the most weight on Hagle's opinion:[2]

> "Hagle found that claimant's test results were not consistent with his work history and other accomplishments. Hagle further reported that claimant's 'ability to communicate, fueled by the moxie, drive and intelligence native to [claimant], make him one of the least likely PTD candidates.'

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[1] ORS 656.214 provides, in pertinent part:

"(1)(b) 'Permanent partial disability' means the loss of either one arm, one hand, one leg, one foot * * * or any other injury known in surgery to be permanent partial disability.

"When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the iniured member due the industrial injury."

[2] Claimant asserts that Hagle's deposition was never entered into evidence and thus, the referee did not have substantial evidence to uphold his opinion and order. There is no listing of Hagle's deposition in the evidence lists and no formal entry of her deposition in the record. Nonetheless, the Board concluded that since the referee referred to the deposition in his order and certified that it was part of the record under ORS 656.295(3), it was properly included in the record. We conclude that the Board properly reviewed the referee's opinion.

" * * * * *

122 Or App 99> "By the time [Hagle] was deposed, she had met with claimant six times. Thus, she had more contact with claimant tha[n] did McLean[3] and Stripe. * * * We agree with the Referee that Hagle's opinion is entitled to the greatest weight. Based on that evidence, along with the supporting opinion of Stripe, we conclude that the claimant is not permanently totally disabled."

If an agency's finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence to support the finding. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988)

Claimant last assigns error to the Board's refusal to further increase his scheduled permanent disability award. The Board stated that "we agree with the Referee that, because claimant's atrophy is not located in the foot or thigh, he is not entitled to an award for that condition under the standards. *See former* OAR 436-35-230(5)." Saviers' March 18, 1991, report states that claimant has "visible atrophy of the left extensor digitorum brevis, " a muscle of the foot.[4] The Board's decision on claimant's permanent disability award was based on a misinterpretation of the evidence, and is not supported by substantial evidence. We remand for reconsideration of the scheduled permanent disability award.

Scheduled permanent disability award reversed and remanded for reconsideration: otherwise affirmed.

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[3] Bruce McLean is a vocational consultant who evaluated claimant and testified on his behalf.

[4] *Stedman's Medical Dictionary*, 2nd Lawyer's Ed, Plate 7 (1966).

Cite as 122 Or App 155 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Terry K. Davis, Claimant.

PRECISION CASTPARTS CORPORATION, *Petitioner*,
v.
Terry K. **DAVIS**, *Respondent*.
(WCB No. 90-09218; CA A74861)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 26, 1993.
Ronald C. Holloway, Portland, argued the cause for petitioner. With him on the briefs were Charles F. Adams and Stoel Rives Boley Jones & Grey, Portland.
Ronald A. Fontana, Portland, argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Affirmed.

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122 Or App 157> Employer seeks review of an order of the Workers' Compensation Board setting aside employer's denial of claimant's work-related stress claim. We affirm.

The Board found that claimant began working for employer in 1979. In August, 1984, one of claimant's co-workers, Force, was working in a slurry pot, cleaning it out. Claimant noticed Force lying in the bottom of the pot, apparently asleep. He decided to wake Force by closing the lid on the pot to startle him. Force did not wake up. Claimant then saw that Force's color had changed, and he realized that something was wrong. He and another co-worker lifted Force out of the pot and attempted to resuscitate him. Force was taken to a hospital. He has remained comatose since then.

Force's injury was caused by argon gas, which was pumped into the slurry pots. Claimant was [illegible] dangerous propensities of argon gas.

Claimant continued to work for employer, although he began to experience recurring nightmares about the 1984 injury to Force. He suffered increasingly severe emotional problems. In February, 1990, claimant saw a worker leaning against a pot, in a position similar to what Force had been in when claimant found him in 1984. Claimant suffered an anxiety attack, and left work. He began receiving counseling, and was diagnosed as suffering from an adjustment disorder. He filed a claim for an occupational disease, which employer denied. The Board concluded that the claim is compensable.

Employer argues that there is not substantial evidence to support the Board's findings that among other things, the 1984 incident was the major contributing cause of claimant's psychological condition, and that claimant's nonwork stressors did not cause his mental disorder. The evidence supports all of those findings.

Employer also argues that substantial evidence does not support the Board's finding that

> "[h]ere, the causal link between both claimant's injury and his co-worker, Force's injury, is the argon gas which was being pumped into the slurry pot in which Force had been working. The evidence indicates that claimant did not know **<122 Or App 157/158>** argon gas was being pumped into the slurry pot where Force was lying.
>
> The argon gas, not claimant's alleged horseplay, caused Force's injury, and the incident in which Force was injured eventually led to the development of claimant's mental disorder. Thus, we conclude that there is a causal link between the occurrence of the injury and a risk (the argon gas) connected with claimant's employment."

We agree with employer that there is not substantial evidence to support the Board's finding that argon gas is the causal link between claimant's mental disease and a risk connected with his employment. However, that failure of evidence does not require reversal.

It appears that the Board made the challenged finding in response to employer's argument that claimant's condition is not compensable under ORS 656.005(7)(b)(A) or (B), which provide:

> "(b) 'Compensable injury' does not include:
>
> "(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a denation from customary duties; [or]
>
> "(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure[.]"

Employer's argument is that claimant's condition is not work related because its cause, claimant's lowering of the lid on the slurry pot in which Force was lying and the resulting remorse that claimant experienced because of that action, was either conduct engaged in for claimant's personal pleasure, or was an assault on Force. A careful reading of the Board's order shows the flaw in employer's argument.

Employer begins with the premise that claimant's condition originated from his own actions in closing the lid on the slurry pot. That is not what the Board found. In analyzing the claim, the Board considered each of the requirements of ORS 656.802(3). It indicated the employment conditions that it concluded had produced claimant's mental disorder: the severe injury to Force and claimant's discovery of him.[1] In **<122 Or App 158/159>** focusing on those causes, it appears that the Board rejected the premise of employer's argument here: that the cause of the mental disorder was claimant's act of closing the lid on the slurry pot in which Force was lying. That rejection was made explicit by the Board's statement that "[t]he argon gas, not claimant's alleged horseplay, caused Force's injury, and the incident in which Force was injured eventually led to the development of claimant's disorder." Because the Board found that claimant's condition was not caused by horseplay or assault, and there is substantial evidence to support that finding, employer's argument fails.

Affirmed.

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[1] It also considered, in passing, claimant's own exposure to argon gas. As we have said, there is not substantial evidence to support a finding that claimant's exposure to gas caused the mental disease. Therefore, we will disregard that finding, which is not significant to the ultimate determination of comparability.

Cite as 122 Or App 160 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Heather I. Smith, Claimant.

SAFEWAY STORES, INC., *Petitioner*,
v.
Heather I. **SMITH**, *Respondent*.
(WCB 91-05062; CA A77600)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs May 12, 1993.
Kenneth L. Kleinsmith and Meyers & Radler, Tigard, filed the brief for petitioner.
Daryll E. Klein, Milwaukie, and Francesconi & Associates, Portland, filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration.

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122 Or App 162> Employer seeks review of an order of the Workers' Compensation Board affirming the referee's award of unscheduled permanent partial disability. We reverse.

The only facts necessary to our opinion are that claimant was not employed at the time the determination order was issued, but was employed part time when the order on reconsideration of the determination order issued. In determining claimant's adaptability for purposes of rating disability, the Board considered claimant's work status as of the time the determination order issued. Employer argues that adaptability should be rated as of the date of the reconsideration order. We agree with employer.

When a determination order issues, a claimant or employer who objects to the order must first request reconsideration. ORS 656.268(5). If any party objects to the reconsideration order, the party may request a hearing before a referee, pursuant to ORS 656.283. ORS 656.268(6)(b). "Evaluation of the worker's disability by the referee shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268." ORS 656.283(7). Under ORS 656.726(3) (f)(A),

> "[t]he 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."

Although the Board acknowledged the directive of ORS 656.283(7) to determine disability as of the date the reconsideration order is issued, it nonetheless rated claimant's adaptability as of the date of the determination order. It considered the legislative history of ORS 656.283(7), and concluded that the legislature did not intend that changes in a claimant's work status between the date of the determination order and the date of the reconsideration order should be taken into account in determining adaptability for purposes of rating the extent of disability. It also relied on ORS 656.268(5), which limits the evidence that may be submitted at the reconsideration proceeding. Because evidence of a change in a claimant's work status after the determination order cannot be submitted on reconsideration, the Board **<122 Or App 162/163>** reasoned that that change cannot be considered by the referee at a hearing challenging the reconsideration order.

The Board erred. The statutory language is not ambiguous and, therefore, is not open to construction. It directs that the referee *shall* evaluate the claimant's disability "as of the date of the reconsideration order pursuant to ORS 656.268." Evaluation of disability includes the claimant's adaptability to perform a given job. ORS 656.726(3) (f)(A).

Further, the Board's reliance on ORS 656.268(5) is misplaced. Although the evidence that may be submitted on reconsideration before DIF is limited to correcting erroneous information and certain medical evidence that should have been but was not submitted at the time of claim closure, ORS 656.268(5), the evidence that may be submitted at the hearing before the referee is not so limited. ORS 656.283(7) provides, in part:

"Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing * * *."

The referee is directed to evaluate disability as of the date of issuance of the reconsideration order. ORS 656.283(7) . There is no limitation similar to ORS 656.268(5) on the evidence that the referee may consider in making that evaluation. The result of ORS 656.268(5) and ORS 656.283(7) is to allow the referee to consider evidence that could not have been submitted to DIF on reconsideration. Although that result seems curious, it is compelled by the statutes.

Accordingly, we remand for the Board to determine claimant's adaptability as of the date of the reconsideration order and to adjust the award based on that determination of adaptability, if necessary.

Reversed and remanded for reconsideration.

Cite as 122 Or App 164 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sandra R. Farrow, Claimant.

FRED MEYER, INC., *Petitioner,*
v.
Sandra R. **FARROW**, *Respondent.*
(WCB 92-02370; CA A78056)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 2, 1993.
Brad G. Garber, Portland, argued the cause for petitioner. With him on the brief was Moscato, Byerly & Skopil, Portland.
Anthony A. Allen, Salem, argued the cause for respondent. On the brief were Jean Fisher LeDoux and Gatti, Gatti, Maier, Jackson & LeDoux, Salem.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
WARREN, P. J.
Affirmed.

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122 Or App 166> Employer seeks review of a Workers' Compensation Board order requiring employer to accept a claim for an aggravation of claimant's compensable hand/wrist condition, a scheduled disability. We affirm the Board's order.

In October, 1991, claimant was awarded temporary total disability benefits for a problem with her right wrist, and her claim was closed with no award for permanent disability. Claimant was laid off from work in November, 1991. In December, 1991, she was diagnosed with bilateral carpal tunnel syndrome. Claimant filed a claim for an aggravation of her wrist condition. Employer denied the claim. Claimant had not returned to work as of the date of her hearing on the denial.

The referee found that claimant had established a worsened condition in both wrists. The Board affirmed and adopted the referee's order. On review, employer does not contest the Board's findings. Employer argues that claimant must prove that her worsened condition for a scheduled disability resulted in a diminished earning capacity.

The Oregon legislature has defined disabilities to specific body parts by means of a schedule set out in ORS 656.214(2) through (4), and has assigned degrees to the loss of use of each member and a dollar amount to each degree. All disabilities that are not within the schedule are "unscheduled" and are rated by deterInining the permanent loss of earning capacity. ORS 656.214(5).

ORS 656.273(1) states, in pertinent part:

"A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

A claimant who alleges a worsening of an unscheduled disability must prove a loss of earning capacity. *Perry v. SAIF*, 307 Or 654, 772 P2d 418 (1989); *Smith v. SAIF*, 302 Or 396, 730 P2d 30 (1986). Employer argues that because the aggravation statute, ORS 656.273(1), does not distinguish between scheduled and unscheduled disabilities, the same standard should apply to scheduled disabilities. Employer relies only on two recent Board decisions that he understands to have **<122 Or App 166/167>** applied the "loss of earning capacity" standard to scheduled disabilities. *Dan R. Armstrong*, 45 Van Natta 453 (1993); *Tony M. Zuniga*, 44 Van Natta 427 (1992).

In *Surratt v. Dungerson Bros.*, 259 Or 65, 70, 485 P2d 410 (1971), the claimant contended that his loss of earnings should be considered in deciding the amount of his permanent partial disability. The Supreme Court stated:

> "Impairment of earning capacity cannot be considered in determining awards for specific *scheduled* permanent partial disabilities because the legislature, by enactment of ORS 666.214(2) and (3), has conclusively foreclosed further consideration of loss of earnings in such situations." 259 Or at 70. (Emphasis supplied.)[1]

See also Matthies v. Tillamook County Creamery Assoc., 101 Or App 44, 788 P2d 1032 (1990).

It is true that ORS 656.273(1) does not distinguish between scheduled and unscheduled disabilities. In evaluating whether a claimant had suffered an aggravation, we stated in a footnote in *International Paper Co. v. Turner*, 84 Or App 248, 250 n 1, 733 P2d 918, *mod* 304 Or 354, 745 P2d 780 (1987):

> "Because compensation for a scheduled disability is for loss of use of a scheduled body part, ORS 656.214, 'more disabled' in this case means increased loss of use of that body part."

We conclude that aggravations are measured by the same standard that made the condition originally compensable. An aggravation of an unscheduled injury is measured by increased loss of earning capacity. An aggravation of a scheduled injury is measured by increased loss of use.

Accordingly, claimant was not required to prove loss of earning capacity in this case.

Affirmed.

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[1] In 1971, OP.S 656.214 did not mention loss of earning capacity. In 1979, the legislature amended ORS 656.214(5) to provide that in all cases of injury that result in nonscheduled permanent partial disability, the criterion for rating the disability shall be permanent 1088 of earning capacity due to the compensable injury.

Cite as 122 Or App 188 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

SISTERS OF ST. JOSEPH OF PEACE, HEALTH, AND HOSPITAL SERVICES, a Washington corporation, dba Sacred Heart General Hospital, *Respondent,*

v.

Nathan G. **RUSSELL**, *Defendant, and* AETNA CASUALTY AND SURETY COMPANY, *Appellant.*

(16-90-04757; CA A74348)

Appeal from Circuit Court, Lane County.

Pierre L. Van Rysselberghe, Judge.

Argued and submitted February 8, 1993.

Jeremy L. Fellows, Portland, argued the cause for appellant. With him on the briefs was Scheminske & Lyons, Portland.

James R. Strickland, Eugene, argued the cause for respondent. With him on the brief was Curtis and Strickland, Eugene.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

EDMONDS, J.

Reversed.

Warren, P. J., concurring.

Landau. J., dissenting.

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122 Or App 190> Defendant Aetna Casualty and Surety Company (Aetna) appeals from a judgment awarding plaintiff $97,092.74.[1] Defendant makes multiple assignments of error. We reverse.

This case arose out of an employment related injury to defendant Russell. At the time of the injury, Russell was uncertain as to who his employer was and, therefore, he filed four separate workers' compensation claims against four purported employers. Following a workers' compensation hearing, the referee held that Aetna's insured was Russell's employer for workers' compensation purposes.

During the pendency of Aetna's appeal to the Workers' Compensation Board, Russell, the four employers and their insurers, including Aetna, entered into a Disputed Claim Settlement (DCS) that was approved by the Workers' Compensation Board. ORS 656.289(4). The DCS absolved the employers and their insurers of any further responsibility for Russell's "disputed and denied conditions" and awarded a lump sum settlement to Russell. The DCS also included specified amounts "alleged" by Russell as medical expenses. It provided that Aetna would be solely responsible for "sums heretofore set forth" and that it would hold Russell harmless from any claim by plaintiff seeking recovery for medical expenses. Moreover, the DCS said that Aetna was "free to make whatever arrangements [it wished] with regard to settlement of the alleged bills. "

Plaintiff brought this action against Russell and Aetna to recover the medical expenses. Plaintiff's claims against Russell are on the basis of an account stated and for the reasonable and necessary value of the medical services furnished. Its claim against Aetna is based on the theory that the DCS constituted a third-party beneficiary contract under which Aetna agreed to be responsible for Russell's obligation. At trial, the jury found against plaintiff on the account stated claim, but in favor of plaintiff on the other claims. The court entered judgment accordingly. Aetna appeals from that judgment.

122 Or App 191> Aetna assigns error to the court's denial of its motion for a directed verdict. ORCP 60. It argues that plaintiff presented no evidence "sufficient to show that the services that were allegedly provided to defendant Russell were services which were reasonable, as alleged, and necessary." We review the denial of a defendant's directed verdict motion to determine whether, viewing the evidence in the light most favorable to plaintiff, there was any evidence from which the jury could have found the facts necessary to establish the elements of its claims. *Brown v. J. C. Penney Co.*, 297 Or 695, 705, 688 P2d 811 (1984).

At issue is the nature of plaintiff's claims. Plaintiff's claim against Aetna alleges that Aetna is indebted to plaintiff in "the reasonable amount of Nathan C. Russell's bills." Its claim against Russell alleges an implied contract for the "reasonable value of goods and services provided." In its opening statement, plaintiff told the trial court:

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[1] Defendant Russell is not a partner to this appeal.

> "We are proceeding on two separate accounts *[sic]*, one which is commonly known as Reasonable Value of Goods and Services Provided. Count 2 is what's called Account Stated. In other words, there has been an account between the parties and nobody disputed it. And then the last is whether or not there is a Third Party Beneficiary Account which Sacred Heart should be able to sue on."

Contrary to plaintiff's argument on appeal that its claim against Aetna is entirely on the basis of an express contract,[2] the claim alleges an express agreement between plaintiff and Aetna that incorporates an implied agreement between plaintiff and Russell. *See Gillman v. Emel*, 89 Or App 153,747 P2d 390 (1987). In other words, Aetna's liability for Russell's bills may arise from an express agreement (the DCS) that Aetna pay Russell's obligation owed to plaintiff, but Russell's liability is on the basis of an implied contract. In order to prevail on the implied contract portion of the claim, plaintiff must prove three elements: (1) that the labor and/or materials were supplied for the benefit of Russell, (2) that what was supplied was necessary and reasonable and (3) that the charges for **<122 Or App 191/192>** what was reasonable. *See Haggard v. Edwards*, 57 Or App 537,539, 645 P2d 590, *rev den* 293 Or 483 (1982).

Plaintiff presented evidence that it provided to Russell the medical services for which it sought payment. Moreover, it presented evidence that the charges for the medical services were reasonable. However, there was no admissible evidence that what was supplied was necessary for the care of Russell. Because plaintiff failed to establish a necessary element of its claim, the trial court erred in not granting defendant's directed verdict motion. *Central Coast Electric, Inc. v. Mendell*, 66 Or App 42, 46, 672 P2d 1224 (1983).

Because of our resolution of this case we need not consider defendant's other assignments of error.

Reversed.

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[2] Plaintiff's argument assumes that the DCS is an enforceable third-party beneficiary contract and that it is the beneficiary. We need not reach that issue because plaintiff has not proven that it is entitled to recover under the agreement between it and Russell.

WARREN, P.J., concurring.

I concur in Judge Edmonds' opinion and write only to address the argument made by the dissent that plaintiff was a third-party beneficiary of the contract between Russell and Aetna. In my view the contract was strictly one in which Aetna settled with Russell and agreed to hold him harmless from any claims made by plaintiff to recover the cost of medical services provided to Russell. The contract provided that as between Russell and Aetna, "[Russell] agrees that, as between Aetna and the medical providers, Aetna is free to make whatever arrangements they [*sic*] wish with regard to settlement of the alleged bills."

There is nothing in the language of the settlement with Russell that evinces an intent to do other than settle the case with Russell and to insulate him from plaintiff's claim. There is no evidence, nor does the writing itself justify an inference, that the parties intended to benefit plaintiff. On the contrary, it appears that Aetna expressly reserved the right to contest plaintiff's claims. Plaintiff was, at best, an incidental beneficiary of the agreement and not entitled to bring an action as a third-party beneficiary of Russell's contract. *See Aetna Casualty & Surety Co. v. OHSU*, 310 Or 61, 65, 793 P2d 320 (1990).

122 Or App 193> LANDAU, J., dissenting.

Plaintiff's third claim for relief alleged that it was an intended third-party beneficiary of an agreement between Russell and Aetna. Under the terms of that express agreement, plaintiffalleged, Aetna became indebted to pay plaintiff the "reasonable amount" of Russell's medical bills. Plaintiff quoted from the agreement, which sets out Russell's claim of $98,872 in medical expenses incurred at plaintiff's facilities, contains provisions calling for Aetna to be "solely responsible for resolving the claims" and provides that "the sums heretofore set forth [are] to be the sole responsibility of the carrier Aetna Casualty & Surety Company." On the basis of those allegations, the claim was tried by both parties on a theory of express contract. It was submitted to the jury on a theory of express contract, and the jury returned a verdict in plaintiff's favor on a theory of express contract.

Now, on appeal, the majority "deems" plaintiff's claim to have been predicated on an entirely different theory, and finds plaintiff's evidence wanting because it fails to satisfy all of the elements of that theory. Specifically, the majority finds fatal plaintiff's failure to present evidence of the necessity of the services it provided Russell. That plaintiff should be found to have failed to establish all the elements of a claim for *quantum meruit* comes as no surprise. It was not the theory under which its claim was pleaded, tried, presented to the jury or decided.

The majority points to the mention of two words--"reasonable amount"--in plaintiff's complaint, as the basis for its decision. In so doing, the majority makes two mistakes. First, it ignores the balance of the complaint, which alleges recovery on the basis of express contract. According to plaintiff, the contract itself expressly defined the "reasonable amount" for services rendered. Where there is a written agreement regarding payment for services rendered, the amount stated in the agreement is sufficient to evidence the value of the services rendered. *Grant v. Yok et al*, 233 Or 491, 495, 378 P2d 962 (1963). Thus, the lack of evidence as to necessity of treatment is of no consequence; it is, in fact, irrelevant. Second, even if that were not the case, the court lacks authority simply to "deem" a complaint to state a claim on a different theory from what is alleged. The majority cites **<122 Or App 193/194>** *Gillman v. Emel*, 89 Or App 153, 747 P2d 390 (1987). However, I have searched that opinion in vain for any mention of the sort of action the majority takes in this case.[1]

The question for us is whether plaintiff presented any evidence to support its claim under the terms of the express agreement. It is not for us to test plaintiff's proof against a theory never so much as contemplated at trial. Instead of disposing of this case on the *quantum meruit* theory, I would evaluate Aetna's assignments of error against the case as it was tried.

Aetna assigns error to the trial court's denial of Aetna's motion for a directed verdict. Aetna argues that there was no evidence of a third-party beneficiary contract. The argument requires us to construe the terms of the agreement between Aetna and Russell. In construing those terms, we first determine whether the contract is ambiguous. If it is not, then we decide the matter as a question of law. If it is, then we determine whether there was evidence of the parties' intentions sufficient to go to the jury as a question of fact. *OSEA v. Rainier School Dist. No.* 13, 311 Or 188, 808 P2d 83 (1991); *Thompson v. Bolliger, Hampton & Tarlow*, 118 Or App 700, 709, 849 P2d 526, *rev den* 317 Or 163 (1993).

There is no question but that the agreement between Aetna and Russell is ambiguous. It sets forth specific amounts Russell claims he incurred for medical services and then provides, several paragraphs later, that "the sums heretofore set forth [are] to be the sole responsibility of the carrier Aetna." Whether "the sums heretofore set forth" refers to the expenses Russell incurred, as plaintiff contends, or to some other expenses referred to in the contract, as Aetna contends, is not at all clear from the language. Therefore, **<122 Or App 194/195>** construction of the term is a factual question, which could not properly have been taken from the jury by way of directed verdict. The trial court, therefore, did not err in denying Aetna's motion.

Aetna next assigns error to the trial court's denial of its motion to strike the testimony of an employee of plaintiff that the amounts of Russell's medical bills were reasonable. It also assigns error to the trial court's denial of Aetna's motion for a directed verdict based on the absence of any admissible testimony that the services plaintiff provided to Russell were reasonable and necessary. However, in both cases, because the jury decided this case on the basis of an express contract, testimony concerning the reasonableness of necessity of the services is irrelevant. *Grant v. Yok et al, supra*, 233 Or at 495; *see also Schade v. Muller*, 75 Or 225, 232, 146 P 144 (1915). The trial court did not err in denying Aetna's motions.

The decisions of the trial court should be affirmed. Therefore, I dissent.

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[1] In *Gillman*, the plaintiff sued her employer to recover unpaid sales commissions. She brought two claims, one on a theory of express contract and the other on a theory of *quantum meruit*. The defendant counterclaimed for over payment of wages, on theory of express contract. The trial court submitted the contract claims to the jury. When the jury returned its verdict in favor of defendant on both the first claim and the express counterclaim, the trial court set aside the verdict and found for plaintiff on the *quantum meruit* claim. We reversed, holding that because the jury had ruled in favor of the defendant on the express contract claims, it was error for the trial court to have entered judgment in favor of plaintiff on the *quantum meruit* claim. We said nothing about "deeming" for the first time on appeal a claim brought on a theory of express contract to be one brought under *quantum meruit* or any other theory.

Cite as 122 Or App 241 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Maria A. Hernandez, Claimant.

LEO POLEHN ORCHARDS and Farmers Insurance Company, *Petitioners,*
v.
Maria L. **HERNANDEZ**, *Respondent.*
(90-18037; CA A75150)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 23, 1993.
Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Richard M. Walsh, Salem, argued the cause for respondent. With him on the brief was Olson, Rowell & Walsh, Salem.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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122 Or App 243> At issue in this case is whether claimant's injury arose out of and in the course of her employment. The Workers' Compensation Board found that it did. Employer seeks review of that decision. We affirm.

Claimant and her husband are migrant farm workers who were hired to work for employer in one of its cherry orchards located near The Dalles. Employer offered its workers temporary housing at a migrant labor camp on the premises. Although it did not contractually require all of its workers to live in the camp, the vast majority of them lived there, due to an absence of available housing in The Dalles and the lack of any public transportation to and from the work site. In 1990, all but one of the 150 workers lived on the premises. Employer cleaned the camp grounds daily and washed the associated outdoor toilet facilities by hosing them down with water.

On July 9, 1990, claimant's husband compensably injured his ankle and was unable to work. Claimant asked employer for permission to take a few days off to care for her husband, and employer agreed, allowing claimant and her husband to remain in the labor camp during husband's recovery.

On July 12, 1990, claimant walked from the camp to the outdoor toilet to empty her husband's bedpan. As she left the outhouse, she slipped in a mud puddle and fell, injuring her right ankle and back. After four days in the hospital, she returned to the camp and remained there until the end of the cherry picking season. She filed a claim for her injuries, and the insurer denied compensability, contending that claimant's injury did not arise out of and in the course of employment. Claimant requested a hearing, and the referee concluded that her injury was not compensable.

The Workers' Compensation Board reversed. It relied on the so-called "bunkhouse rule," which provides that injuries to employees required to live on employer's premises generally are compensable if the source of the injury was a risk distinctly associated with the conditions under which the employees are required to live. *See generally* 1A Larson, **<122 Or App 243/244>** *Workmen's Compensation Law* 5-234, 24.10 (1993). According to the Board, the bunkhouse rule is consistent with the general principles of compensability found in the applicable statutes and case law. It then found that claimant was, for all practical purposes, required to live on the premises because there was no other housing readily available and that the source of her injuries was the mud puddles created by employer's own maintenance activities.

Employer assigns error to the Board's conclusion that claimant's injury is compensable. According to employer, the Board misapplied the statutory requirement that a compensable injury "aris[e] out of and in the course of" claimant's employment. ORS 656.005(7)(a). Applying the proper test, employer argues, compels the conclusion that claimant's injury is noncompensable, because it occurred while she was off work, caring for her husband. We disagree.

Claimant has the burden of provingthat her injury is compensable. *Phil A. Livesley Co. v. Russ,* 296 Or 25, 28, 672 P2d 337 (1983). A "compensable injury" is one "arising out of and in the course of employment." ORS 656.005(7)(a). The Supreme Court has held that "arising out of" and "in the course of" employment are not to be treated as two separate tests, both of which must be met to establish compensability. Instead, the statute requires a "unitary 'work connection' approach," which focuses on the single inquiry of whether the relationship between the injury and the employment is sufficient to allow compensability. *Rogers v. SAIF,* 289 Or 633, 642, 616 P2d 485 (1980). That inquiry should be conducted in a manner that best effectuates the basic purpose of the Workers' Compensation Act, which is

> "the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. " *289* Or at 643 (quoting *Allen v. SAIF,* 29 Or App 631, 633, 564 P2d 1086 (1977).

The variety of claims brought under the Act has led to the articulation of several specialized concepts and ways of categorizing employee activities that help to determine whether an injury has sufficient "work connection" to make it compensable; for example, going and coming cases, special errand **<122 Or App 244/245>** cases, lunch hour cases, dual purpose trip cases and horseplay cases. *Allen v. SAIF, supra,* 29 Or App at 634.

One such category of cases involves "personal comfort" actinties that occur on the employer's premises. Injuries arising out of such actinties at work may be compensable. *Clark v. U.S. Plywood,* 288 Or 265,266-67,605 P2d 265 (1980). Similarly, injuries arising out of personal comfort activities are compensable when the employee was not at work but was required to reside on the premises and remain corltinuously on call. *Wallace v. Green Thumb,* 296 Or 79, 84, 672 P2d 344 (1983). The basic underpinning of those cases is that it is the obligation of employment to be on the premises that creates the risk of injury to the employee; when the employee is free to leave when he or she pleases, that employment connection does not exist.

The bunkhouse rule represents an incremental extension of that line of cases. According to this rule, as it is generally formulated, if the resident employee has fixed hours of work and is not continuously on call, an injury suffered on the premises is compensable

> "if the course of injury was a risk associated with the conditions under which claimant lived because of the requirement of remaining on the premises." lA Larson, *Workmen's Compensation Law* 5-234, 24.00 (1993).

Although it has been adopted in many jurisdictions,[1] the courts in Oregon have not yet had occasion to decide whether **<122 Or App 245/246>** the bunkhouse rule represents a proper application of the work connection requirement of ORS 656.005(7)(a).

The rule was mentioned by the Supreme Court in *SAIF v. Reel,* 303 Or 210, 735 P2d 364 (1987). There, the claimant was injured in an explosion in his camper, which he had parked at a construction site where he worked. He lived in the camper because the job site was located some 90 miles from his home. He was not, however, required by the employer to do so; other employees commuted from their

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[1] *See, e.g., Lujan v. Payroll Exp., Inc.,* 114 NM 257, 837 P2d 451 (NM Ct App 1992) (logger died from carbon monoxide poisoning while sleeping in van on-site; held compensable under bunkhouse rule); *McCall v. McCall Amusement,* Inc., 748 SW2d 827 (Mo App 1988) (employee injured in fire while on amusement park premises; held not compensable under bunkhouse rule because residence at park not required); *Torres v. Laurell Hill Nursery,* 470 NYS2d 897 (1983), *affd mem,* 64 NY2d 895, 476 NE2d 1005 (1985) (resident migrant worker injured on employer's premises; held compensable because employer provided living quarters as part of wage and required workers to live there); *Mecca Farms, Inc. v. Espino,* 414 So 2d 572 (Fla Ct App), *rev den* 422 So 2d 842 (Fla 1982) (migrant worker shot by co-resident in employer-provided labor camp; held compensable under bunkhouse rule); *Doe v. St. Michael's Medical Ctr.,* 184 NJ Super 1, 445 A2d 40 (1982) (medical technologist sexually assaulted while living in hospital dormitory, but not on duty; held compensable under bunkhouse rule); *Pearson v. Taylor Fruit Farm,* 180 Ohio App 2d 193, 248 NE2d 231 (1969) (fixed-hour resident farm hand burned in bunkhouse fire while off duty; held compensable under bunkhouse rule); *Argonaut Ins. Co. v. Workmen's Compensation Appeals Bd.,* 247 Cal App 2d 669, 55 Cal Rptr 810 (1967) (resident ranch hand injured during leisure time; held compensable under bunkhouse rule).

homes, stayed in apartments or mobile homes or lived on site as did the claimant. The court held that, under the circumstances, the claimant's injury did not occur within the course of his employment. While it noted the bunkhouse rule, it observed that, "[a]ssuming without deciding that we would adopt the same or similar rule were the case presented," the claimant's case did not fall within that rule because he was in no way required to live on the employer's premises. 303 Or at 218.

We agree with the Board that the bunkhouse rule is consistent with the work connection requirement of ORS 656.005(7)(a). When an employee is required to live on an employer's premises and is injured as a result of the condition in which the employer maintains those premises, there is a sufficient connection between injury and employment to establish compensability. Whether the resident employee is continuously on call is not determinative. It is the obligation of employment to reside on the premises that subjects the employee to the risk that resulted in injury. *See Wallace v. Green Thumb, supra,* 296 Or at 84.

The Board found that claimant's injury was compensable under the bunkhouse rule, because she was required to live on the employer's labor camp and because her injury was a direct result of the conditions in which employer maintained that camp. We review those findings for substantial evidence. ORS 656.298(6); ORS 183.482(7), (8).

We address first the question of whether claimant was required to live on the employer's premises. It is true that claimant was not required in any contractual sense to live on the employer's premises. Nevertheless, there is evidence that **<122 Or App 246/247>** claimant had no other practical alternative.[2] There is testimony from employer's field manager that it did not want to provide housing for its workers, but it had to, "[b]ecause there's no place to live otherwise." The manager testified that, at least during the picking season, The Dalles simply does not have any housing for workers such as claimant. Claimant testified that it was her understanding that she was required to live at the employer's migrant labor camp, and that, in any event, she and her family had no other place to live. Consistent with that testimony, there is evidence that, of the 150 workers who picked cherries for employer, all but one lived at the camp. Taken as a whole, the testimony provides substantial evidence that claimant was required to live on employer's premises.

Employer argues that the record establishes no real obligation to live on the premises, only that claimant was permitted to do so. In particular, employer contends that the Board incorrectly found that nearly all of the workers lived at employer's camp. According to employer, its camp facilities had a capacity of only 120 people, so a significant number of employees must have been living elsewhere. In so arguing, employer ignores its own testimony to the contrary.[3] Moreover, it implies that we should weigh the evidence in a way that is inappropriate on appellate review. That the camps had a capacity of only 120 could support an inference that no more than 120 workers actually resided on the premises, but that is not the only inference that reasonably could be drawn from the evidence.

We next address the Board's finding that claimant's injury was a result of the condition in which employer maintained the premises. Employer apparently concedes that the Board's finding on this issue is supported by substantial **<122 Or App 147/148>** evidence. In any event, the record is clear that claimant was injured when she slipped in a mud puddle that was created by employer's act of hosing down the outhouse areas as part of its routine maintenance of the camp.

Employer also assigns error to the Board's award of attorney fees to claimant in the amount of $7,020. It argues that the Board failed to explain adequately the basis for the award. In the alternative, it argues that the Board awarded an excessive amount. We review the Board's decision for an abuse of discretion. ORS 666.298(6); ORS 183.482(7), (8).

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[2] Larson observes that, while the cases are less than uniform where on-premises living is not contractually required, the "better view" upholds compensability when living on the premises is practically required. 1A Larson, *Workmen's Compensation Law* 5-271, 24.40 (1993). We have previously expressed approval of Larson's view. *SAIF v. Reel,* 81 Or App 258, 260, 724 P2d 914 (1986), *aff'd on other grounds* 303 Or 210, 735 P2d 364 (1987).

[3] Employer also argues that there is no evidence to support the Board's conclusion that all but one of the workers lived in the camp. The record, however, indicates that employer's own field manager testified that he knew of only one worker who did not live in the labor camp).

Although the Board is required to consider all relevant factors in determining whether to make an award of attorney fees, it is not required to make specific findings as to each one. *Diamond Fruit Growers v. Davies,* 103 Or App 280, 282, 796 P2d 1248 (1990). Here, the Board noted that it had considered all of the factors in the relevant rules and based its award on its evaluation of the time claimant's attorney devoted to the case, the complexity of the issues, the value of the interest involved and the risk that counsel's efforts might go uncompensated. That evaluation is sufficient.

As for the amount of the award, we find no abuse of discretion.

Affirmed.

Cite as 122 Or App 276 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David R. Boyles, Claimant.

David R. **BOYLES**, *Petitioner,*
v.
LUM AND UTTI and Safeco Insurance Company, *Respondents.*
(91-05958; CA A75549)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 30, 1993.
Jan H. Faber, Astoria, argued the cause for petitioner. With him on the brief was Patrick Lavis, P.C., Astoria.
Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Before Deits, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Affirmed.

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122 Or App 278> Claimant seeks review of a Workers' Compensation Board order that terminated temporary total disability benefits (TTD) because of his failure to accept modified employment. We affirm.

Claimant began receiving TTD on March 11, 1991. His union went on strike against his employer on May 1, 1991. TTD continued after the strike began. Claimant's physician released him to modified employment beginning June, 17, 1991. Employer offered him, in writing, a clerical job at $11.35 per hour, to begin on that date. Claimant found the job acceptable, but declined it because it would have required him to cross the picket line. Employer then terminated claimant's TTD and paid him temporary partial disability benefits (TPD) until July 22, 1991, when claimant began to work for another employer.

TTD may be terminated if the

> "attending physician * * * release[s the claimant] to return to modified employment, such employment is offered in writing to the [claimant] and the [claimant] fails to begin such employment." ORS 656.268(3).

Claimant contends that TTD was improperly terminated on June 17, 1991, and that he was entitled to TTD between June 17, 1991, and July 22, 1991. At the hearing, he argued that his participation in a labor dispute excused his refusal of modified employment. That issue has since been resolved against him. *Roseburg Forest Products v. Wilson,* 110 Or App 72, 76, 821 P2d 426 (1991).

He also argues that there was no offer of modified employment, because what was offered was a sham. Assuming that that argument was adequately raised at the hearing, substantial evidence supports the Board's finding that there was an offer of modified employment.

Affirmed.

Cite as 122 Or App 279 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Betty Barnett, Claimant.

Betty BARNETT, *Petitioner,*
v.
SAIF CORPORATION and The Shaw's Lounge, *Respondents.*
(91-06319; CA A76833)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 15, 1993.
Robert G. Dolton, Clackamas, argued the cause and filed the briefs for petitioner.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
LEESON, J.
Reversed and remanded for reconsideration.

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122 Or App 281> Claimant petitions for judicial review of a Workers' Compensation Board (Board) order denying her claim for benefits. We reverse.

The following facts are not in dispute. Claimant worked as a bartender for The Shaw's Lounge on and off for 15 years. On July 15, 1989, she compensably injured her upper back (near the shoulder blade) while lifting cases of beer. The claim was closed without an award for disability. On March 21, 1991, near the end of her shift, claimant restocked the bar, which required her to lift cases of beer from an overhead shelf in a walk-in refrigerator and place them on the floor. She came out of the refrigerator appearing pale and distressed, and told a customer that she had "pulled the heck out of my back" while pulling a case of beer from a shelf. Although visibly in pain, claimant finished her shift. She believed it was too late in the evening to seek medical treatment.

The next morning claimant's lower back pain had not abated. She reported to work limping and suffering from low back pain, muscle spasms and bilateral leg pain. Approximately one hour after her shift began, the owner and manager asked her, "How are you going to work like this today?" Claimant responded that she was waiting for another employee to arrive to work for her. The manager relieved her of her duties so she could seek medical attention. Claimant went directly to the hospital emergency room, where she explained the history of her injury to the staff. Emergency room physician Dr. Kimball diagnosed low back strain and referred claimant to Dr. Cummings. Cummings subsequently referred claimant to Dr. Ure, a back specialist. Ure diagnosed lumbosacral strain.

Claimant filed a claim. SAIF denied compensability, stating that "there is insufficient evidence that your low back pain is the result of either a work-related injury or disease." At a hearing on that denial, claimant and her witnesses testified that she suffered severe low back pain lifting a case of beer, for which she sought medical treatment the next morning. Claimant had not experienced low back pain prior to the March 21 work incident.

122 Or App 282> The referee found that claimant and her witnesses were credible, that her injury was demonstrated by objective medical evidence, and that she had had no low back problems before March 21, 1991. Nonetheless, he affirmed SAIF's denial. He concluded that claimant had not established "medical causation," because "no doctor has tendered any medical opinion about the cause-effect relationship between claimant's work activities (injury) and the post-March 21, 1991 back condition." The Board affirmed.

To establish a compensable injury, an injured worker must prove by a preponderance of the evidence that the injury occurred in the course of employment, and that the disability and/or need for medical treatment was caused by the employment. ORS 656.005(7)(a); ORS 656.266. The fact of an injury must be established by medical evidence. ORS 656.005(7)(a). Where a claimant's injuries are of

such a nature as to require skilled and professional persons to establish causation, expert medical evidence is necessary to meet the burden of proof. *Madewell v. Salvation Army,* 49 Or App 713, 717, 620 P2d 953 (1980).

Claimant argues that the Board erred in holding that expert testimony was necessary to establish that the March 21 incident at work caused her lumbosacral strain. SAIF contends that *Edwards v. SAIF,* 30 Or App 21, 566 P2d 189, *rev den* (1977), creates *a per se* rule that expert testimony is always required to establish such causation.

In *Edwards,* the claimant fell at work, compensably breaking her hand and bruising her hip. Subsequently, she experienced pain in her pelvic region, requiring an anthrodecis of the symphysis pubis, a surgical procedure to fuse the cartilaginous joint between the two pubic bones. Three months later, the claimant had surgery for urological conditions. SAIF denied her claim for that surgery. The medical evidence that claimant's urological condition was caused by her compensable injury was inconclusive. On *de novo* review, she argued that we should find the requisite medical causation as a natural inference drawn from the timing and location of the injury. We held:

> "In a complex and technical medical problem like the etiology of a urethritis or a cystourethrocele condition[,] we are not prepared to indulge a 'natural inference' where the medical evidence has failed to do so." 30 Or App at 24.

122 Or App 283> This case is not complex. The facts are virtually identical to those in *Uris v. Compensation Department,* 247 Or 420, 427 P2d 753, 430 P2d 861 (1967). In that case, the plaintiff claimant was moving books into a college library. He suffered a sharp pain in his low back when he reached out to prevent a load of books from falling off a book cart. The injury was diagnosed as "chronic lumbosacral (low back) strain." The defendant employer contended that medical testimony was essential to establish causation. The court held that it was not, and enumerated relevant factors for determining whether expert testimony of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. 274 Or at 426. The court specifically held that expert medical testimony establishing causation of the plaintiff claimant's lumbosacral strain was not required because "there is nothing very complicated about such an injury and its cause." 247 Or at 427. *See also Madewell v. Salvation Army, supra,* 49 Or App at 713, 717-18, and cases there cited; *Westmoreland v. Iowa Beef Processors,* 70 Or App 642, 465, 690 P2d 1105 (1984), *rev den* 298 Or 597 (1985).

In this case, claimant suffered immediate pain in her low back when she pulled a case of beer from an overhead shelf while at work. Employer was not on the premises at the time, but claimant reported the injury to those who were present and reported it to her employer the next morning. She sought medical treatment for the injury within 24 hours. Prior to the work incident, she had been in good health and had never before experienced low back problems. Finally, no expert testimony suggested that pulling the case of beer from the overhead shelf could not have been the cause of claimant's lumbosacral strain.

On these facts, the Board erred in holding that claimant was required to introduce expert medical testimony to prove causation.

Reversed and remanded for reconsideration.

Cite as 122 Or App 288 (1993) August 4, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bertha Paniagua, Claimant.

Bertha **PANIAGUA**, *Petitioner,*
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and Woodburn Child Care Clinic, *Respondents.*
(WCB 92-00275; CA A77730)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 8, 1993.
Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief were Stanley Fields and Law Offices of Michael B. Dye, Salem.
Alexander Libmann, Portland, argued the cause for respondents. On the brief was James D. McVittie, Portland.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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122 Or App 289> In this workers' compensation case, claimant contended that her claim was prematurely closed and that notice, pursuant to OAR 436-30-035(7), was inadequate. The Board addressed the merits of claimant's contention without first addressing the alleged irregularity of the notice. Employer concedes that that issue should have been reached before reaching the merits of claimant's contention. We accept the concession and remand to the Board for reconsideration.

Reversed and remanded for reconsideration.

Cite as 122 Or App 366 (1993) August 18, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Tor J. East, Claimant.

SISTERS OF PROVIDENCE and Aetna Casualty and Surety Company, *Petitioners,*
v.
Tor J. **EAST**, *Respondent.*
(WCB 91-01861; CA A73920)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 3, 1993.
Ronald M. Johnson, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Anthony Allen, Salem, argued the cause for respondent. On the brief was Jean Fisher LeBoux, Salem.
Before Deits, Presiding Judge, and Riggs and Durham, Judges.
RIGGS, J.
Affirmed.

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122 Or App 368> Employer seeks review of a Workers' Compensation Board (Board) order that held that employer could not stay payment of permanent partial disability benefits pending an order on reconsideration and awarded attorney fees and penalties. We affirm.

In 1990, claimant filed an aggravation claim based on a 1988 compensable injury. The claim was closed on December 6,1990, by determination order issued by the Department of Insurance and Finance (DIF) awarding additional time loss benefits and 20 percent unscheduled permanent partial disability (PPD). On December 13, 1990, employer requested reconsideration of the determination order and requested designation of a medical panel for evaluation of claimant's impairment by DIF. On February 13, 1991, claimant requested a hearing at the Board after employer had failed to pay his benefits within 30 days of the December 6, 1990, determination order, as required by OAR 436-60-150(6). On May 6, 1991, DIF issued its order on reconsideration, which reduced claimant's unscheduled PPD award from 20 percent to 8 percent. Employer claims, that pursuant to ORS 656.313, payment of claimant's benefits was stayed until DIF issued its order on reconsideration.

The referee concluded that employer was not entitled to stay payment of benefits pending reconsideration of the determination order. In addition, he determined that he had jurisdiction to assess penalties and attorney fees and awarded claimant attorney fees and assessed penalties for employer's unreasonable refusal to pay claimant's benefits. On reconsideration, the referee again ordered employer to pay claimant his time loss benefits and 20 percent unscheduled PPD from the date of the determination order, December 6, 1990, to the date of the order on reconsideration, May 6, 1991, and to pay penalties. The Board affirmed and adopted the referee's order.

We review the Board's order for errors of law. *Bailey v. Board on Police Standards,* 100 Or App 739, 788 P2d 1022 (1990); ORS 183.482(8)(a). Employer assigns error to the Board's conclusion that OAR 436-60-150(6)(c) and ORS 656.313 do not conflict. OAR 436-60-150(6) provides, in relevant part:

122 Or App 369> "Permanent disability benefits shall be paid no later than the 30th day after:

"* * * * *

"(c) The date of any department order which orders payment of compensation for permanent partial disability * * * unless the order has been appealed by the insurer pursuant to ORS 656.313. *A request for reconsideration of a determination order does not stay payment of permanent partial disability compensation * * * ordered."* (Emphasis supplied.)

ORS 656.313(1) provides, part:

> "(a) Filing by an employer or the insurer of a *request for hearing on a reconsideration order or a request for board review or court appeal, stays payment of the compensation appealed* * * *." (*Emphasis* supplied.)

The Board held that the rule and the statute plainly say what they mean and do not conflict: OAR 436-60-150(6) applies to *requests for reconsideration,* while ORS 656.313 applies to hearing, board or court review of a *reconsideration order,* among other things. We agree. A request for reconsideration of a determination order by DIF is not the same as review of an order on reconsideration. OAR 436-60-150(6) applies to the period *before* an order on reconsideration is issued. ORS 656.313(1) applies to the review process *after* the order on reconsideration has been issued.

DIF issued a determination order on December 6, 1990. Employer requested a reconsideration of the determination order by DIF on December 13, 1990. Thus, OAR 436-60-150(6) applies and employer was required by statute to pay claimant's benefits for time loss and 20 percent unscheduled PPD within 30 days of the date of the determination order.

Employer also assigns error to the Board's holding that it had jurisdiction to assess penalties and attorney fees. It claims that only the Director has jurisdiction. ORS 656.708 provides, in part, that the hearings division of the Board "has the responsibility for providing an impartial forum for deciding all cases, disputes and controversies * * * regarding *matters concerning a claim."* (Emphasis supplied.) When the employer has unreasonably delayed payment and the issue is **<122 Or App 369/370>** *"solely* the assessment and payment of the additional amount," ORS 656.262(10)(a) provides that "the Director shall have exclusive jurisdiction over [the] proceedings." (Emphasis supplied.) ORS 656.262(10)(b) provides:

> *"When the Director does not have exclusiue jurisdiction* over proceedings regarding the assessment and payment of the additional amount described in this subsection, *the provision for attorney fees prouided in this subsection shall apply in the other proceeding.* (Emphasis supplied.)

The main issue in dispute was claimant's right to receive the compensation awarded by the determination order. The referee had statutory authority to assume jurisdiction for assessing penalties and attorney fees pursuant to ORS 656.704(3)[1] and ORS 656.708. The Board properly concluded that the proceeding was not one "regarding solely the assessment and payment of the additional amount described in this subsection." ORS 656.262(10)(a).

Employer's second assignment of error is to the Board's finding that employer acted unreasonably and for assessment of penalties and attorney fees. The Board found the employer's failure to pay benefits before DIF issued its order on reconsideration was unreasonable in light of the plain language of OAR 436-60-150(6)(c). The determination order awarded payment for a disability. Regardless of the final rate of payment in the order on reconsideration, employer had a duty to make payments to claimant within 30 days of the date of the determination order. *See Georgia Pacific v. Piwowar,* 305 Or 494,506, 753 P2d 948 (1988). The Board did not err in awarding penalties and attorney fees.

Affirmed.

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[1] ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under this chapter are those matters in which a workers' right to receiue compensation, or the amount thereof, are directly in issue.* However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." (Emphasis supplied.)

Cite as 122 Or App 424 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jerry B. Mathel, Claimant.

Jerry B. **MATHEL**, *Petitioner,*
v.
JOSEPHINE COUNTY, *Respondent.*
(WCB 90-18752; CA A76236)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted March 15, 1993; resubmitted in banc July 14, 1993.
Karsten H. Rassmussen, Eugene, argued the cause for petitioner. With him on the brief was Michael M. Bruce, Eugene.
Michael G. Bostwick, Portland, argued the cause for respondent. With him on the brief was Davis & Bostwick, Portland.
WARREN, J.
Affirmed.
Deits, J., dissenting.

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122 Or App 426> Claimant seeks review of a Workers' Compensation Board order that upheld employer's denial of his claim for myocardial infarction. We vvrite only to address claimant's argument that 1990 changes to the occupational disease law affect the compensability of his claim, and affirm.

Claimant had hypertension, which had been under control for many years. On August 23, 1990, after experiencing two days of abnormally high emotional stress at his employment with employer, he suffered a myocardial infarction. Employer denied his claim for compensation. The Board, following our decision in *SAIF v. Hukari,* 113 Or App 475, 833 P2d 1307, *rev den* 314 Or 391 (1992), upheld the denial. In *Hukari,* we held that, under the 1987 amendments to the workers' compensation law, any claim that a condition is independently compensable because it was caused by onthejob stress must be treated as a claim for a mental disorder under the occupational disease provisions of ORS 656.802. A mental disorder is not compensable unless, *inter alia,* "there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." ORS 656.802(3) *(formerly* ORS 667.802(2)). It is undisputed that claimant does not have a diagnosed mental disorder, and therefore the Board concluded that his claim is not compensable.

The 1987 formulation of ORS 656.802 provided, in part:

> "(1) As used in this chapter, 'occupational disease' means:
>
> "(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
>
> **122 Or App 427>** "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

In 1990, the legislature amended that statute by moving the language emphasized below from paragraph (1)(a) into subsection (1) and adding "caused by," "or activities," and "including." ORS 656.802(1) now provides, in part:

"(1) As used in this chapter, 'occupational disease' means *any disease or infection arising out of and in the course of employment* caused by *substances* or activities *to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death,* including:

"(a) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death." (Emphasis supplied.)

Claimant asserts that, under the new definition, his claim is compensable, because his work activities caused his heart attack.

The 1987 version of the statute listed three types of claims that were occupational diseases. ORS 656.802 (1)(a)-(c). ORS 656.802(1), as amended in 1990, may have been intended to expand that definition to include conditions that do not fit within one of the three listed categories of claims. However, the amendments did not change the mental disorder provisions or the determination in *Hukari* that any claim that a condition is caused by on-thejob stress must be considered a claim for mental disorder under ORS 656.802. Claims for mental disorders continue to be subject to the requirements of ORS 656.802(3). Thus, because claimant seeks compensation for myocardial infarction caused by on-thejob stress, that is a claim for mental disorder under ORS 656.802. Claimant does not have a diagnosed mental condition and, therefore, his claim is not compensable. ORS 656.802(3).

122 Or App 428> We have considered and reject claimant's other arguments.

Affirmed.

DEITS, J., dissenting.

I agree with the majority that our decision in *SAIF v. Hukari,* 113 Or App 475, 833 P2d 1307, *rev den* 314 Or 391 (1992), is controlling in this case. *Hukari* holds that any claim that a condition is independently compensable because it is caused by on-the-job stress must be considered as a claim for a mental disorder under the occupational disease statute, ORS 656.802. Because a heart attack cannot qualify as a mental disorder, under *Hukari,* claimant loses even if his condition was caused by on-the-job stress.

However, after reviewing our holding in *Hukari,* I now believe that our decision in that case was incorrect and that we should overrule it. I recognize the value of *stare decisis.* However, the rule of *stare decisis* has never prevented Oregon appellate courts from reversing precedent that was "inadequately considered or wrong when it was decided." *See Heino v. Harper,* 306 Or 347, 373, 759 P2d 253 (1988). The role of *stare decisis* in upholding precedents involving the construction of a statute is perhaps unique, because the court's interpretation becomes a part of the statute subject to change by the legislature. *State v. White,* 303 Or 333, 736 P2d 552 (1987). However, I do not believe that *stare decisis* prevents us from reconsidering a recent and, in my view, wrongly decided case, even if it involves the construction of a statute. In circumstances such as these, where we may have made an error that has a significant impact on the application of the law, I believe that we should acknowledge the error and overrule the earlier decision.

In *Hukari,* we held that, under the 1987 amendments to the workers' compensation law, any claim that a condition is independently compensable because it was caused by on-the-job stress must be treated as a claim for a mental disorder under the occupational disease provisions of ORS 656.802. A mental disorder is not compensable unless, *inter alia,* "there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." ORS 656.802(3) (*formerly* ORS **<122 Or App 428/429>** 656.802(2)). Because physical disorders, such as heart attacks, are not "mental disorders," such physical conditions can never be compensable under *former* ORS 656.802(2).

The relevant statute, *former* ORS 656.802, provided in pertinent part:

> (1) As used in this chapter, "occupational disease" means:
>
> "* * * * *
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
>
> "* * * * *
>
> "(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.
>
> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

In *Hukari,* this court interpreted the 1987 amendments to ORS 656.802. We determined that the "legislature's use of the term 'mental disorder' was intended to encompass all claims for mental or physical disorders arising from job stress." 113 Or App at 480. In construing a statute, legislative intent is evidenced most persuasively by the words used in a statute and absent *clear* legislative intent to the contrary, this court must give the words of a statute their natural and ordinary meaning. *OSAA v. Stout,* 71 Or App 405, 416, 692 P2d 633 (1984). In *Hukari,* we departed from that principle because our reading of the term "mental disorder" is not consistent with its natural and ordinary meaning. The ordinary meaning of the term "mental disorder" does not include **<122 Or App 429/430>** a physical disorder, as opposed to physical manifestations of a mental disorder, *i.e.* fatigue caused by depression. There is nothing in the language of the statute that indicates that the term "mental disorder" was used in other than its ordinary sense. Further, there is nothing in the legislative history that clearly supports our interpretation of "mental disorder" in *Hukari.* Eliminating claims for physical disorders caused by job stress is a significant change in the law. It would seem that, if the legislature intended to do away with such claims, it would have done so explicitly or there would have been something in the legislative history to show that was what they intended.

We reasoned in *Hukari* that, because "[a]ll claims involving disabilities that were the result of work-caused stress, regardless of whether the manifestations were psychological or physical, were subjectto the same compensability analysis," the legislature must have intended that all stress-caused claims are compensable only if they meet the requirements *of former* ORS 656.802(2). 113 Or App at 479. However, *former* ORS 656.802(2) specifically refers to "mental disorders"; it does not refer to physical disorders. The fact that before the statute was amended, claims for physical disorders and mental disorders caused by stress were subject to the same compensability analysis does not compel the conclusion that they are to be treated the same under the amended statute, particularly when the amended statute does not say that.

There are logical reasons for analyzing claims for mental disorders different from claims for physical disorders. Claims for mental disorders and resulting physical symptoms are harder for an employer to "disprove." In other words, the legislature's concern could have been the type of injury alleged, rather than the cause of the injury. There is support for this distinction in the legislative history of this amendment. The original version of the proposed amendment to ORS 656.802 provided that an occupational disease included:

> "(b) Any mental disorder arising out of and in the course of employment [caused by psychological stress or physical trauma] and which requires medical services or results in physical or mental disability or death."

That version of the amendment showed that the legislature was concerned with the compensability of *all* claims for *mental disorders,* not just mental disorders caused by stress. **<122 Or App 430/431>** It does not support the conclusion that the legislature intended by the use of the term "mental disorder" to encompass all claims for physical disorders caused by on-thejob stress. If it did, *physical disorders* caused *by physical trauma* would have been subject to *former* ORS 656.802(2). Additionally, during the discussions of this amendment, legislators cited as examples of claimants subject to the new requirements those who suffer a "breakdown" as the result of stress. The legislature did not mention claims in which stress is alleged to have caused a purely physical condition, such as a heart attack or a stroke, except to note erroneously that such claims were not compensable. That misstatement also suggests that the legislature did not intend by its use of the term "mental disorder" to include physical disorders caused by on-thejob stress. Additionally, the legislators debated whether psychologists should be allowed to treat claimant's with mental disorders and authorize time loss. An important consideration for the legislators was whether psychologists and psychiatrists used the same diagnostic criteria to define a mental disorder. Representative Hill asked at least two different "experts" to define a mental disorder and he asked whether it differed from an emotional disorder.

Hukari's definition of a mental disorder abolishes any claim for a physical condition caused by on-the-job stress. This results from the requirements in *former* ORS 656.802(2)(c) and ORS 656.802(3)(c) that a mental disorder must be generally recognized in the medical or psychological community before it is compensable. As the claimant in this case will soon discover, he loses, because his physical disorder, a heart attack, is not a mental disorder generally recognized by the psychological community. In its adoption of this legislation, the legislature was attempting to place limits on claims for mental disorders. However, there is little support in either the language of the statute or in the legislative history that the legislators intended to abolish claims for physical disorders caused by stress absent a diagnosed mental disorder. I would overrule *Hukari* and hold that the mental disorder provisions of ORS 656.802 do not apply to claims for physical disorders allegedly caused by on-the-job stress.

Accordingly, I dissent. Rossman, Riggs, and Durham, JJ., join in this dissent.

Cite as 122 Or 432 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert L. Wells, Claimant.

Ronald **ASTLEFORD**, *Petitioner,*
v.
SAIF CORPORATION, Tillamook County Creamery Association and Robert L. Wells,
Respondents.
(WCB 90-18739, 90-19654; CA A75105)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1993.
William J. Blitz, Eugene, argued the cause for petitioner. With him on the brief were David O. Wilson and Employers Defense Counsel, Eugene.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Ronald Atwood, Portland, argued the cause for respondent Tillamook County Creamery Association. With him on the brief was Williams Zografos Peck & Atwood, Portland.
No appearance by respondent Robert L. Wells.
Before Warren, Presiding Judge, and Edmonds and De Muniz, Judges.
WARREN, P. J.
Portion of order approving DCS vacated; otherwise affirmed.

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122 Or App 434> Employer seeks review of a Workers' Compensation Board order refusing to remand for a hearing and approving a disputed claim settlement (DCS) entered into by the Department of Insurance and Finance (DIF), SAIF and claimant. We vacate the portion of the order approving the DCS, and otherwise affirm.

This case presents a somewhat complex procedural history. It centers around two injuries suffered by claimant. We set forth separately the facts related to each injury.

On September 16, 1988, claimant injured his left shoulder. He filed a claim against employer concerning that injury. On December 22, 1988, DIF entered a proposed order declaring that employer was a noncomplying employer, ORS 656.052(2), and notified employer that, if he disagreed, he could request a hearing within 20 days after receipt of the order. ORS 666.740(1). More than 20 days later, employer requested a hearing. The referee dismissed that request as untimely. Employer appealed to the Board, but later withdrew the appeal.

After determining that employer was a noncomplying employer, DIF referred the claim to SAIF for processing. ORS 656.054(1). On January 16, 1989, SAIF accepted the claim and notified employer that he had 60 days to request a hearing on compensability. Employer did not request a hearing. On August 21, 1990, he instead issued claimant a notice disclaiming responsibility, on the ground that SAIF's insured, Tillamook County Creamery Association (TCCA), was the employer responsible for providing claimant workers' compensation coverage. On October 17, 1990, claimant requested a hearing on the denial of responsibility. That request was assigned case number WCB 90-19654.

On November 27, 1990, SAIF denied compensability of claimant's left shoulder condition on behalf of its insured, TCCA. Claimant requested a hearing on that denial.[1]

The second injury was to claimant's left hand on July 27, 1990. His physician notified SAIF of that injury. On **<122 Or App 434/435>** September 7, as processing agent for DIF, SAIF issued a denial of claimant's claim for his left wrist condition on the ground that that condition was not the result of the accepted left shoulder condition. Claimant requested a hearing on that denial. That request was assigned case number WCB 90-18739.

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[1] That request for hearing was not assigned a separate case number.

The referee consolidated the two cases for hearing. Employer filed a motion to join TCCA and SAIF, again asserting that TCCA was the employer responsible for providing insurance coverage. The referee denied the motion. On March 26, 1991, claimant and SAIF filed a motion to dismiss both claimant's request for hearing in WCB 90-19654 and his request for a hearing on SAIF's November 27, 1990, denial. The next day, without employer's consent, DIF, SAIF and claimant entered into a DCS that awarded claimant $28,000. They stipulated that a bona fide dispute existed among them over the compensability of a claim and that they resolved that dispute pursuant to ORS 656.289(4). The referee approved the DCS and dismissed, with prejudice, claimant's requests for hearing in both cases. On appeal to the Board, employer argued that the dismissal order should be set aside and the case remanded for a hearing on the question of who should provide insurance coverage under ORS 656.029(1).[2] He also argued that he should be allowed to approve the DCS or at least be heard on it. The Board affirmed the referee.

Employer first argues that the Board erred in refusing to remand for a hearing on his ORS 656.029 argument. That argument, in essence, is that he was not a noncomplying employer. Employer relies on ORS 656.283(1) and **<122 Or App 435/436>** *Blain v. Owen,* 106 Or App 285, 807 P2d 313, *rev den* 312 Or 80 (1991). Under the facts of this case, we conclude that the Board correctly refused to remand.

When DIF issued the order declaring employer to be a noncomplying employer, it notified him of the right to request a hearing. Had employer timely exercised that right, the issue that he claims should be determined on remand would have been decided at that time. He did not. Consequently, the order became final, and neither the Board nor we can review it. ORS 656.740(1) and (3);[3] *Brown v. Bunch Tire Bailer, Inc.,* 73 Or App 250, 254, 698 P2d 522 (1985).

ORS 656.283(1) does not assist employer. That statute gives the parties in a workers' compensation proceeding a right to request a hearing at any time "on any question concerning a claim." It is general in nature. On the other hand, ORS 656.740(1) and (3) deal specifically with the right of an employer to contest noncomplying status and the time frame for doing so. We apply ORS 656.740(1) and (3), the specific provisions. ORS 174.020; *Perlenfein and Perlenfein,* 316 Or 16, 20, 848 P2d 604 (1993).

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[2] ORS 656.029(1) provides:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by that person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer."

[3] ORS 656.740 provides, in part

"(1) A person may contest a proposed order of the director declaring that person to be a noncomplying employer, * * * by filing with the department, within 20 days of receipt of notice thereof, a written request for a hearing. * * * An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect.

"* * * * *

"(3) A hearing relating to a proposed order declaring a person to be a noncomplying employer, * * * shall be held by a referee of the board's Hearings Division; but a hearing shall not be granted unless a request for hearing is filed within the period specified in subsection (1) of this section, and if a request for hearing is not so filed, the order * * * as proposed shall be a final order of the department and shall not be subject to review by any agency or court."

Employer's reliance on *Blain v. Owen, supra,* is also misplaced. There, we interpreted ORS 656.283(1) to allow a noncomplying employer to challenge compensability of a claim. Here, however, the hearing that employer requested does not concern compensability, but rather his noncomplying status. The Board did not err in denying that request.[4]

122 Or App 437> Employer next argues that the Board erred in approving the DCS entered into by DIF, SAIF and claimant. He relies on ORS 656.289(4), which provides:

> "Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable."

Employer argues that "the parties" include a noncomplymg employer. We agree. ORS 656.005(20) defines "party" to include "the employer of the injured worker at the time of injury[.]" OAR 438-05-040(10) is more specific: " 'Party' means * * * an employer, including a noncomplying employer[.]" In *Trojan Concrete v. Tallant,* 107 Or App 429, 434, 812 P2d 433, *rev den* 312 Or 151 (1991), we stated that a noncomplying employer was a party and that "[n]o settlement can be binding under ORS 656.289(4) without all parties agreeing to it." Neither TCCA nor SAIF addresses employer's arg~ment concerning the applicability of ORS 656.289(4). We conclude that, under that statute, DIF, SAIF and claimant could not enter into a valid DCS without employer's consent.

TCCA and SAIF nonetheless argue that they can settle without employer's consent pursuant to ORS 656.054, which provides, in part:

> "(1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. * * * A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer * * *. *At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim. If an order becomes final holding the claim to be compensable, the employer is liable for all costs imposed by this chapter, incl ud ing reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim.*
>
> "* * * * *
>
> "(3) * * * all costs to the Industrial Accident Fund of a claim processed under subsection (1) of this section shall be a **<122 Or App 437/438>** liability of the non-complying employer. Such costs include compensation, reasonable administrative costs and any attorney fees awarded to the claimant * * *." (Emphasis supplied.)

Although both TCCA and SAIF rely on ORS 656.054, their reasoning is different. ORS 656.054(1) provides that SAIF shall process a claim against a noncomplying employer in the same manner as it processes a claim against a complying employer. TCCA thus reasons that, although a complying employer can influence an insurer's settlement of a claim through its insurance contract, a noncomplying employer cannot, because it does not pay premiums. It argues, therefore, that "[t]here is no statutory basis for the noncomplying employer to challenge the settlement." We disagree. Although ORS 656.064(1) gives SAIF the authority to accept or deny a claim that is filed against a noncomplying employer, it does not say that it can settle a claim without the noncomplying employer's consent. Especially in light of ORS 666.289(4), we conclude that the legislature intended that a noncomplying employer be a party to any proposed DCS.[5]

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[4] Employer also argues that claim or issue preclusion does not bar him from challenging his noncomplying status. We need not decide that issue, because we conclude that we cannot review his challenge under ORS 656.740(1) and (3).

[5] In affirming the settlement order, the Board relied on *Jerry J. Johnson,* 43 Van Natta 2758 (1991), which held that SAIF had the authority to enter into a settlement on behalf of a noncomplying employer. On review, neither TCCA nor SAIF cites *Johnson* as authority. In *Johnson,* the Board did not discuss the effect of ORS 656.289(4).

Unlike TCCA, SAIF focuses its argument only on the emphasized language of ORS 656.054(1). It argues that, after it accepted claimant's left shoulder claim, it notified employer of his right to request a hearing on compensability, but that he failed to make such a request. It argues that employer is therefore liable for "all costs imposed" under ORS 656.054(1), and that he has no right to approve or disapprove the settlement. SAIF misconstrues ORS 656.054(1). The emphasized language of ORS 656.054(1) was enacted as part of House Bill 2726 and became effective on July 25, 1991. Or Laws 1991, ch 679, 1. The amendment does not provide that it applies retroactively. Therefore, the 1991 change does not apply here, because claimant suffered his injuries in 1988 and 1990.[6] *See Barnes v. City of Portland*, 120 Or App 24, 27, 852 **<122 Or App 438/439>** P2d 265 (1993); *see also Thorpe v. Seige Logging*, 115 Or App 335, 339, 838 P2d 628 (1992), *rev den* 315 Or 313 (1993). Before the 1991 amendment, the law allowed a noncomplying employer to request a hearing on compensability of a claim "at any time." ORS 656.283(1); *Blain v. Owen, supra*, 106 Or App at 289; *Clark v. Linn*, 98 Or App 393, 397, 779 P2d 203 (1989); *see also Salter v. SAIF*, 108 Or App 717, 720,816 P2d 1208 (1991). Because there is no statutory basis on which DIF, SAIF and claimant could enter into a DCS without employer's consent, the Board erred in approving it.[7]

The portion of the order approving the DCS vacated; otherwise affirmed.

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[6] Even if the 1991 amendment to ORS 656.054 applies, that does not necessarily lead to the conclusion that a noncomplying employer need not be "party" to a settlement. SAIF's argument would carve out an exception to ORS 656.289(4), which the legislature did not make. Further, that a noncomplying employer is liable for "all costs imposed" does not mean that the employer is liable for all amounts imposed by a DCS to which the employer is not a party. Here, if employer were liable under ORS 656.054(1), he would be liable only for the costs relating to the 1988 injury, not the one sustained in 1990, because it was the 1988 injury on which he failed to request a hearing. However, the DCS shows that DIF, SAIF and claimant settled both the 1988 and 1990 injuries.

[7] We note that the DCS contained a back-up denial by SAIF concerning the 1988 injury. In light of our disposition, that issue may arise again. However, it is not clear whether ORS 656.262(6) applies, *see CNA Ins. Co. v. Magnuson*, 119 Or App 282, 850 P2d 396 (1993), and if it does, whether SAIF has the responsibility to issue a back-up denial when it processes a claim on behalf of a noncomplying employer.

Cite as 122 Or App 467 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Susie Fimbres, Claimant.

Susie **FIMBRES**, *Petitioner,*
v.
GIBBONS SUPPLY CO. and Liberty Northwest Insurance Corporation, *Respondents.*
(90-16803; CA A76888)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 23, 1993.
Robert F. Webber, Medford, argued the cause for petitioner. With him on the brief was Black, Chapman & Webber, Medford.
Alexander D. Libmann, Portland, argued the cause and filed the brief for respondents.
Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.
ROSSMAN, P. J.
Reversed and remanded for reconsideration.

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122 Or App 469> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of her aggravation claim for cervical spondylosis. We agree with claimant that employer was precluded from denying the claim by its prior stipulation that claimant's condition is compensable. Accordingly, we reverse.

Claimant injured her neck and left arm in May,1987. Employer accepted the claim in July, 1987. The nature of the injury was described on the Form 801 as stiff neck and arm pain, and the claim was accepted as nondisabling by a check mark on that form. At the time, the injury was diagnosed as "cervical/dorsal strain/sprain," and suspected thoracic outlet syndrome.

Claimant continued to experience symptoms, and in February, 1989, Dr. Corson diagnosed cervical spondylosis. On March 7, 1989, employer denied the cervical spondylosis claim, on the ground that it was not related to the injury. Claimant requested a hearing. Corson was unable to relate claimant's symptoms to the 1987 injury, but later, in a letter to claimant's attorney, he checked a box indicating that claimant's current problems were related to her injury. In a July, 1989, letter to the insurer's attorney, he expressed the opinion that it was not possible to say, with any degree of medical probability, that claimant's accepted injury had either caused or worsened her spondylosis. In September, 1989, he reported that the injury had caused claimant's preexisting spondylosis to become symptomatic.

In March, 1990, employer amended its March, 1989, denial to deny only responsibility for claimant's spondylosis, and indicated the claimant's subsequent employment had independently contributed to a worsening of her condition. In June, 1990, the parties reached an agreement whereby employer rescinded its March, 1990, denial and agreed to "reopen the claimant's May 1, 1987 nondisabling claim." Claimant dismissed her request for hearing "with prejudice as to all issues raised or raisable."[1]

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[1] The "Stipulation and Order of Settlement" provides:

"The parties stipulate as follows:

"(1) That Gibbons Builders Supply/Liberty Northwest hereby rescinds its denial of responsibility dated March 7, 1990 and shall reopen the claimant's May 1, 1987 non-disabling claim.

"(2) Gibbons Builders Supply/Liberty Northwest shall pay claimant's attorney a reasonable attorney fee of $1,500.

"(3) Interstate Stone & Block/Liberty Northwest shall pay claimant's attorney a reasonable attorney fee of $500.

"(4) Claimant's request for hearing shall be dismissed with prejudice as to all issues raised or raisable."

The "order" portion of the document, signed by the referee, states, in part:

"ORDERED that said settlement is approved as set forth in above stipulation and the claimant's request for hearing is dismissed with prejudice as to all issues raised or raisable."

122 Or App 470> In July, 1990, Corson reported that claimant's condition had continued to worsen. He recommended that claimant have surgery. In August, 1990, claimant was examined by Medical Consultants Northwest, and it reported that claimant's worsened cervical condition was due to a natural progression of her cervical spondylosis, and not due to the compensable injury. On August 16, 1990, employer denied claimant's "current condition diagnosed as cervical spondylosis," on the ground that the condition was not related to the compensable injury. In November, 1990, employer rescinded that denial and issued a partial denial related to the cervical spondylosis:

> "We have recently received information that you are seeking treatment and surgery for a degenerative neck condition, diagnosed as cervical spondylosis which you allege to be related to your injury of May 1, 1987. Medical evidence in your file indicates that your current degenerative condition, diagnosed as cervical spondylosis is unrelated to your industrial injury of May 1, 1987 and, therefore, without waiving further questions of compensability, we submit this partial denial of your claim for benefits."

The parties do not contend that the condition for which claimant now seeks benefits is different from the condition that employer agreed to compensate when it reopened the claim pursuant to the parties' agreement in June, 1990. The Board held, and employer contends, that employer is permitted to deny the claim pursuant to ORS 656.262(6), which provides, in part:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not **<122 Or App 470/471>** compensable * * * the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

We conclude that the agreement is not an "acceptance," for the purpose of ORS 656.262(6). It is a negotiated, signed, meeting of the minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party. It is approved by the referee, and has the finality and effect of a judgment. *See International Paper Co. v. Pearson*, 106 Or App 121, 806 P2d 189 (1991). We conclude that ORS 656.262(6) cannot and should not be construed to apply to such an agreement.

Reversed and remanded for reconsideration.

Cite as 122 Or App 499 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Henry Johnsen, Claimant.

MEL-KEN MOTORS, INC. and Safeco Insurance Companies, *Petitioners,*
v.
Henry **JOHNSEN**, *Respondent.*
(WCB 91-15336; CA A77133)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 14, 1993.
Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, Portland.
Merrill Schneider, Portland, argued the cause for respondent. On the brief were Daniel J. DeNorch and Schneider, DeNorch & Galaviz-Stoller, Portland.
Before Deits, Presiding Judge, and Riggs and Durham, Judges.
RIGGS, J.
Motion to strike granted; affirmed.

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122 Or App 501> Employer seeks review of a Workers' Compensation Board order holding that the Board lacks authority to sanction an attorney for an allegedly frivolous request for a hearing. It also moves to strike portions of claimant's brief on appeal. We grant the motion to strike and affirm.

Claimant suffered a compensable knee injury. Employer filed a notice of claimant's "likely eligibility" for vocational retraining services pursuant to ORS 656.340(1). Meanwhile, employer and claimant arranged a modified work program for claimant. On the basis of their agreement, the Department of Insurance and Finance denied claimant vocational retraining benefits. Claimant's counsel requested a hearing. Employer also requested a hearing. It sought dismissal of claimant's request for a hearing and sanctions against claimant's attorney. At the time of the hearing, claimant's counsel requested a dismissal of his request for a hearing. The referee granted both parties' requests to dismiss, and rejected employer's request for sanctions and attorney fees. The Board affirmed the referee's order. Employer has moved to strike portions of claimant's brief that contain material not in the record. We grant the motion and we have not considered that material.

Employer claims that the Board has implied authority to impose sanctions and attorney fees under ORS 656.283(7), ORS 656.382(3), and ORS 656.390. We disagree. ORS 656.283(7) governs the manner in which a hearing is conducted, how evidence is submitted, the standard of review and the referee's authority to rescind determination orders or notices of closure. It does not mention penalties or sanctions.

ORS 656.382(3) specifically provides for penalties against an employer for the frivolous initiation of a hearing. There is no provision in that statute for sanctions against a claimant or his attorney. ORS 656.390 provides for penalties against either party for initiating a frivolous request for review to the Court of Appeals or the Supreme Court. It does not mention frivolous "requests for hearings."

> "It is fundamental that the legislature provides rights and remedies for workers and employers. This court cannot exceed the legislative limitations even though an inequity to **<122 Or App 501/502>** the employee or the employer might result. Unless a specific statute authorizes an award of attorney fees to a claimant, this court cannot award them." *Forney v. Western States Plywood,* 297 Or 628,632,686 P2d 1027 (1984).

The Board properly concluded that, if the legislature had intended to give the authority to sanction a claimant or his attorney for frivolously initiating a hearing, it would have made specific provisions for a sanction.

Motion to strike granted; affirmed.

Cite as 122 Or App 578 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Mary E. Shores, Claimant.

Mary E. **SHORES**, *Petitioner,*
v.
RUSS' DAY-N-NITE and Liberty Northwest Insurance Corporation, *Respondents.*
(90-06677; CA A74857)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 25, 1992.
Darrell E. Bewley, Salem, argued the cause for petitioner. With him on the brief was Richard F. McGinty, Salem.
Alexander Libmann, Portland, argued the cause for respondents. On the brief was James D. McVittie, Appellate Counsel, Liberty Northwest Insurance Corp., Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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122 Or App 580> Claimant seeks review of a Workers' Compensation Board order that reinstated insurer's denial of her aggravation claim for a back condition. She assigns error to the Board's application of ORS 656.266 to an aggravation claim.

We do not accept claimant's construction of the order. The Board said:

> "In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the industrial injury. ORS 656.273(1); *Perry v. SAIF,* 307 Or 654[, 772 P2d 418] (1989).
>
> "In the present case, there is no real dispute over the worsening element of claimant's aggravation claim. * * *
>
> "Claimant's burden regarding compensability is not carried by simply disproving other possible causal explanations. ORS 656.266. Here, considering the number of potential causal factors, particularly previous back injuries and other work exposures, the causation issue is a complex medical question. Thus, resolution of this issue requires expert medical evidence. (Citations omitted.)"

The Board found, on the basis of substantial medical evidence, that

> "it is as likely as not that claimant's recently discovered disc herniation is related to a cause other than her 1989 strain injury. Therefore, claimant has not carried her burden of proof. "

We are satisfied that the Board correctly addressed whether claimant proved that her worsened condition resulted from her original injury. ORS 656.273(1).[1] Although ORS 656.266[2] applies only to proving the compensability of **<122 Or App 580/581>** injury or occupational disease claims, we do not construe the Board's citation to that statute and its accompanying comment to modify claimant's burden under ORS 656.273(1). We find no error. ORS 183.482(8); ORS 656.298(6).

Affirmed.

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[1] ORS 656.273(1) provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

[2] ORS 656.266 provides:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

Cite as 122 Or App 582 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kati A. Hanks, Claimant.

SAFEWAY STORES, INC., *Petitioner,*
v.
Kati A. **HANKS**, *Respondent.*
(90-16204; CA A74809)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 25, 1992.
Kenneth L. Kleinsmith, Tigard, argued the cause for petitioner. With him on the brief was Meyers & Radler, Tigard.
Gregory Gibson, Eugene, argued the cause for respondent. On the brief were Roger Ousey and Bischoff & Strooband, Eugene.
Before Richardson, Chief Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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122 Or App 584> Employer seeks review of a Workers' Compensation Board order that awarded claimant temporary disability benefits for a three-week period when she was prevented from working due to a labor dispute lock out at her place of work. We affirm.

Claimant, a retail clerk, injured her wrist. Employer accepted the claim and offered her modified work, which she accepted. On July 21,1990, employer locked out its employees due to a labor dispute. When the labor dispute ended, claimant returned to her modified job. The Board held that, by locking her out of her job, employer withdrew its offer of modified employment:

> "By locking claimant out of the workplace, the employer effectively, even if only temporarily withdrew modified employment from the claimant. Claimant could not voluntarily choose to participate in the employment, neither *[sic]* is she able to return to her regular employment for another employer because of the disabling effects of her compensable injury. So long as she is unable to perform her regular work, and her modified job remained unavailable as a result of the conduct of the employer, she is unable to work on account of her injury for purposes of determining her entitlement to temporary total disability."

Employer contends that claimant lost wages because of a labor dispute, not her compensable injury, and that claimant was not incapacitated and suffered no loss of earning power due to the injury. It relies on *Roseburg Forest Products v. Wilson,* 110 Or App 72, 821 P2d 426 (1991), and *Safeway Stores v. Owsley, 91* Or App 475, 756 P2d 48 (1988).

We reject employer's arguments. Claimant was released by her doctor to perform a light duty job, and was unable to perform her regular job because of her injury. The lock out separated her from the modified job. She is entitled to temporary disability payments under ORS 656.210 only if "the requisite incapacity to work exists." *Cutright v. Weyerhaeuser Co.,* 299 Or 290, 295, 702 P2d 403 (1985). When employer barred her from the modified job, she was unable, due to injury, to work and earn wages. She did not remove herself from the work force.

122 Or App 585> 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.*" (Emphasis supplied.)

The Board held that the emphasized provisions did not aid employer here, because the premise of employer's statutory right to terminate temporary disability benefits is that claimant could be working and earning a wage:

> "ORS 656.268 does not mandate a different result. The unilateral termination provisions in ORS 656.268(3)(c) are based on the premise that the client is *or could be* working. Here, claimant is physically unable to perform her regular work, and the offer of modified employment has been temporarily withdrawn. Through no fault, or choice of her own, claimant is unable to work, as a result of her injury." (Emphasis in original.)

We agree with the Board's construction of the statute. There was no evidence that claimant's separation from employment was due to her voluntary choice.

The cases relied on by employer are inapposite. In *Roseburg Forest Products v. Wilson, supra,* we upheld an employer's termination of temporary total disability (TTD) because the claimant refused modified work due to a strike at the worksite. 110 Or App at 75. *See also Roseburg Forest Products v. Phillips,* 113 Or App 721, 725, 833 P2d 1359, *rev den 314* Or 727, (employer was not required to begin paying TTD, because the claimant "withdrew from the work force when he decided to participate in the strike"). Unlike in those cases, claimant did not withdraw from the work force. The separation resulted from employer's action.

In *Safeway Stores v. Owsley, supra,* the injured worker returned to a modified job that, due to a union contract, paid higher wages than the worker earned at injury. **<122 Or App 585/586>** The employer terminated her benefits, fired her and refused to reinstate benefits. We held that the claimant was not entitled to temporary partial disability (TPD) benefits after the discharge, because her wages increased after the injury and, therefore, she had suffered no diminished "earning power" under ORS 656.212. We rejected her contention that employer was required to reinstate TPD after the discharge because,

> "[e]ven assuming that claimant's termination did not preclude recovery of benefits for temporary partial disability, she would have been entitled only to the amount that she could have received on account of her disability had she not been fired. In this case, that is nothing." 91 Or App at 480.

The determination in *Owsley* that the claimant was not entitled to TPD because she had not lost earning power under ORS 656.212 and *former* OAR 436-60-030 does not support employer's argument that claimant was not disabled. Here claimant suffered disability due to her injury which gave rise to the need for modified work.

Finally, employer contends that it locked out its employees because claimant's union called a strike against one of employer's associates in a multi-employer bargaining unit and, in effect, claimant lost wages only because she was a party to a strike. The Board rejected that argument, and we concur. An employer that decides to withdraw a modified job from an injured worker is not saved from the ordinary consequence of that decision because it does so to enhance its position in a labor dispute. *Cf. Roseburg Forest Products v. Wilson, supra,* 110 Or App at 76 (applying same principle to an injured worker's decision to refuse modified work at the site of a strike).

Affirmed.

Cite as 122 Or App 591 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ervin E. Young, Claimant.

BOEING COMPANY and Aetna Casualty & Surety Company, *Petitioners,*
v.
Ervin E. **YOUNG**, *Respondent.*
(89-25185; CA A72213)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted July 22, 1992; resubmitted in banc July 14, 1993.
Darren L. Otto, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Geoffrey G. Wren, Portland, argued the cause for respondent. With him on the brief was Royce, Swanson & Thomas, Portland.
DURHAM, J.
Affirmed.

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122 Or App 593> Employer seeks review of an order of the Workers' Compensation Board setting aside employer's denial and back-up denial of claimant's claims arising from his exposure to toxic fumes at work.

In August, 1989, an incident occurred at the plant where claimant worked involving a compound used to seal the inside of gearboxes: A mixture of a styrene monomer and a polymerizing catalyst, dicumyl peroxide, overflowed while being heated in an oven. Claimant said that he smelled an "extremely foul odor, no sweetness" when he walked through the area adjacent to the spill and that he immediately became ill. He did not feel any better as time passed and developed a severe headache and nausea. He was taken to the plant's nurse, and complained of a numb, tingling right hand, a tingling left ear, sudden flashes of light on the left side of his head, difficulty in speaking, loss of motor coordination, acute anxiety, trouble in concentrating, loss of feeling in his lower lip, a visual field that "moved in and out," and shortness of breath. Claimant was admitted to the intensive care unit of a nearby hospital for observation. The initial diagnosis was a central nervous system disorder resulting from vinyl benzene exposure. In September, 1989, employer accepted his claim for a physical disorder identified as a central nervous system depression.

Claimant continued to have physical symptoms similar to those that he experienced immediately after the exposure to the toxic fumes. However, the doctors who examined him were unable to find a physical disorder. Claimant was referred to Dr. Colbach, a psychiatrist, for an evaluation. Colbach determined that claimant was suffering from a conversion disorder. Colbach referred claimant to Dr. Reiter for a neuropsychological examination. Reiter believed that claimant was consciously producing many of his physical symptoms. Claimant sought benefits for a conversion disorder. Employer denied that claim on November 14, 1989.

Claimant was released for work without restrictions. He returned to work, but his symptoms recurred shortly thereafter. He was sent to the emergency room at a nearby hospital, where he was examined by Dr. Karsten. Karsten **<122 Or App 593/594>** concluded that claimant was "malingering." Dr. Turco examined claimant and agreed with Colbach that claimant suffered from a conversion disorder. However, Turco eventually withdrew his initial diagnosis and concluded that claimant was a malingerer after reviewing Karsten's report and the report of Dr. Zivin, a neurologist who also believed that claimant was consciously producing his symptoms. On November 2, 1990, employer issued a "back-up" denial of claimant's claim for a central nervous system depression. The Board set aside both employer's denial of the claim for a conversion disorder and its back-up denial of the claim for central nervous system depression.

Employer first assigns error to the Board's order setting aside the back-up denial of the claim for central nervous system depression. As a threshold matter, claimant argues that the applicable statute is the former version of ORS 656.262(6), which allowed an employer to issue a backup denial only if it could prove fraud, misrepresentation or other illegal activity on the part of claimant. *See Bauman v. SAIF,*

295 Or 788, 794, 670 P2d 1027 (1983). The 1990 special session added new language to ORS 656.262(6) providing that an employer may also deny an accepted claim if, within two years of the date of acceptance, it can prove by clear and convincing evidence that the claim is not compensable. Claimant argues that the former version applies, because he requested a hearing on the initial denial of his conversion disorder claim before May 1, 1990, and that that hearing was originally convened before July 1, 1990, even though it was reconvened on November 6, 1990. *Astoria Plywood v. Culp,* 115 Or App 737, 743, 840 P2d 99 (1992); *SAIF v. Herron,* 114 Or App 64, 836 P2d 131, *rev den* 315 Or 271 (1992). Claimant argues that the propriety of the "backup" denial was made a part of the reconvened hearing under a single Workers' Compensation Board case number and, therefore, the timing of the hearing on the conversion disorder claim determines the applicable law for the back-up denial as well.

We agree with claimant that, if the back-up denial had been at issue in the earlier hearing, the fact that the hearing was reconvened after July 1, 1990, would not affect the applicability of the earlier version of ORS 656.262(6). *See* **<122 Or App 594/595>** *Astoria Plywood v. Culp, supra.* However, the back-up denial in this case was issued on November 2, 1990, and claimant could not have requested a hearing on that matter before May 1,1990, nor could a hearing on it have been held before July 1, 1990. Accordingly, we agree with the Board's determination that ORS 656.262(6) as amended applies to the back-up denial.

Applying the amended version of ORS 656.262(6), we hold that the Board's findings relating to what happened to claimant at work are supported by substantial evidence and that those findings support its conclusion that employer failed to prove by clear and convincing evidence that claimant experienced no compensable physical injury as a result of his exposure at work to styrene fumes. There was evidence that toxic fumes were released at claimant's work site and that other employees suffered minor reactions. Further, the doctors involved in claimant's emergency care stated that claimant suffered an acute physical reaction to exposure to styrene fumes. Dr. Smith, the emergency room physician, diagnosed central nervous system depression. Dr. Custis, an internal medicine specialist, initially concurred with that diagnosis. Claimant's physical symptoms, as chronicled by the emergency care personnel, were consistent with that diagnosis.

We also hold that the Board's conclusion that employer failed to prove that claimant engaged in fraud, misrepresentation, or other illegal activity is correct. Employer argues that the evidence establishes that claimant is a "malingerer" and that he consciously produced his continuing physical symptoms. There is evidence that would support that conclusion. However, as discussed above, there also is evidence that claimant's immediate physical reaction to his exposure to styrene fumes was not faked. In view of that evidence, we cannot say, as a matter of law, that employer's initial acceptance was obtained by fraud, misrepresentation or illegality. The Board properly set aside employer's back-up denial of claimant's claim for a central nervous system depression.

Employer next argues that the Board erred in setting aside its denial of the claim for conversion disorder. Employer argues that the Board erred in using the *material* contributing cause standard for an industrial injury, ORS **<122 Or App 595/596>** 656.005(7)(a), *(since amended by* Or Laws 1990, ch 2, 3), rather than the *major* contributing cause standard of an occupational disease. ORS 656.802(2).[1] It contends that the 1987 legislative changes to ORS 656.802 provide that a claim for a mental disorder may only be brought under the occupational disease law.

We have held that not all claims for a mental disorder must be brought as occupational disease claims under ORS 656.802. *Aetna Casualty Co. v. Robinson,* 115 Or App 154, 156,836 P2d 1362 (1992); *Boeing Co. v. Viltrakis,* 112 Or App 396, 398, 829 P2d 738 (1992). As we explained in *Viltrakis,* if a claim for a medical disorder is brought as an independent claim, it must be brought under ORS 656.802 as a claim for an occupational disease. However, if the condition results from a compensable injury, it may be treated as a claim for the consequences of an injury.

> "[Wlhen a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply." 112 Or App at 399.

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[1] The parties agree that the 1990 amendments do not apply to claimant's claim for a conversion disorder, because he requested a hearing before May 1, 1990, and a hearing was convened before July 1, 1990.

A mental disorder is compensable as a consequence of a work-related accidental injury if the injury materially caused the mental disorder. *Nordstrom, Inc. v. Gaul,* 108 Or App 237, 240, 815 P2d 710 (1991).[2]

Claimant has at all times contended that he suffered a compensable injury from a sudden toxic fume exposure and, as a consequence of that accident, developed a conversion disorder. Although employer sought to characterize the conversion disorder claim as one for an occupational disease, the Board rejected that approach. We have previously affirmed the Board's rejection of an employer's effort to recharacterize a consequential psychological condition claim as one for an **<122 Or App 596/597>** occupational disease. *American Nursing v. Yost,* 108 Or App 243,245, 815 P2d 708 (1991). We do so again in this case. The Board adopted the referee's extensive findings that "claimant suffered a real physical event caused by exposure to styrene which required medical care and treatment," that he "began having some physical symptoms from that exposure, [and that] he developed a powerful psychological reaction." Substantial evidence supports these findings.

Affirmed.

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[2] ORS 656.005(7) has since been amended to provide that

"[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." Or Laws 1990, ch 2, 3.

That amendment does not govern this proceeding.

Cite as 122 Or App 598 (1993) August 25, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Marvin **MOUSTACHETTI**, *Appellant,*
v.
STATE OF OREGON, Fairview Training Center, George Gray, and John Does 1-10, *Respondents.*
(9OC-10101; CA A69332)

In Banc*
Appeal from Circuit Court, Marion County.
Rodney W. Miller, Judge.
Argued and submitted April 24,1992; resubmitted in banc June 9, 1993. Mark K. Grider, Salem, argued the cause and filed the brief for appellant.
Harrison Latto, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
DURHAM, J.
Reversed and remanded.
Deits, J., Concurring in part; dissenting in part.
*Landau. J.. not participating.

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122 Or App 600> Plaintiff appeals from a summary judgment for defendants. The trial court held that, under ORS 30.265(3)(a), defendants are immune from plaintiff's claim for wrongful termination. We reverse.

Plaintiff worked at Fairview Training Center as a psychiatric security aide. Defendants are plaintiff's employer, a public body, and individuals who are employees or agents of the employer. In September, 1987, plaintiff's employer placed him on administrative leave and terminated him in January, 1988.[1] In September, 1987, plaintiff filed a workers' compensation claim for an on-the-job injury that he described as "stress." He asserted that the stress arose from problems with his job and from his suspension. SAIF concluded that plaintiff suffered from "emotional stress due to anxiety over his employment, suspension and termination" and accepted the claim. Claimant received time loss and payment for medical expenses.

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[1] Plaintiff was reinstated in December, 1988, with an award of back-pay as the result of a grievance arbitration award.

In January, 1990, plaintiff filed a complaint for wrongful termination, alleging that defendants wrongfully terminated him with intent to cause severe emotional distress. Plaintiff sought damages for:

> "severe emotional distress, sleeplessness, loss of control over his emotions, alienation of his friends and family, [and] diminution and damages to his self-confidence and self-esteem, all to his non-economic damage in an unspecified amount."

The trial court granted defendants' motion for summary judgment on the ground that there were no disputed issues of material fact and that, as a matter of law, defendants were entitled to immunity under ORS 30.265(3)(a). That statute provides in pertinent part:

> "(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:
>
> "(a) Any claim for injury to * * * any person covered by any workers' compensation law."

122 Or App 601> We examine the record in the light most favorable to the non-moving party to determine if there are no genuine issues of material fact and whether the moving party is entitled to judgment as a matter of law. ORCP 47C; *Poirier v. United Grocers, Inc.*, 110 Or App 592, 595, 824 P2d 1158, *rev den* 313 Or 210 (1992).

The controlling question is whether ORS 30.265(3)(a) grants immunity to a public body and its agents for liability resulting from its *intentional* injury of a worker who is subject to a workers' compensation law. Plaintiff argues that ORS 656.156(2) preserves his right to bring the action even though he is a worker "covered" by the workers' compensation law. Defendant argues that the immunity applies to all claims by "persons" covered by the workers' compensation law and that plaintiff is such a "person."

Our objective in construing ORS 30.265(3)(a) is to discern the legislature's intention. ORS 174.020. We must construe the statute as a whole to determine that intention.[2] The state enjoys immunity from "claims for injury to * * * any person covered by any workers' compensation law. " The language requires us to resort to the workers' compensation law as an initial matter to determine who and what that law "covers."[3] When we interpret several related statutes, we should adopt such construction "as will give effect to all." ORS 174.010. In general, we "construe together statutes on the same subject as consistent with and in harmony with each other." *Davis v. Wasco IED*, 286 Or 261, 272, 593 P2d 1152 (1979).

122 Or App 602> The general policy of Oregon's Workers' Compensation Law, as expressed in ORS 656.012, is to require

> "industry to bear the costs of injury or disease to workers, just as industry must do with respect to damage to machinery, and to avoid 'common law' litigation by granting to employers immunity against liability for 'compensable injuries,' ORS 656.018." *Dethlefs v. Hyster Co.*, 295 Or 298,309, 667 P2d 487 (1983).

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[2] The partial dissent is flawed because it begins and ends its analysis with the term "person" in ORS 30.265(3)(a), and disregards the other key phrases, "claims for injury" and "covered by any workers' compensation law." In contrast, we choose to construe ORS 30.265(3)(a) as a whole and to give effect to every word and phrase, if possible. *Kankhonen v. Hendrickson et al* 232 Or 49, 67,374 P2d 393 (1962). The partial dissent does not explain how it can discern whether an injury claim is covered by workers' compensation law, and is, therefore, a claim for which the state is immune, without making any effort to interpret and apply the workers' compensation law, as the text of ORS 30.265(3)(a) contemplates.

[3] Coverage exists when the employer satisfies its duties under ORS 656.017 and thereby qualifies for the exclusive remedy protection in ORS 656.018. For purposes of ORS 30.265(3)(a), a claim is "covered" by the workers' compensation law even if, due to insufficiency of evidence or an error on the part of the claimant or the claimant's attorney, the Board rejects all or part of the claim or does not grant the requested relief.

In *Wright v. Bekins Moving & Storage Co.*, 97 Or App 45, 49, 775 P2d 857, *rev den* 308 Or 466 (1989), we said:

> "The workers' compensation system is purely a creature of statute and many of the provisions * * * involve political accommodations of the competing interests of employers and claimants and the need for an orderly litigation system."

The principal political accommodation compels the employee to give up the right to sue for negligence and the right to secure a potentially larger award of damages through ajury trial. The employer gives up its common law defenses to negligence and is exposed to liability regardless of fault for the limited compensation provided by statute.

However, with regard to an employer's intentional injury of an employee, the law strikes a different political accommodation. ORS 656.156(2) provides:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

The statute grants statutory compensation to the employee injured through the deliberate intention of the employer *and* guarantees that the employee has the right to pursue a cause of action against the employer *as if the Workers' Compensation Law had never been passed.*

We construe ORS 30.265(3)(a) and ORS 656.156(2) together to give effect to each. *Davis v. Wasco IED, supra,* 286 Or at 272. Plaintiff's intentional tort claim is not "covered" by the workers' compensation law, within the meaning of ORS 30.265(3)(a), because ORS 656.156(2) preserves his **<122 Or App 602/603>** common law tort remedies and compels us to assume that the legislature did not enact a workers' compensation law regarding that claim.[4] We do not ascribe to the legislature an intention to immunize the state or its agents from liability for intentional torts committed within the scope of employment. *See Crosby v. SAIF,* 73 Or App 372, 376, 699 P2d 198 (1985), reachingthe same conclusion under ORS 30.265(3)(c), which creates immunity for discretionary acts. *See also Clackamas Co. Fire Protection v. Bureau of Labor,* 50 Or App 337, 353, 624 P2d 141, *rev den* 291 Or 9 (1981).

Reversed and remanded.

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[4] Despite the partial dissent's contrary suggestion, it is not mere coincidence that the scope of immunity under ORS 30.265(3)(a) parallels the immunity of employers from claims by injured workers under ORS 656.018 and ORS 656.156(2). Our construction of the two statutes effectuates the legislative intention that they be construed together to achieve a consistent application. The partial dissent's construction would defeat that consistency by immunizing the state from its intentional torts against its employees even though, as to those claims, we are bound to assume that the workers' compensation laws do not exist. ORS 656.156(2).

DEITS, J., concurring in part; dissenting in part.

I agree with the majority that the summary judgment for the individual defendants should be reversed, but for a different reason from the majority's. I would hold that the Oregon Tort Claims Act (OTCA) itself does not provide immunity for intentional acts that are outside the scope of an individual defendants' employment. Because of that, I believe that there are questions of fact concerning whether the individual defendants were acting outside the scope of their employment, and accordingly, summary judgment for them was not appropriate. In my view, however, summary judgment was properly granted to the defendant State of Oregon because, under my reading of the pertinent statutes, the state did have immunity.

ORS 30.265(3)(a) provides:

> "(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:

"(a) Any claim for injury to * * * any person covered by any workers' compensation law."

122 Or App 604> The majority concludes that, because plaintiff's tort claim is putatively not covered by the workers' compensation law,[1] ORS 30.265(3)(a) does not provide immunity to any of the defendants. In effect, the majority disregards the OTCA immunity provision and makes its analysis of the workers' compensation law the sole basis for deciding whether defendants have immunity from this OTCA claim.

The majority is wrong for a number of reasons. First, the majority's conclusion is contrary to the plain language of ORS 30.265(3)(a). That statute provides that public bodies and their officers, employees and agents are immune from liability for claims for injury to "any person covered by any workers' compensation law." Plaintiff acknowledges that he is a "person covered by the workers' compensation law." The majority recognizes that the statute gives immunity from claims by *persons* covered by workers' compensation. However, it concludes that, contrary to the plain words of the statute, what the legislature really meant to say is that immunity is available only when a person's *claim is* covered by the workers' compensation law.

The majority decides that it is necessary here to construe the immunity provision of the OTCA and ORS 656.156(2), the exception to immunity in the workers' compensation law, together. Interestingly, however, it does not look to or rely on the language or legislative history of the OTCA provision, but looks exclusively at the language and purposes of the workers' compensation law. Perhaps because of that, the majority's conclusion is completely inconsistent with the language of the OTCA. The immunity provided in ORS 30.265 applies to any claims for on-thejob injuries to "any *person* covered by any workers' compensation law." (Emphasis supplied.) The language of the statute does not limit the grant of immunity only to tort *claims* for injuries that are covered by workers' compensation.

122 Or App 605> The majority concludes that its reading of the OTCA immunity provision is compelled by ORS 656.156(2), the workers' compensation law provision that excepts an employer's intentional acts from the exclusive remedy and immunity provisions of *that* law:

"If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and *also* have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes." (Emphasis supplied.)

The majority appears to reason that, because plaintiff's *claim* against his employer comes within the language of ORS 656.156(2) and, if the employer were a private one rather than the state, it would therefore not be immune from a tort action, a parallel reading must be given to ORS 30.265(3)(a), despite the fact that its language is very different from that of ORS 656.156(2) and clearly vests the state with immunity from claims by *persons* covered by the workers' compensation law. That effort to give the two statutes a parallel interpretation is inappropriate because, in addition to the clear difference in their relevant language, there is no parallel in the purposes of the two statutes: ORS 30.265(3)(a) is one of the OTCA provisions that narrows the circumstances under which the state consents to be sued, while ORS 656.156(2) carves out an exception within the workers' compensation law itself to the general rule of that law that makes workers' compensation an employee's exclusive remedy and immunizes the employer from other remedies.

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[1] In fact, under usual workers' compensation parlance, the claim is covered. Plaintiff's argument and the majority's turn on the proposition, discussed below, that the claim is not compensable to the extent of the damages he sustained and that ORS 656.156(2) would allow him to bring a tort "claim" against his employer for damages in excess of the recovery he could obtain through a "claim" under the workers' compensation law. Therefore, they reason, the tort claim is not covered (or at least not fully) within the meaning of the statute. For purposes of my discussion only, I accept that proposition.

Given the fact that the ORS 30.265(3)(a) and ORS 656.156(2) have different purposes and contexts, there is no reason to strain their language, as the majority does, to make them say the same thing. The assumption that they were meant to coincide is wholly unwarranted and, by their clear terms, they do not coincide. ORS 30.265(3)(a) immunizes the defendants to whom it applies from any action for an injury to a person covered by workers' compensation. Plaintiff is covered and he, in fact, received compensation for his injuries. It is immaterial that his claim might be actionable under a **<122 Or App 605/606>** different statute that applies to different parties and circumstances. The majority's reading of the OTCA seems to be based on its policy decision that workers should be entitled to the same remedies against public and private employers. That may or may not be a good policy decision, but it is not one that the legislature chose to make in its adoption of the OTCA. I would hold that the summary judgment for the state was properly granted.

With respect to the individual defendants, however, I would hold that ORS 30.265(3)(a) does not provide immunity for intentional tortious conduct that falls outside "the scope of their employment or duties." We have answered the analogous question under ORS 30.265(3)(c), the "discretionary acts" immunity provision. In *Crosby v. SAIF,* 73 Or App 372, 376, 699 P2d 198 (1985), we rejected the defendant state agency's argument "that intentional torts that involve unlawful conduct can be immune under ORS 30.265(3)(c)." *See also Clackamas Co. Fire Protection v. Bureau of Labor,* 50 Or App 337, 353, 624 P2d 141, *rev den* 291 Or 9 (1981). The purposes of paragraphs (a) and (c) of the immunity statute are not precisely the same. *See* note 2, *infra.* However, their similarities are greater than their differences. To enjoy immunity under *any* of the paragraphs in ORS 30.265(3), public employees must have acted "within the scope of their employment or duties."

As a general proposition in employment law, an employee's intentional torts that, *inter alia,* are not aimed at serving the employer and are not of a kind that the employee was hired to perform are not within the scope of employment. *Chesterman v. Barmon,* 305 Or 439,442,753 P2d 404 (1988); *Dunn v. Gracia,* 95 Or App 150, 768 P2d 419, *rev den* 307 Or 719 (1989). I would hold that that general proposition is applicable in determining whether a public of ficer, employee or agent is immune under ORS 30.265(3)(a).[2] The structure of the Oregon Tort Claims Act supports that conclusion. Under ORS 30.285(1), public bodies have a duty to indemnify and defend officers, employees and agents for tort claims **<122 Or App 606/607>** arising out of "the performance of duty." However, subsection (2) makes the public body's duty of defense and indemnification inapplicable in cases of "willful or wanton neglect of duty. " In *Stevenson v. State of Oregon,* 290 Or 3, 13, 619 P2d 247 (1980), the court characterized that statutory language as encompassing claims "based on aggravated misconduct." It would make no sense, and I decline to ascribe to the legislature the intent, to immunize under ORS 30.265(3) conduct that ORS 30.285(2) makes ineligible for the other protections of the OTCA.

Under my reading of the statute, there are questions of fact as to whether the individual defendants were acting within the scope of their employment or duties and, therefore, whether they are immune under ORS 30.265(3)(a). I agree with the majority that the summary judgment for those defendants was error. However, because the statute does not make the immunity of public bodies contingent on the scope of employment test, I would hold that the summary judgment for the state was proper.

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[2] Arguably, as we suggested in *Crosby,* the test for discretionary acts immunity for intentional misconduct should be even more stringent. In addition to the scope of employment question, immunity under ORS 30.265(3)(c) may also turn on the proposition that there *can* be no discretion to act unlawfully.

Cite as 123 Or App 1 (1993) September 1,1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David A. Pitzer, Claimant.

WEYERHAEUSER COMPANY, *Petitioner,*
v.
David A. **PITZER**, Reedsport Auto, Inc., and SAIF Corporation, *Respondents.*
(WCB 91-04855, 91-06246; CA A74818)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1993.
John M. Pitcher, Springfield, argued the cause and filed the brief for petitioner.
Karen Werner, Eugene, argued the cause for respondent David A. Pitzer. With her on the brief was Stebbins & Coffey, North Bend.
Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents Reedsport Auto, Inc., and SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Edmonds and De Muniz, Judges.
WARREN, P. J.
Affirmed.

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123 Or App 3> Employer seeks review of a Workers' Compensation Board order that set aside its denial of claimant's claim. We affirm.

In 1985, claimant filed a claim for a back strain while working for employer. The referee concluded that claimant's work with employer over a period of years had resulted in a degenerative condition and that that condition, together with specific work activity, had resulted in a compensable condition. Employer did not appeal and the claim was closed.

In 1991, while working for another employer insured by SAIF, claimant experienced pain in his lower back and legs. The diagnosis associated his pain with the degenerative condition and, for the first time, with spinal stenosis. His treating physician recommended surgery.

Claimant then filed a claim for the current condition as well as for an aggravation, which employer denied.[1] The referee set aside the denial and the Board affirmed.[2]

Both employer and claimant agree that ORS 656.005(7)(a) governs this case. That statute defines "compensable injury" with the following limitations:

> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.
>
> "(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment.

The Board found that claimant's current condition was compensable under both ORS 656.005(7)(a)(A) and (B). **<123 Or App 3/4>** We agree with the Board that the claim is compensable under ORS 656.005(7)(a)(A).

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[1] Claimant also filed with SAIF a new injury claim, which was denied. That denial is not challenged on review.

[2] Because the Board concluded that the spinal stenosis was compensable as a current condition, it did not decide whether it was compensable as an aggravation under ORS 656.273.

Under ORS 656.005(7)(a)(A), a subsequent condition is compensable if there is "a compensable injury" and that injury is "the major contributing cause of the consequential condition." *Kephart v. Green Riuer Lumber,* 118 Or App 76, 79, 846 P2d 428 (1993); *Hicks v. Spectra Physics,* 117 Or App 293, 296, 843 P2d 1009 (1992); *Albany General Hospital v. Gasperino,* 113 Or App 411, 415, 833 P2d 1292 (1992). The Board concluded, on the basis of issue preclusion, that claimant's spinal stenosis was compensable. Employer assigns error to that ruling, arguing that the Board misapplied the doctrine of issue preclusion.

"Issue preclusion precludes future litigation of an issue only when the issue was actually litigated and determined in a setting where its determination was essential to the final decision." *Marshall v. Korpa,* 118 Or App 144, 147, 846 P2d 445, *rev den* 316 Or 528 (1993); *see also Drews v.EBI Companies,* 310 Or 134, 796 P2d 531 (1990). Employer is precluded from arguing now that claimant's degenerative disc disease is not compensable, because that issue has been litigated and determined. In 198~, claimant filed a claim with employer for low back strain. His treating physician then diagnosed it as being "related to some degeneration of the disc." Employer denied the claim, asserting that claimant's injury was not a result of his employment with employer. After a hearing, the referee set aside the denial, concluding that the degenerative disc condition was work-related and therefore compensable. Employer did not appeal that order. Because the determination that the degenerative disc disease was compensable was essential to the referee's order, we agree with the Board that employer is precluded from relitigating that issue.[3]

Because there was a compensable degenerative disc disease, the question is whether that condition was the major contributing cause of claimant's spinal stenosis. The Board **<123 Or App 4/5>** found that, on the basis of medical evidence in the record, it was. Employer does not argue that that finding is not supported by substantial evidence.

Affirmed.

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[3] Employer also argues that the finding, contained in a 1988 order, that claimant's degenerative disc disease was compensable, was not essential, because that order merely determined the extent of claimant's permanent partial disability. We need not address that issue, because the Board did not rely on that order for the issue preclusion analysis.

Cite as 123 Or App 83 (1993) September 1, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Everett L. Weems, Claimant.

Everett L. **WEEMS**, Metropolitan Disposal Corporation, an Oregon corporation, and EE Equipment, Inc., an Oregon corporation, *Petitioners,*
v.
AMERICAN INTERNATIONAL ADJUSTMENT COMPANY and AIG Risk Management, Inc., *Respondents.*
(TP-91026; CA A75753)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 8, 1993.
Stephen R. Frank, Portland, argued the cause for petitioners. With him on the brief were Alison K. Greene and Tooze, Shenker, Holloway & Duden, Portland.
Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Before Warren, Presiding Judge, and Edmonds and Landau, Judges.
LANDAU, J.
Affirmed.

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123 Or App 85> Petitioners seek review of a decision of the Workers' Compensation Board disapproving a proposed settlement of a third-party action. We affirm.

Claimant was injured while operating an industrialsized garbage compactor. As a result of his injuries, his left leg was amputated six inches below the hip. He filed an action against the companies that supplied his employer with the compactor, Metropolitan Disposal Corporation and EE Equipment,

Inc. (collectively referred to as MDC), asserting negligence and products liability claims. Claimant's wife also brought a claim for loss of consortium. MDC denied any negligence and alleged that claimant's injuries resulted from his own negligence.

The products liability claims were dismissed on statute of limitations grounds. Claimant and MDC then agreed to settle the remaining negligence claim for $250,000. At the same time, claimant's wife and MDC agreed to settle her loss of consortium claim for $330,000. American International Adjustment Company and AIG Risk Management, Inc. (collectively referred to as AIAC), as paying agencies, asserted their right to disapprove the settlement. The matter then was submitted to the Board for approval. ORS 656.587.

Before the Board, claimant and MDC argued that the proposed settlement with claimant should be approved. They supported their argument with affidavits of MDC's counsel and of the judge who presided over the settlement negotiations. Both individuals stated that they believed that the proposed settlement was fair and reasonable. In opposition, AIAC argued that the settlement represented an attempt to circumvent the workers' compensation statutes that provide for a lien on damages awarded in third-party actions. Based on an affidavit of its counsel, AIAC argued that the proposed settlement amount of $250,000 for claimant's negligence claim was grossly out of proportion to the proposed settlement amount of $330,000 for the wife's derivative loss of consortium claim. AIAC noted that the value of loss of consortium claims ordinarily does not exceed 10 percent of the underlying injury claim. Particularly in the light of certain factual weaknesses in the wife's claim, it argued, MDC's **<123 Or App 85/86>** proposed settlement represents an attempt to allocate a large portion of funds to the wife, so as to be beyond the reach of the workers' compensation insurer.

The Board rejected the proposed settlement of claimant's negligence claim. It found that the proposed settlement figure of $250,000 for claimant was "grossly unreasonable" when compared to the $330,000 to be paid to claimant's wife for her loss of consortium claim.

Claimant and MDC assign error to the Board's finding that the proposed settlement was not reasonable. Although they agree that we must review the Board's findings for substantial evidence, they contend that the Board's findings in this case are supported by no evidence at all. Several arguments are offered in support of that contention.

Claimant and MDC first argue that the Board erred in considering evidence of the value of the loss of consortium claim. According to claimant and MDC, that evidence is not merely irrelevant; it is beyond the statutory authority of the Board even to consider. That conclusion, they argue, is compelled by our decision in *SAIF v. Cowart*, 65 Or App 733, 672 P2d 389 (1983). That case, however, says nothing of the sort. In *Cowart*, we said only that the Board lacks the statutory authority to approve or disapprove a proposed settlement of a claimant's spouse's loss of consortium claim. We did not say that the Board cannot consider the value of such a claim as evidence of the reasonableness of a proposed settlement of claimant's underlying claim. Here, no one has submitted for Board approval the proposed settlement of claimant's wife's claim. *SAIF v. Cowart*, therefore, is inapposite.

Claimant and MDC argue that the Board should not have considered claimant's wife's settlement even as evidence, because it constitutes an offer to compromise, which is inadmissible under OEC 408. That argument, too, misses the mark. Even assuming the Board is subject to common law or statutory rules of evidence, OEC 408 proscribes the admission of offers of compromise to prove liability on the same claim. Evidence of claimant's wife's settlement was not offered for that purpose here. Claimant and MDC argue that the policy of encouraging frank and open settlement negotiations, which underlies OEC 408, nevertheless warrants **<123 Or App 86/87>** exclusion of evidence of claimant's wife's settlement. We disagree. Claimant's and his wife's settlements were negotiated as a package. It makes no more sense to exclude evidence of claimant's wife's settlement than to exclude evidence of claimant's own. Moreover, adopting a hard and fast rule excluding evidence of all parts of a settlement package would be tantamount to an invitation to "game" the third-party review process. We decline to extend such an invitation. *See Scarino v. SAIF*, *91* Or App 350,355 n 2, 755 P2d 139, *rev den* 306 Or 660 (1988). The Board did not err in considering the value of the proposed settlement of the loss of consortium claim.

Claimant and MDC argue that, even if the evidence is admissible, the Board's decision cannot be affirmed because it is not supported by the record, when viewed as a whole. Of particular importance to claimant and MDC is the opinion of the settlement judge, which they argue should have "bound" the Board "absent clear and convincing evidence to the contrary." Relying on federal cases concerning

review of class action settlements, *e.g., City of Detroit v. Grinnell Corporation,* 495 F2d 448 (2d Cir 1974), they contend that the Board erred when it presumed to second guess the judge's opinion that the proposed settlement with claimant was fair and reasonable. Claimant and MDC are wrong. The Board is not "bound" by any particular affidavit or other piece of evidence. The authorities on which claimant and MDC rely concern an entirely different process in which the trial judge is required to evaluate the merits of proposed settlements of class actions to determine whether the terms are fair and reasonable. *See generally* FRCP 23(e); Wright, Miller & Kane, *Federal Practice and Procedure* 1797.1 (2d ed 1986). Here, the supposedly controlling opinion consists of the observations of a judge who facilitated the settlement. The functions are not parallel, and there is no reason to require the Board to defer to the settlement judge's opinion.

Claimant and MDC insist that the Board should have agreed with the settlement judge, because her opinion rested on a solid factual foundation. In other words, claimant and MDC wish the Board had weighed the evidence differently. We will not engage in such a re-evaluation of the evidence. Our standard of review is limited to determining whether the **<123 Or App 87/88>** record, when viewed as a whole, permits a reasonable person to reach the conclusion that the Board did. *Armstrong v. Asten-Hill Co., 90* Or App 200, 205, 752 P2d 312 (1988). It does.

In concluding that the proposed settlement with claimant was "grossly unreasonable," the Board considered the opinion of the settlement judge, as well as the evidence that claimant and MDC offered to show that the proposed settlement was reasonable, even when compared to the proposed settlement of the loss of consortium claim. The Board found that evidence unpersuasive. It acknowledged that claimant's injury may require claimant's wife to assume greater responsibilities for household chores and that she may suffer adverse emotional consequences from the injury. Nevertheless, the Board observed, the wife has not sought medical care for the supposed increase in stress. The Board also examined the law and compared other cases to determine claimant's and his wife's likelihood of recovery on each of their claims. It correctly found that both claimant's and his wife's claims are subject to the same defenses, in view of the derivative nature of the loss of consortium claim. *See Ross v. Cuthbert,* 239 Or 429,435,397 P2d 529 (1965); *see also Fox v. Flescher,* 274 Or 599,602,547 P2d 1392 (1976). It then found that, whatever the wife's settlement was, a reasonable settlement for claimant would necessarily be larger, because claimant's injuries included the harm to the relationship about which the wife complained *plus* the burden of living the remainder of his life without his leg.

We cannot say that a reasonable person could not reach the same conclusion. The Board's decision, therefore, is supported by substantial evidence.

Affirmed.

Cite as 123 Or App 113 (1993) September 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Eldon Burbank, Claimant.

Eldon **BURBANK**, *Petitioner,*
v.
SEE DESIGN & PRODUCTION, North Pacific Insurance Company, North Metro RV Center and SAIF Corporation, *Respondents.*
(90-14100 & 89-25312; CA A75891)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 30, 1993.

Glen H. Downs, Portland, argued the cause for petitioner. With him on the brief were Gerald C. Doblie and Doblie & Associates, Portland.

Steve Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents North Metro RV Center and SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondents See Design & Production and North Pacific Insurance Company.

Before Deits, Presiding Judge, and De Muniz and Leeson, Judges.

De MUNIZ, J.

Affirmed.

123 Or App 115> Claimant seeks review of an order of the Workers' Compensation Board holding that SAIF, as processing agent for the noncomplying employer, is not responsible for claimant's back condition. The Board's decision is supported by substantial evidence, and we therefore affirm it.

In 1983, claimant compensably injured his low back while working for See Design & Production, Inc. (See); and doctors diagnosed a disc condition at L5-6. See was insured by North Pacific Insurance Company. While employed by See, claimant had four back surgeries, which included a fusion at L5-6. In 1989, he began to work for Metro North RV Center (Metro), selling parts. While lifting a canopy, he felt pain in his low back and left hip. Dr. Poulson reported that claimant's fusion at L5-6 was not solid and recommended surgery. Claimant filed a claim with Metro, which was, at that time, a noncomplying employer. SAIF, as processing agent, denied responsibility for the claim. The Board found that claimant's work at Metro had not worsened his underlying back condition and held that See remained responsible for the claim.

There is substantial evidence to support the Board's finding that claimant's employment at Metro did not independently contribute to his disc condition. Poulson testified that claimant's earlier surgeries had never resulted in a solid fusion of his discs, that claimant had not suffered a protruded disc as a result of the October, 1989, incident and that he had found no neurological changes in claimant's back. Although Poulson's written reports contain statements that might be read to indicate that claimant's condition had worsened, considering Poulson's opinion in its entirety, the Board was entitled to find that the October, 1989, incident had merely resulted in an increase in symptoms.

The Board stated in its opinion:

> "[Wle agree with the Referee that claimant has failed to establish that he experienced a worsening in October 1989 sufficient to shift responsibility to the later employer."

Claimant contends that the Board erred in assigning to him, rather than to See, the burden to prove that his employment at Metro had worsened his condition. We agree with SAIF that claimant mischaracterizes the Board's statement. In his **<123 Or App 115/116>** brief to the Board, *claimant* contended that Metro, not See, was responsible for his condition. As the party seeking to shift responsibility to a later employer, claimant had the burden to show that his employment at Metro independently contributed to his condition. *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 724 P2d 919 (1986).[1] In the statement quoted, the Board simply concluded that the evidence did not support claimant's contention.

Claimant argues that the Board's order is internally inconsistent because, on the one hand, it notes and adopts the referee's determination that SAIF's denial of compensability should be set aside, but on the other hand, it upholds SAIF's denial of responsibility and finds the entire denial to have been reasonable. We conclude that, reading the Board's order in its entirety, it is clear that the Board treated SAIF's denial of compensability and responsibility as a single denial and concluded that SAIF had acted reasonably.[2] The evidence supports that determination.

Claimant asserts, finally, that SAIF's denial was unreasonable, because it did not comply with the provisions of ORS 656.262(8), regarding the content of the notice of denial. The issue was not raised before the Board, and we will not consider it here.

Affirmed.

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[1] This case is not subject to the 1990 legislative amendments.

[2] SAIF issued one denial, stating that claimant's "injury did not arise from * * * employment at [North Metro]. Therefore, without waiving any further questions of compensability, we must deny your claim. "

Cite as 317 Or 432 (1993) August 19, 1993

IN THE SUPREME COURT OF THE STATE OF OREGON

Necole Eve **FIELDS**, *Respondent on Review,*
v.
JANTEC, INC., *Respondent, and* Edgar C. BROWN, *Petitioner on Reuiew, and*
BROUGHTON & HARRELL CORPORATION, an Oregon corporation, *Respondent.*
(CC 16-90-06820; CA A71071; SC S39747)

In Banc
On review from the Court of Appeals.*
Argued and submitted May 4, 1993; reassigned July 27, 1993.
James C. Chaney, of Jaqua & Wheatley, P.C., Eugene, filed the petition and argued the cause for petitioner on review.
Carl G. Kiss, Portland, argued the cause for respondent on review. Also on the response was Charles Paulson, of Paulson & Baisch, P.C., Portland.
Arthur C. Johnson and Douglas G. Schaller, of *amicus curiae* Johnson, Clifton, Larson, Corson & Phillips, P.C., Eugene, filed a brief. Robert K. Udziela, of Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, joined in the brief on behalf of *amicus curiae* Oregon Trial Lawyers Association.
GRABER, J.
The decision of the Court of Appeals is reversed and the judgment of the circuit court is affirmed as to Edgar C. Brown. The case is remanded to the circuit court for further proceedings.

* Appeal from Lane County Circuit Court, Maurice K. Merten, Judge. 115 Or App 350, 839 P2d 723 (1992).

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317 Or 435> This is a negligence action, arising out of a workplace injury, in which we consider the personal liability of an individual in his capacity as an officer, director, and shareholder of the corporation that employed plaintiff before her injury but not at the time of her injury.

At the time the events material to our review began, Edgar C. Brown (Brown) was the sole shareholder of defendant Jantec, Inc. (Jantec). Brown also was an officer and director of Jantec. Under a franchise arrangement, Jantec operated three pizza restaurants, including Abby's Pizza Inn in Florence (Abby's).

In 1988, plaintiff began working at Abby's. Part of her job involved the use of a cheese grinder that had been installed in the early 1970s. The cheese grinder did not have a safety guard on it. Brown knew that there was no guard on the grinder.

On April 26,1989, Brown sold all outstanding shares of Jantec to defendant Broughton & Harrell Corporation (B & H). Brown also ceased to be an of ficer and director of Jantec, and he had no interest in or position with B & H. On May 1, 1989, Jantec filed articles of dissolution and conveyed all assets, including the cheese grinder, to B & H. Plaintiff continued to work at Abby's under the ownership of B & H.

On January 14, 1990, while operating the cheese grinder, plaintiff lost her right hand. Plaintiff filed a workers' compensation claim, which was accepted.

Later, plaintiff filed this action for personal injury against Brown, Jantec, and B & H. As pertinent here, the second amended complaint alleged that

"Brown and Jantec were negligent in one or more of the following particulars:

"a. In having removed the safety guard from the grinder, thereby making the grinder dangerous for its intended use, having no reason to believe Plaintiff would realize the danger, and in failing to warn of its dangerous condition;

"b. In having failed to replace the safety guard, knowing or having reason to know that without said safety guard the <317 Or 435/436> grinder was dangerous for its intended use, having no reason to believe Plaintiff would realize the danger, and in failing to warn of its dangerous condition;

"c. In transferring the assets of Jantec Corporation to Defendant Broughton & Harrell, including the open-bowl Stimpson Grinder that was not equipped with a safety guard, knowing or having reason to know the grinder was dangerous for its intended use, having no reason to believe Plaintiff would realize the danger, and failing to warn of its dangerous condition."

All defendants moved for summary judgment pursuant to ORCP 47. The trial court granted the motions and entered judgment for all defendants. Plaintiff appealed.

The Court of Appeals held that the trial court did not err in granting summary judgment to defendant B & H, because plaintiff's exclusive remedy against her employer was under the Workers' Compensation Law, ORS 656.018.[1] *Fields v. Jantec, Inc.*, 115 Or App 350, 352-54, 839 P2d 723 (1992). The Court of Appeals held, however, that the trial court erred in granting summary judgment to defendants Jantec and Brown. The court held that Jantec and Brown were not shielded from liability under ORS 656.018, because Jantec was not plaintiff's employer at the time of the compensable injury. *Id.* at 358-59. The court also held that Brown was not protected from personal liability by his status as a <317 Or 436/437> corporate officer if he "authorized, directed, or participated in tortious conduct." *Id.* at 358. Finally, the Court of Appeals held that the liability of Jantec and Brown for damages caused by a failure to warn of a latent danger is not limited to that described in Restatement (Second) of Torts 388 (1965), relating to the particular standard of care owed by a supplier of chattels. *Id.* at 354-58. *Citing Fazzolari v. Portland School Dist. No. 1J*, 303 Or 1, 734 P2d 1326 (1987), and *Fuhrer v. Gearhart By The Sea, Inc.*, 306 Or 434, 760 P2d 874 (1988), the court stated that, instead, "[t]he real issue is whether it was reasonably foreseeable that plaintiff would be injured by defendants' conduct and whether their conduct was unreasonable." *Id.* at 357. Concluding that that issue should be determined by the trier of fact, the Court of Appeals reversed the judgment of the trial court as to Jantec and Brown and remanded the case against them. *Id.* at 358-59.

Brown petitioned for review. We allowed the petition and now reverse the decision of the Court of Appeals with respect to him.[2]

On review of a summary judgment, this court determines whether there was a genuine issue as to any material fact and whether the moving party was entitled to judgment as a matter of law. ORCP 47C; *Stevens v. Bispham*, 316 Or 221, 223, 851 P2d 556 (1993). In reviewing a trial court's ruling on a motion for summary judgment, this court views the evidence and all reasonable inferences to be drawn from it in the light most favorable to the nonmoving party. *Whitaker v. Bank of Newport*, 313 Or 450, 452, 836 P2d 695 (1992).

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[1] ORS 656.018 provides in part:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656 017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom * * *

" * * * * *

"(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under this chapter are in lieu of any remedies they might otherwise have for such injuries against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury.

"(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the [Department of Insurance and Finance], and the contracted agents, employees, officers and directors of the employer, the employer's insurer, the self-insured employer's claims administrator and the [Department of Insurance and Finance] * * *."

[2] Because Jantec did not petition for review we do not consider issues related to its potential liability to plaintiff. Because plaintiff did not petition for review, we do not consider issues related to the summary judgment in favor of B & H.

We will consider each of plaintiff's three specifications of negligence against Brown in turn. The first specification of negligence is Brown's alleged removal of the safety guard from the cheese grinder. With respect to that allegation, there was no genuine issue of material fact. The affidavits and other evidence in support of, and in opposition to, defendants' motions for summary judgment demonstrate without dispute that the grinder had no safety guard when <317 Or 437/438> Jantec first acquired it and that Brown did not remove a safety guard.

We next consider plaintiff's second specification of negligence. Therein, plaintiff alleged that Brown was liable for failing "to replace the safety guard on the cheese grinder" and failing to warn plaintiff of its dangerous condition.

3A Fletcher Cyclopedia of the Law of Private Corporations 1135 (1986 ed & Supp 1992 at 66-67) states:

> "The fact that one is acting as a corporate representative does not insulate him [or her] from individual liability for his [or her] tortious acts. In other words, if an of ficer or agent of the corporation through his or her own fault injures another to whom he or she owes a personal duty, that of ficer or agent is personally liable to the injured third party regardless of whether the act resulting in injury is committed by or for the corporation. It does not matter that liability might also attach to the corporation. Personal liability attached, regardless of whether the breach was through malfeasance, misfeasance or nonfeasance." (Footnotes omitted.)

See also Beri, Inc. v. Salishan Properties, Inc., 282 Or 569, 580, 580 P2d 173 (1978) (where the defendants were "charged with active participation on their own account[s], not merely in their capacities as corporate officers," in the tortious conduct alleged by the plaintiffs, the trial court erred in sustaining the defendants' demurrers). Under those principles, Brown is not insulated from liability for his negligence, if any, merely because of his status as a corporate officer, director, or agent of Jantec.

The question remains, however, whether the second specification of negligence against Brown nevertheless is barred by the provisions of the Workers' Compensation Law, ORS 656.001 *et seq.* ORS 656.018(1)(a), set out *ante* at note 1, provides that the workers' compensation liability of an employer who has complied with the requirements of the Workers' Compensation Law

> "is exclusive and in place of all other liability arising out of compensable injuries to the subject workers[.]"

ORS 656.018(2), also set out *ante* at note 1, further provides that a subject worker's rights under the Workers' Compensation Law "are in lieu of any remedies that [the worker] might <317 Or 438/439> otherwise have for such injuries against the worker's employer * * *, common law or statutory, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury." *See also* ORS 656.005(13) (defining an "employer" as a person who "contracts to pay a remuneration for and secures the right to direct and control the services of any person"); ORS 656.017 (establishing employers' duties in regard to compliance with the Workers' Compensation Law).

Jantec was a complying employer under the Workers' Compensation Law when Brown allegedly failed to replace the safety guard on the cheese grinder and failed to warn plaintiff of the machine's dangerous condition. Jantec's compliance conferred a statutory exemption from liability on Brown, as well as on the corporation. *See* ORS 656.018(3), set out ante at note 1 (providing that "[t]he exemption from liability given an employer under this section is also extended to the * * * officers and directors of the employer").[3] Jantec was not, however, a complying employer, within the meaning of the Workers' Compensation Law, at the time that plaintiff suffered her injury; it no longer was her employer at all.

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[3] With regard to Brown's status as a shareholder of Jantec, ORS 60.151 provides that a shareholder is not liable for the acts or debts of the corporation merely by reason of being a shareholder. Plaintiff does not allege, and the record does not demonstrate, any reason not to respect the corporate form of Jantec.

This court has not previously considered whether the immunity from tort liability conferred by ORS 656.018(1)(a) and confirmed by ORS 656.018(2) is available to a former employer of an injured plaintiff for alleged negligence that occurred during, and in the course and scope of, the former complying employment.[4]

In answering that question, we begin with the text and context of the statute. *See State ex rel Juv. Dept. v. Ashley*, 312 Or 169, 174, 818 P2d 1270 (1991) (describing methodology). Plaintiff's alleged damages, and Brown's asserted liability therefor, arose out of a compensable injury, which is a predicate for the application of ORS 656.018. However, the text of ORS 656.018 does not state expressly **<317 Or 439/440)** whether the statutory exemption applies to a former complying employer of an injured plaintiff with respect to alleged negligence that occurred during, and in the course and scope of, the former complying employment.

The context provides some, albeit limited, assistance. ORS 656.005(18) defines a "noncomplying employer" as "a subject employer who has failed to comply with ORS 656.017." ORS 656.020 provides that an injured worker may bring an action for damages "against any employer who has failed to comply with ORS 656.017." By implication, an injured worker may *not* bring an action for damages against any employer who *has* complied with ORS 656.017 unless a statutory exception, such as the exception for certain intentional behavior, ORS 656.018(3)(a), applies. Jantec, and hence Brown, complied with ORS 656.017 at the time of the act or omission described in plaintiff's second specification of negligence.

The text and context of ORS 656.018 are not dispositive of the issue before us. We turn, therefore, to legislative history. *See Bartz v. State of Oregon*, 314 Or 353, 357, 839 P2d 217 (1992) ("When the text and context of the statute do not make the legislature's intention clear, we turn to the legislative history to aid us in construing the statute."). We have examined the legislative history of ORS 656.018 and have found nothing that bears on the present question.

We also consider, more generally, the purpose of the exclusive remedy provision of the Workers' Compensation Law. *See Bartz v. State of Oregon, supra*, 314 Or at 358 (in addition to considering the wording and the legislative history of a statute, court considered its purpose). ORS 656.154 provides in part that, " [i]f the injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker * * * may elect to seek a remedy against such third person."[5] Construing an earlier version of that section in a somewhat different context, this court noted:

> "All common-law and statutory remedies for tortious injuries by third parties are open to an injured covered workman unless barred by the provisions of ORS 656.154, **<317 Or App 440/441>** and, if barred, the [workers' compensation] act itself provides the sole remedy.
>
> "* * * * *
>
> " * * * [U]nder the act the injured workman may not sue his own employer, regardless of when the negligence occurs that leads to the injury * * *

Mason v. Sutherlin Machine Works, 240 Or 51, 54-55, 399 P2d 1016 (1965) (citations omitted).[6]

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[4] *See* ORS 656.005(7)(a), which defines a "compensable injury" as "an accidental injury * * * arising out of and in the course of employment."

[5] Plaintiff does not allege that Brown was an employee of Jantec, and Brown does not assert that he was in the same employ as plaintiff.

[6] In *Mason v. Sutherlin Machine Works, supra*, the plaintiff sued for wrongful death when the plaintiff's decedent was fatally injured on the job by a logging spar. The defendant had manufactured the spar on its premises at the request of the decedent's employer. The plaintiff's theory was that the defendant had designed and manufactured the spar negligently. This court held that the defendant and the employer were engaged in a common enterprise so that, under the then-existing version of the statute, they were regarded as a single employer. As a complying employer, the defendant was not subject to liability for the alleged negligence. The joint-supervision portion of ORS 656.154 has been deleted by legislative amendment. Or Laws 1975, ch 152, 1.

That is, a current complying employer may not be held liable in negligence for a workplace injury, even if the negligence occurred before the relevant employment relationship began. Brown asks this court to apply a corollary principle: that a prior complying employer whose alleged negligence is at issue should not be liable in negligence if the alleged negligence occurred during, and in the course and scope of, the former complying employment, even if the workplace injury occurs after the employment relationship with that employer ends.

The overall bargain that the legislature struck in fashioning the workers' compensation system supports Brown's position.

> "Workers' compensation laws provide a form of strict liability requiring employers, regardless of fault, to compensate employes for injuries arising out of and in the course of employment. In exchange for that relief under this no-fault recovery system, employes are limited to a fixed schedule of recovery and must abandon any common law right of action against their employers."

McGarrah v. SAIF, 296 Or 145, 160-61, 675 P2d 159 (1983) (footnote omitted).

> **317 Or 442>** "When the parties are covered by the act, the rights of a covered [employee] are based upon the contract between the employee, the employer and the state. And the rights and remedies provided by the act are exclusive."

Shoemaker v. Johnson, 241 Or 511, 519, 407 P2d 257 (1965) (citations omitted). An employer who complied fully with its statutory obligations to its employees has fulfilled its part of the bargain entirely. Under ordinary contract principles, a party who has fulfilled its part of the bargain entirely is entitled to performance by the other parties to the contract. The legislative *quid pro quo* should, therefore, apply with respect to a later-occurring workplace injury if the alleged negligence occurred during, and in the course and scope of, the former complying employment and if, for that reason, the workers' compensation remedy would have been exclusive had the same injury occurred during the complying employment.

The opposite rule would have anomalous results. Two employees who are otherwise situated identically could recover different amounts depending solely on whether the employer of one of them had changed ownership. Another anomaly is that a complying employer whose employee suffered *no workplace injury at all* during the entire course of employment would be liable for damages, while a complying employer whose employee suffers a substantial workplace injury during the course of employment would not be liable for damages. Finally, an employer who has sold its business and ceased employing workers would be faced with uncertain future liability for workplace injuries that have not yet occurred, but would be powerless to agree with the buyer of the business to be held harmless. *See* ORS 656.018(1)(a), (c) (agreements for contribution or indemnity, asserted by third persons from whom damages are sought on account of workplace injuries, are void).

We recognize that at least two other jurisdictions have reached a different result. *See Duvon v. Rockwell Intern.*, 116 Wash 2d 749, 807 P2d 876 (1991) (rejecting a former employer's argument that, because it had complied with the requirements of that state's "industrial insurance" scheme while it was the plaintiff's employer, it was entitled to immunity from the plaintiff's tort claim for an injury that **<317 Or 442/443>** occurred after the plaintiff became employed by a successor employer); *Konken v. Oakland Farmers Elevator Co.*, 425 NW2d 302, 304-06 (Minn App 1988) (holding that the plaintiff could sue his former employer for negligence, because he would have been injured even if he had not been employed by that employer and because the former employer no longer was subject to the burdens of the workers' compensation law on the plaintiff's behalf at the time of the workplace injury).[7] Those cases contain little reasoning, however, and we are not persuaded by them.

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[7] *See also* 2A A. Larson, The Law of Workmen's Compensation 12-17, 65.13 (1993):

> "The controlling fact in establishing exclusiveness [of the workers' compensation remedyl is the relationship of the parties at the time of occurrence of the injury. Their relationship at other times, such as the time of the employer's misconduct or the time of bringing the suit, is immaterial."

We conclude that ORS 656.018 protects a complying former employer of an injured plaintiff from common-law liability with respect to alleged negligence that occurred during, and in the course and scope of, the former complying employment. Plaintiff's second specification of negligence in this case falls within that category.

Plaintiff's third specification of negligence is the only one that refers to a time after Brown ceased to be associated with Jantec. That specification is very limited. It alleges that Brown was negligent in "transferring [to B & H] the assets of Jantec Corporation," including the cheese grinder, knowing of the grinder's dangerous condition, and in failing to warn B & H of that condition.[8]

We conclude that Brown is not personally liable under plaintiff's third specification of negligence, because the factual predicate for the allegation is missing. The undisputed evidence is contrary to plaintiff's assertion. Brown never owned the cheese grinder and did not effect its transfer. Brown *did not transfer assets;* he *sold his shares* of Jantec to <317 Or 443/444> B & H. After B & H had acquired ownership of Jantec through that transaction, *Jantec,* not Brown, transferred Jantec's *assets* (including the grinder) to B & H. *See* ORS 60.531(1)(c) (a corporation may "[t]ransfer any or all of its property to a corporation all the shares of which are owned by the corporation").

We conclude that the trial court did not err in granting Brown's motion for summary judgment.

The decision of the Court of Appeals is reversed and the judgment of the circuit court is affirmed as to Edgar C. Brown. The case is remanded to the circuit court for further proceedings.

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[8] Brown does not assert that he is protected from liability for the third specification of negligence by ORS 656.018. *See Hull v. Aurora Corp. of Illinois,* 89 AD2d 681, 454 NYS2d 39 (App Div 1982) (former employer could be sued in negligence for workplace injury occurring after sale of plant and machinery to successor; injured worker alleged that former employer succeeded to liabilities of manufacturer of defective machine, so its status as former employer was a "fortuity").

Cite as 317 Or 526 (1993) September 2, 1993

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Richard A. Colclasure, Claimant.

Richard A. **COLCLASURE**, *Petitioner on Review,*
v.
WASHINGTON COUNTY SCHOOL DISTRICT NO. 48-J, *Respondent on Review.*
(WCB 88-15666; CA A67543 (Control))

In the Matter of the Compensation of Richard Colclasure, Claimant.

Richard **COLCLASURE**, *Petitioner on Review,*
v.
BEAVERTON SCHOOL DISTRICT NO. 48-J, *Respondent on Review.*
(WCB 89-05949; CA A67666; SC S39928)

In Banc
On review from the Court of Appeals.*
Argued and submitted May 4, 1993.
Merrill Schneider, of Schneider, DeNorch & Galaviz-Stoller, Portland, argued the cause for petitioner on review. Daniel J. DeNorch filed the petition.
Patric J. Doherty, of VavRosky, MacColl, Olson, Doherty & Miller, P.C., Portland, argued the cause for respondents on review. With him on the response was Karli L. Olson.
Kevin Keaney, of Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, filed an *amici curiae* brief on behalf of the Oregon Workers' Compensation Attorneys and Oregon Trial Lawyers Association.
* Judicial review from the Workers' Compensation Board. 117 Or App 128, 843 P2d 953 (1992).
FADELEY, J.
The decision of the Court of Appeals is reversed. The orders of the Workers' Compensation Board are vacated, and the case is remanded to the Workers' Compensation Board for further proceedings.

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317 Or 529> In this workers' compensation case, the dispositive issue is the proper scope for a hearing referee's review of an order of the director of the Department of Insurance and Finance under ORS 656.283(2).[1]

Claimant suffered a work-related back injury in 1982. The claim was closed in 1984 with an award of unscheduled permanent disability. Claimant returned to his usual work with the employer. After experiencing intermittent back problems at work and consulting both his treating physician and a psychiatrist, claimant filed a claim for aggravation of his back injury on February 9, 1987. One month later, claimant asserted a new issue, that he suffered from a psychological stress condition arising from his original 1982 back injury. The employer initially reopened the claim, but then issued a denial on May 26, 1987, denying both the injury aggravation claim and any responsibility for the psychological stress condition. Claimant and his employer's insurance carrier entered into a stipulation and disputed claim settlement with the employer in 1987. The parties agreed that:

> (1) under the heading of "Aggravation of Low Back, " claimant should be paid an additional percentage for unscheduled disability for "additional loss of earning capacity," doubling the amount of that disability provided by the 1984 order, and
>
> (2) claimant would be referred for "whatever vocational assistance to which he is administratively entitled."

The parties additionally agreed, under the heading of "Psychological Stress Claim," that claimant's psychological condition was not a compensable consequence of his undisputedly disabling 1982 injury at work.

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[1] The text of ORS 656.283(2) is quoted and discussed below.

Lastly, the parties stipulated that claimant would resign his position as a custodian with the employer and expressly agreed that the employer had no suitable work available for claimant. The stipulation explained the reason why the resignation was in order by acknowledging that **<317 Or 530/531>** claimant's "low back condition in conjunction with his psychological stress condition has rendered him *physically* incapable of performing any type of employment at" the employer's work place. (Emphasis added.)

When claimant later applied for vocational assistance, it was denied on the basis of "ineligibility" by the vocational assistance provider engaged by the employer. Denial was stated to be on the ground that claimant left work for reasons unrelated to his compensable injury. The denial of eligibility was based on a contact between Columbia Rehabilitation Consultants, the rehabilitation provider hired by claimant's employer, and a member of the director's staff assigned to the Rehabilitation Review section of the Department of Insurance and Finance. The service provider reported on January 21, 1988, in a letter to claimant and the employer's agent:

> "I staffed your file with the Rehab Review Section. They informed me that the Stipulation signed on 12/15/87 is not sufficient to provide vocational assistance as there was no accepted aggravation reopening your claim."

That legal conclusion--that there was no cognizable aggravation--arrived at between the private rehabilitation consultants and the state agency, became the dispositive determination in the later stages of administrative consideration of claimant's eligibility for vocational rehabilitation assistance. There is no other record of the discussion between the two or of what facts, if any, were considered by them in arriving at that dispositive conclusion.

Following denial of vocational assistance on grounds of ineligibility based on the "no aggravation" conclusion, claimant sought review by the director under ORS 656.283(2). After negotiations, the department issued a "Letter of Agreement" based on contacts with representatives of both parties, stating in part as follows:

> "ISSUES
>
> "Whether [claimant] is eligible for vocational assistance.
>
> "Whether the Stipulation/Disputed Claims Settlement and Order of Dismissal, dated December 15, 1987, intended to **<317 Or 530/531>** acknowledge that [claimant] sustained an accepted aggravation to his low back on February 9,1987.
>
> "AGREEMENTS
>
> "Both the insurer's attorney and worker's attorney agree that the above stipulation intended that a dry aggravation was to be accepted, and vocational eligibility would be determined.
>
> "[Claimant] will be referred to Columbia Rehabilitation for *eligibility determination only.* If it is determined that [claimant] is eligible for vocational services, a mutually agreed upon vocational rehabilitation organization will be decided upon.
>
> "If any party disagrees with any of the statements in this agreement, please contact me by March 16 to advise of corrections." (Emphasis added.)

That letter served as the department's initial ruling on the claimant's request for review.

The service provider again denied that claimant was eligible for vocational assistance. Claimant requested review of that eligibility decision by the director pursuant to ORS 656.283(1) and (2). The director again ruled that claimant was ineligible for consideration for vocational assistance, stating that claimant "left this job in February 1987, not because of any physical difficulties in performing his job duties, but because of psychological stress," a noncompensable condition. The director recognized that the parties may have had a different intention than his ruling. He stated: "While the intent of the parties to the December 15, 1987, Stipulation and Order may have been to recognize * * * aggravation of [claimant's] back injury," that did not matter. The director explained:

> "[I]n the absence of a reopening of [claimant's] back injury claim and evidence that he stopped working because of a worsening of his back condition, there is no causal link between the injury and the need for vocational assistance. What the parties intended in this regard, therefore, has no bearing on the issue of vocational assistance."

In arriving at that conclusion, the director developed no evidentiary record and held no evidentiary hearing. Dissatisfied, claimant requested further review before a hearing referee, pursuant to ORS 656.283(1) and (3).

317 Or 532> The referee found that claimant left work for a good reason, one related to the disability from his compensable injury, and, thus, that claimant was eligible for vocational services. The employer then appealed to the Workers' Compensation Board on the ground that, under ORS 656.283(2), the referee could not find facts different from those on which the director could have based his action, whether or not the director's version of the facts was found in the administrative record or was based on evidence in that record at the time of the director's decision. The Board--apparently deciding to apply to its review, by analog.,v, the standard applicable to judicial reviews of agency determinations that are based upon a full record and findings of fact made under procedures that comport with due process -- agreed with the employer. A majority of the Board held that the referee was not permitted to find facts in relation to a review to determine eligibility for vocational assistance.[2] The Court of Appeals affirmed. *Colclasure v. Wash. County School Dist. No. 48-J,* 117 Or App 128, 843 P2d 953 (1992).

The statute authorizing both hearings before referees and reviews of the director's vocational assistance decisions is ORS 656.283, which provides in part:

> "(1) Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim.
>
> "(2) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter. Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time, unless the worker's dissatisfaction is otherwise resolved. The decision of the director may be modified only if it:
>
> "(a) Violates a statute or rule;
>
> "(b) Exceeds the statutory authority of the agency;
>
> "(c) Was made upon unlawful procedure; or
>
> "(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

The legal issue to be resolved in this case is whether a referee has authority, when reviewing a vocational assistance decision of the director under ORS 656.283(2), to find facts independently before exercising his or her power. In answering that question, we follow the usual trail: We first examine the text and context of the pertinent statute, then, if the text and context are ambiguous, look to legislative history and, if those avenues of inquiry do not answer the question, we look to other aids. *Bartz v. State of Oregon,* 314 Or 353, 357-58, 839 P2d 217 (1992).

The first few parts of this effort may be summarized easily. The statute's text does not decide the question. Neither can we find assistance in the context of the statute within the Workers' Compensation Law itself. Neither does an examination of the legislative history of the statute enlighten us; it appears that the legislature did not give conscious consideration to the fact-finding role, if any, that the hearing referee would play. This leaves us looking for guidance in the broader administrative law context in which cases like this one traditionally are resolved.

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[2] The Board also stated: "The parties further agreed that claimant's compensable condition *[i.e.,* his low back injury] had aggravated * * *."

There can be no doubt that the proceeding before the referee is a classic contested case. It is "a proceeding before an agency [i]n which the individual legal rights * * * of specific parties are required by statute * * * to be determined only after an agency hearing at which such specific parties are entitled to appear and be heard." ORS 183.310(2)(a), 2(a)(A).3 The individualized nature of the proceeding is made clear by the context of statutes and administrative rules governing eligibility for vocational assistance for persons suffering from disabling injuries incurred on the job.

317 Or 534> ORS 656.340(1)(a) provides:

> "The insurer or self-insured employer shall cause vocational assistance to be provided to an injured worker who is eligible for assistance in returning to work."

Subsection (6) of the same statute provides:

> "(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment.
>
> "(b) As used in this subsection:
>
> "(A) A 'substantial handicap to employment' exists when the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.
>
> "(B) 'Suitable employment' means:
>
> "(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;
>
> "(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and
>
> "(iii) Employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment."

Subsection (7) then provides:

> "Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training.

In sum, granting or denying vocational assistance is an individual decision that depends on the facts of each individual case.

The director claimed that a "condition" that he had prescribed pursuant to his rule-making authority makes claimant ineligible. OAR 436-120-050 states in part:

317 Or 535> "The eligibility of a worker for vocational assistance ends when * * *

---

3 The contested ease procedures of the Oregon Admmistrative Procedures Act (APA), of which ORS 183.310 is a part, do not apply directly to proceedings under ORS chapter 656. ORS 183.315. However, we use the definition of "contested case" from the APA as a convenient shorthand to describe the concept of an agency proceeding in which individual rights are deeided based on a reeord. As we discuss below, general legal and constitutional principles require that such proceedings be conducted substantially in the manner prescribed for most state agencies by the APA.

> "(3) The worker's suitable employment after the injury or aggravation ended for a reason unrelated to the injury * * *."

It is clear that claimant is eligible for consideration for vocational assistance if he left employment based on the facts found by the referee. It is equally clear that the foregoing rule of the director would end his eligibility if he left for a reason not related to his injuries, *i.e.*, if the director's conclusions are applied.

In this case, a general rule or policy is being applied to a specific individual interest in eligibility. That being true, our cases require a more substantial hearing and decisional process, a process with which the director's procedure did not comply but the referee's hearing did.[4]

Describing attributes of the procedure required, the court in *Fasano v. Washington Co. Comm.*, 264 Or 574, 588, 507 P2d 23 (1973), stated:

> "Parties at the hearing before the county governing body are entitled to an opportunity to be heard, to an opportunity to present and rebut evidence, to a tribunal which is impartial in the matter--i.e., having had no pre-hearing or ex parte contacts concerning the question at issue--and to a record made and *adequate findings executed.*" (Emphasis added.)

This court held in *Fasano*, that " [t]he record now before us is insufficient to ascertain whether there was a justifiable basis for the decision. The only evidence in the record, that of the staff report * * *, is too conclusory and superficial to support the [decision]." *Id.* at 588.[5]

In *Neuberger v. City of Portland*, 288 Or 155, 161, 603 P2d 771 (1980), this court discussed when fuller procedures are required, stating that, "when a particular action **<317 Or 535/536>** by * * * government is directed at a relatively small number of identifiable persons, and when that action also involves the application of existing policy to a specific factual setting, the requirement of quasijudicial procedures has been implied from the governing law."

The treatise authorities agree. *See* 3 Davis, Administrative Law 20, 14.4 (2d ed 1980) ("[t]he generalization is a safe one that * * * a dispute about adjudicative facts should almost always be resolved by trial procedure"). In adjudicative hearings, unlike in legislative policy-making hearings, the agency usually must rely on the factual record from the hearing, and *ex parte* contacts are forbidden. 1 Pike & Fischer, Administrative Law 500-40, at Hear-5 (3d ed 1989). There was no real "hearing" at all before the director, much less a quasijudicial one.

Another deficiency of the director's decision on review, disqualifying it from use as a final determination of fact, is the absence of a *reuiewable record.* Such a record is required. *See e.g., Doherty v. Oregon Water Resources Director*, 308 Or 543, 547,783 P2d 519 (1989) (agency order must adequately explain how agency applied criteria set out in applicable statute by pointing to facts that permit it to make findings and the conclusions it draws from them; findings also must be adequate for meaningful judicial review); *Diack v. City of Portland*, 306 Or 287, 301, 759 P2d 1070 (1988) (Water Resources Commission did not explain adequately how it applied statutory criteria; remand necessary so that Commission may more fully explain and "point[] to the facts that it believes (if it still does) permit it to make the 'ultimate' findings and the conclusions it draws from them"); *Benton County v. Friends of Benton County*, 294 Or 79,88-89,653 P2d 1249 (1982) ("A quasijudicial proceeding, on the other hand, implies that the decision involves application of preexisting criteria or the determination of particular facts or both, and that some persons are entitled to be heard before a decision is reached").

---

[4] Our ruling in this regard follows the procedure actually used in this case. A different result would have been obtained had the director conducted a contested case hearing, made a record, and entered findings of fact thereon.

[5] Similarly, in *de St. Germain v. Employment Division*, 74 Or App 484, 489, 703 P2d 986 (1985), the Court of Appeals stated: "Oregon's appellate courts have long held that an administrative agency decision must clearly and precisely state what it finds to be the facts and why those facts rationally lead to the decision it makes."

The requirement of a record in adjudicative hearings also is emphasized in ORS 183.415(10), which provides that, in contested cases under the Oregon Administrative Procedures Act (APA),

> "[t]he officer presiding at the hearing shall insure that the record developed at the hearing shows a full and fair inquiry <317 Or 536/537> into the facts necessary for consideration of all issues properly before the presiding officer in the case."

While not directly applicable to this proceeding because of the limitation in ORS 183.315, it is apparent that the requirement of a record in the APA is nothing more than a codification of the more general principle found in our case law.[6]

In summary, use of the director's decision in the manner approved by both the Board and the Court of Appeals flies in the face of traditional and well-understood procedures long made applicable to contested cases in Oregon. By contrast, use of the findings of fact and record made by the referee fully comports with all of the same procedures. We are unwilling to assume that the legislature would make such a departure from normal practice in this area, and invite the kind of constitutional litigation that such a departure virtually would ensure, without very clear indications that it intended to do so. As noted, there are no such indications. Accordingly, we construe the provisions of ORS 656.283 at issue here to contemplate the following process: The director informally investigates and issues an order; the referee conducts a hearing at which the parties develop a record; on the basis of that record, the referee finds the facts from which to conclude whether, among other things, the director's decision survives review; the Board reviews under ORS 656.283(2) upon the record developed before the referee. The contrary conclusion of the Board and of the Court of Appeals was error.[7]

The decision of the Court of Appeals is reversed. The orders of the Workers' Compensation Board are vacated, and the case is remanded to the Workers' Compensation Board for further proceedings.

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[6] The generally accepted rule relating to judicial reviewability of administrative actions, in the absence of an express exclusion of such review, also is to that effect under federal law. *See Lincoln v. Virgil*, 508 US ___ 113 S Ct 2024, 124 L Ed 2d 101, 111 (1993) (stating that proposition).

[7] Because of the manner of our decision on the first petition for judicial review, we do not reach the second petition. Claimant filed two petitions for judicial review in the Court of Appeals. The second petition raised issues concerning claimant's entitlement to temporary payments pending a judicial review. Our decision also returns that related and consolidated petition to the Board for further proceedings.

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656.262(4)(b)
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656.295(8)
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656.313(1)
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656.313(1)(a)
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656.340(6)
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656.382(1)
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