

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

VOLUME 45

(Pages 1991-END)

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

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

OCTOBER-DECEMBER 1993

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CITE AS

45 Van Natta ____ (1993)

In the Matter of the Compensation of
PAUL J. LaFRANCE, Claimant
WCB Case Nos. 91-18117 & 91-18116
ORDER ON REVIEW
Davis, Gilstrap, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Mongrain's order that: (1) found that Liberty Northwest Insurance Corporation's denial of responsibility for claimant's low back condition was not unreasonable; and (2) declined to award an assessed fee for prevailing against Liberty's denial. Liberty cross-requests review of that portion of the order that set aside its denial of responsibility for claimant's low back condition and upheld the SAIF Corporation's denial of responsibility for the same condition. On review, the issues are responsibility and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

SAIF asserts that Liberty's brief was not timely and that any argument regarding responsibility should be stricken. In particular, SAIF contends that, since Liberty filed a cross-request for review, its brief was "due within the same original time period as any other appellant."

The party requesting Board review must file its appellant's brief within 21 days after the date of mailing of the transcript of record to the parties. OAR 438-11-020(1). Respondents must file their briefs within 21 days after the mailing of the appellant's brief. *Id.* "Any party who has filed a cross-request for review shall include its cross-appellant's opening brief as a part of its respondent's brief." *Id.*

Under this rule, Liberty, as the party filing a cross-request for review, was required to file its cross-appellant's brief with its respondent's brief. Since the respondent's brief must be filed within 21 days after the mailing of the appellant's brief, contrary to SAIF's argument, Liberty was not required to file its cross-appellant's brief at the same time as the appellant's brief.

Here, claimant's brief was mailed January 6, 1993. Liberty filed its brief on January 26, 1993. Because Liberty filed its brief within 21 days of the mailing of claimant's brief, Liberty's brief was timely filed. *See* OAR 438-11-020(1).

SAIF also contends that Liberty is attempting to contest compensability on review and that, because the sole issue litigated at hearing concerned responsibility, it should not be permitted to now raise compensability. We agree that the issue of compensability was not litigated at hearing but instead was limited to responsibility. (*See* Tr. 1-6 (July 17, 1992)). However, although its cross-request for review stated that the Referee had made erroneous factual and legal findings regarding "compensability/responsibility", its brief addresses only responsibility. Therefore, we find no attempt by Liberty to now contest the issue of compensability.

Responsibility

Liberty originally accepted a low back strain based on a May 1987 work incident. (Ex. 1). In August 1990, while working for SAIF's insured, claimant experienced increased back pain and left leg pain while lifting a wheel barrow carrying hay. Liberty and SAIF denied responsibility. Liberty, on review, challenges the Referee's conclusion that it remains responsible for claimant's condition.

Under ORS 656.308(1), when an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains a "new compensable injury" during the subsequent work exposure. *SAIF v. Drews*, 117 Or App 596, 599 (1993); *Ricardo Vasquez*, 43 Van Natta 1678, 1680 (1991). Therefore, in order to avoid responsibility, Liberty has the burden of establishing that claimant sustained a "new compensable injury" involving the same condition while working for SAIF's insured.

In proving a "new compensable injury", Liberty must show that the August 1990 lifting incident was a material contributing cause of claimant's disability or need for treatment. SAIF v. Drews, *supra*, 117 Or App at 600. Moreover, a review of our cases also demonstrates that Liberty must show that any injury that resulted from the lifting incident is independent from claimant's 1987 compensable injury. In other words, if the August 1990 event merely caused a symptomatic exacerbation of the 1987 injury rather than an actual independent injury, then responsibility does not shift. See William J. Emery, 45 Van Natta 1521 (1993); Leland G. Townsend, 45 Van Natta 1074 (1993); Michael L. Whitney, 45 Van Natta 446 (1993); Joseph W. Manley, 44 Van Natta 2225 (1992); Gerald K. Mael, 44 Van Natta 1481 (1992).

The medical evidence regarding this issue is provided by Dr. Louie, neurologist and claimant's treating physician, Dr. Woolpert, orthopedic surgeon, and Drs. Barth, neurologist, and Fry, orthopedist. Dr. Louie reported that, following the August 1990 lifting incident, claimant sustained a low back strain. (Ex. 51). He explained that claimant's original back injury and resultant surgery caused him to have mechanical back weakness. (Exs. 65, 68-7). Although Dr. Louie found the lifting incident to be a factor for claimant's need for treatment, he stated that, for the most part, claimant's mechanical back weakness caused the low back strain. (Ex. 68-6, 68-7, 68-8, 68-9).

Dr. Woolpert conducted an independent medical examination at SAIF's request. Dr. Woolpert found that claimant had a "symptomatic aggravation of his L3-4 disc abnormality." (Ex. 57-4). He further stated that the "prior lumbar condition is definitely contributing to [claimant's] current need for treatment. I think he did have a symptomatic exacerbation with his leaning over, but I think the major cause and need for treatment is that of his pre-existing condition." (*Id.*)

Drs. Barth and Fry conducted a second independent medical examination at Liberty's request. The panel found that claimant sustained an acute lumbar strain that was superimposed upon a preexisting low back strain and that this condition was the result of the original 1987 injury. (Ex. 66-5). The panel further noted that the "August 1990 incident was a transient exacerbation of a pre-existing condition which produced the need for treatment." (*Id.*)

We find that the medical evidence proves that claimant's need for treatment following the August 1990 lifting incident was attributable to a symptomatic exacerbation of his compensable 1987 injury and subsequent surgery. In other words, the August 1990 lifting incident does not represent an actual independent injury to his low back. Therefore, we conclude that responsibility does not shift to SAIF but remains with Liberty.

Penalties and Attorney Fees

Claimant asserts that he is entitled to a penalty and related attorney fees pursuant to ORS 656.262(10) on the basis that Liberty's denial of responsibility was unreasonable. We first note that the Referee awarded the maximum available penalty after concluding that Liberty's denial was untimely. Therefore, claimant is not entitled to another penalty under ORS 656.262(10), although an attorney fee is available under ORS 656.382(1) if we find that the denial was unreasonable. See Ben Santos, 44 Van Natta 2228, 2231, on recon 44 Van Natta 2385 (1992).

A denial is unreasonable if the carrier lacks a legitimate doubt as to its liability based on all the evidence available to it. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Moreover, continuation of a denial in light of new evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability. *Id.* at 592.

Liberty denied responsibility on April 10, 1992. At that time, all medical evidence except Dr. Louie's deposition transcript was available to it. Because at least some of this evidence showed that the August 1990 lifting incident was a material contributing cause of claimant's need for treatment, and in light of case law stating that such a showing was sufficient to shift responsibility, we find that Liberty had a legitimate doubt regarding its liability. Furthermore, we find that the receipt of Dr. Louie's deposition transcript, inasmuch as it also demonstrated that the lifting event was a contributing factor to claimant's symptoms, did not destroy Liberty's legitimate doubt about liability. Consequently, we conclude that Liberty's denial of responsibility was not unreasonable.

Finally, claimant objects to the Referee's conclusion that his counsel was not entitled to an attorney fee pursuant to ORS 656.386(1) for his efforts in overturning Liberty's denial of responsibility. As we found above, neither Liberty nor SAIF contested compensability and only the issue of responsibility was litigated at hearing. Therefore, claimant is not entitled to an assessed attorney fee under ORS 656.386(1). See Multnomah County School District v. Tigner, 113 Or App 405 (1992).

Finally, finding no proof that claimant's compensation was at risk of reduction on review, we find that claimant's counsel is not entitled to an assessed attorney fee under ORS 656.382(2) for his efforts on review concerning Liberty's cross-request for review. See ORS 656.382(2); Shoulders v. SAIF, 300 Or 606, 609-10 (1986).

ORDER

The Referee's order dated August 26, 1992, as reconsidered October 27, 1992, is affirmed.

October 1, 1993

Cite as 45 Van Natta 1993 (1993)

In the Matter of the Compensation of
MARK A. STORES, Claimant
WCB Case No. 92-13897
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Daughtry's order that set aside its denial of claimant's left shoulder injury claim. On review, the issue is compensability.

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

On review, SAIF argues that claimant was "outside the bounds of his employment" when he was injured. As a general rule, an employee who performs an act outside of his regular duties which is undertaken in good faith to advance the employer's interests is within the course of employment. Not every act, however, which benefits the employer is in the course of employment and, therefore, compensable; for instance, although advancing the employer's interests, the act may be outside the reasonable bounds of employment or expressly prohibited by the employer. Dave G. Owens, 43 Van Natta 2680 (1991), citing 1A Larson, Workmen's Compensation Law 27.13-27.14 (1979).

Claimant works as an evergreens caser. On the morning of the injury, claimant worked for several hours assisting an independent refrigeration contractor with the repair of the employer's cooler. Claimant was later injured while descending a ladder after accompanying a roofer friend onto the employer's leaky roof. We find, as did the Referee, that repairing the roof was for the benefit of the employer. Moreover, we find that claimant did not exceed the reasonable bounds of his employment. Owens, supra. Another roofing contractor had failed to keep an appointment to inspect the roof. The employer told claimant to have his roofer friend come by (although, unknown to claimant, it was to tell him not to do the work). Claimant was at work on a scheduled work day and was paid for the time he was on the roof. Finally, claimant regularly performed or helped perform maintenance on the employer's premises.

Although climbing onto the roof was a departure from his usual duties as an evergreens caser, on these facts, we agree that claimant's injury arose "out of and in the course of employment." ORS 656.005(7)(a). See Progressive Casualty Ins. Co., v. Marca, 100 Or App 726, 730 (1990); Owens, supra.

Claimant's attorney is entitled to an assessed fee for defending against SAIF's appeal. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$800. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated February 12, 1993 is affirmed. For services on review, claimant's counsel is awarded an \$800 assessed fee, payable by the SAIF Corporation.

October 4, 1993

Cite as 45 Van Natta 1994 (1993)

In the Matter of the Compensation of
GERALD M. LOKAN, Claimant
WCB Case Nos. 92-01916, 92-07653 & 92-04462
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation, on behalf of Elmer Thompson Logging, requests review of Referee Daughtry's order that set aside its denial of claimant's current neck condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, a logger, was injured three times while working for three different employers. Each claim is in own motion status.

Claimant's first injury occurred on August 30, 1973, when he was employed by Elmer Thompson Logging. A 7/8 inch thick choker cable came loose and hit claimant on the left side of the head, lacerating his jaw and tearing off his earlobe. X-rays of claimant's cervical spine revealed that all vertebral bodies, disc spaces and intervertebral foramina were normal. (Exs. 5, 6 and 9). Dr. Hockey released claimant to work on October 22, 1973. (Ex. 10). The claim was closed by Determination Order on November 6, 1973 with no permanent disability. (Ex. 11).

On December 10, 1973, claimant returned to Dr. Hockey complaining of numbness in the right thumb and index finger, neck pain, and paresthesia in the arms and down the back into the legs when he put his neck in certain positions. Dr. Hockey found no evidence of a cervical disc problem and opined that claimant remained neurologically intact. He recommended physical therapy. (Ex. 14).

On March 27, 1974, Dr. Young, orthopedic surgeon, evaluated claimant's reports of pain in the right trapezius area, radiating to the elbow, and occasional numbness in the right forearm and hand. The pain worsened when claimant did heavy work, although the numbness had been improving. Examination revealed mild hypesthesia at the base of the neck over the T8 dermatome. Dr. Young diagnosed residuals of a cervical strain with radicular symptoms in the right shoulder and upper arm. He recommended conservative treatment, which was not successful. (Exs. 17 and 20).

Claimant was referred to the Disability Prevention Division for work evaluation. Dr. Van Osdel reported that the numbness in the right arm had cleared up completely and the neck and shoulder soreness had decreased "95 percent." (Ex. 21). Claimant did not complete the work evaluation. His claim was again closed with no permanent disability on August 29, 1974. (Ex. 24).

On February 1, 1982, claimant experienced upper GI bleeding. He had been diagnosed with a peptic ulcer and note was made of his excessive use of aspirin for neck and headache pain. (Exs. 25, 26 and 27).

The second injury took place on July 26, 1982, while claimant was working for Bud Hammitt Logging. A skyline slacked down and claimant was hit on the head by a tree. (Ex. 28). He experienced pain and stiffness in his neck. (Ex. 30). X-rays revealed no significant structural abnormality, degenerative change, fracture or acute bony lesion in the cervical spine. (Ex. 29). Dr. Daskalos diagnosed a cervical strain. (Ex. 30).

Dr. Young again evaluated claimant's condition. Claimant had full range of motion in the cervical spine, the shoulders, and no sensory abnormality. Young concluded that he was unable to find any significant objective abnormalities. (Ex. 31). Claimant was also examined by Dr. Hockey, who reported no radicular symptoms. He found tenderness at the base of the skull where the cervical muscles are attached. He diagnosed a cervical strain and recommended conservative treatment. (Exs. 32, 32A and 32B). This claim was closed by a November 24, 1982 Determination Order that awarded temporary disability and no permanent disability. (Ex. 32C).

On February 25, 1983, claimant returned to Dr. Hockey complaining of constant pain in the neck. Hockey found claimant neurologically intact and recommended pain clinic treatment. (Ex. 32D).

Dr. Holmes, medical director of the pain clinic, reported that claimant ached over both shoulders and at the base of the skull, had headaches and intermittent bilateral hand numbness. He found muscular trigger points and tension and nonspecific hand numbness. Holmes recommended biofeedback for the pain and an examination to rule out thoracic outlet syndrome. (Ex. 33). Dr. Patterson, who saw claimant for the bilateral hand symptoms, found borderline distal sensory latency in the right median nerve, not enough to be diagnostic of carpal tunnel syndrome, and mild slowing in the left ulnar nerve, diagnosed as a mild ulnar neuropathy. (Ex. 36).

On June 7, 1983, claimant sought treatment for a flare-up of bilateral neck pain after heavy jostling in a dunebuggy. Dr. Holmes diagnosed myofascial pain syndrome in the trapezius musculature with chronic neck pain. (Ex. 38).

A month later, after claimant had been working long hours as a rigging slinger, he sought treatment from Dr. Holmes for worsened neck and shoulder pain. Holmes found full range of motion, myofascial triggers, and no evidence of thoracic outlet syndrome or neurological deficit. Holmes recommended that claimant continue to work, using various techniques of breaking the tension cycle in his neck and shoulders. (Ex. 38). On June 21, 1983, Dr. Holmes ceased treating claimant and referred him to Dr. Woolpert for orthopedic evaluation. (Ex. 40). Woolpert found no indications of outlet syndrome or cervical disc pathology to warrant studies. He agreed with the plan to have claimant continue to work and continue exercises. (Ex. 41). On August 4, 1983, claimant was referred to Dr. Redfield, who took claimant off work and recommended chiropractic and acupuncture. (Ex. 42).

The third injury occurred on January 19, 1984. Claimant was then working for Robert Fuggate Logging as a rigging slinger. A pole was picked up by the haul back and dropped on claimant's back and shoulders. (Exs. 44B and 44C). Claimant was off work for a week. He was released to regular work with the proviso that he would occasionally have upper and lower back pain, causing him to miss work. (Ex. 44F). This claim was closed by an October 16, 1984 Determination Order that awarded temporary disability and no permanent disability. (Ex. 44G).

Claimant did not seek medical treatment for his neck until August 26, 1991, when he sought treatment from Dr. Daven, M.D., who reported that claimant had continued to have moderate pain since the 1973 accident which had worsened significantly over the past six months. The severe pain was localized primarily in the sub-occipital regions bilaterally, radiating down to the shoulders and upper arms, worse on the left than the right. Claimant also complained of bilateral tingling in the tips of the fingers, worse on the left. Cervical spine x-ray films revealed degenerative changes at C3-4, and C4-5 and C5 radiculopathy. (Ex. 48). Dr. Daven referred claimant to Dr. Freeman, neurosurgeon, who diagnosed recess stenosis and foraminal encroachment bilaterally, right greater than left at C4-5, C3-4 and C5-6. (Ex. 54). Freeman performed laminectomies at C4, C5 and C6, and a partial laminectomy at C3. He also performed foraminotomies left at C3-4, C4-5 and C5-6.

On December 31, 1991, SAIF, on behalf of Elmer Thompson Logging Co., issued a partial denial of the compensability of claimant's current condition, alleging that the accepted mastoid contusion and laceration of the 1973 left ear injury is not the major contributing cause of claimant's condition. On January 3, 1992, SAIF issued a responsibility disclaimer. (Exs. 58 and 59).

On February 18, 1992, SAIF, on behalf of Bud Hammitt Logging, issued a partial denial of the compensability of claimant's current condition, alleging that the July 26, 1982 accepted cervical strain injury is not the major contributing cause of the current condition. (Ex. 60B).

On May 8, 1992, SAIF, on behalf of Robert Fuggate Logging, issued a partial denial of the compensability of claimant's current condition as unrelated to the accepted January 19, 1984 thoracic contusion. (Ex. 63A).

FINDINGS OF ULTIMATE FACT

Claimant's compensable 1973 head injury is not the major contributing cause of his current cervical degenerative condition.

CONCLUSIONS OF LAW AND OPINION

Although claimant joined all three claims, the sole issue as agreed to by the parties at hearing was the compensability of claimant's current cervical condition. (Tr. 1).

The Referee concluded that claimant's current degenerative neck condition was caused by the August 1973 compensable injury in both a major and material way, specifically that claimant's degenerative changes were a consequence of claimant's industrial injuries beginning in 1973 and were typically slow and progressive. SAIF contends that claimant's current condition is not related to any of his previous injuries pursuant to ORS 656.005(7)(a)(A).

There is no evidence that claimant had a preexisting condition pursuant to ORS 656.005(7)(a)(B). ORS 656.005(7)(a)(A) provides: "No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." If the condition is caused not by the accident, but by the compensable injury, claimant must prove that the injury is the major contributing cause of his current condition. Albany General Hospital v. Gasperino, 111 Or App 411 (1992).

The medical evidence indicates that, to the extent that claimant's degenerative neck condition is injury-related, it is an indirect, rather than a direct, consequence of the compensable work injury. Accordingly, ORS 656.005(7)(a)(A) applies to this case. Therefore, claimant must prove that his August 1973 compensable head injury is the major contributing cause of his current degenerative condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, supra.

The issue of whether claimant's compensable injury is the major contributing cause of his degenerative neck condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant's treating neurosurgeon, Dr. Freeman, stated that the cause of claimant's cervical degenerative disc disease was the 1973, 1982 and 1984 injuries, which produced the same symptoms and distribution of pain and discomfort. (Ex. 60). He explained that claimant had been consistent with his complaints of neck, left shoulder and arm pain, and opined that the severe traumas to the cervical axis plus claimant's heavy labor in the interim periods was the major contributing cause of the current degenerative process. (Ex. 62).

In contrast, Dr. Jansen, SAIF's occupational disease consultant who performed a file review, noted that the 1973 and 1982 injuries resulted in neck and shoulder problems caused by musculoligamentous structures and no damage to the cervical spine. She noted that the current findings indicate that the spine and neural foramina are the source of claimant's symptoms. She opined that a number of factors could cause osteoarthritic changes in the cervical spine, such as aging, impact trauma, or heredity. She opined that, because there was no indication of spine damage after the two injuries, that the injuries are not the major contributing cause of claimant's current condition. (Ex. 57).

The third expert to offer an opinion is Dr. Woolpert, orthopedic surgeon, who had evaluated claimant in 1983 after the second injury. Woolpert performed a record review. He noted that there was no indication in the records prior to the 1991 evaluation that claimant had nerve root problems or cervical spine pathology. He explained that claimant's current problem is caused by disc degeneration at two different levels with subsequent hypertrophy and stenosis. He also explained that degenerative disease can occur with or without trauma. Because there was no evidence of multiple level disc damage

after the injuries, he did not think the injuries caused claimant's current condition. In addition, he opined that if there had been a severe disc problem that resulted from either injury, that it would not have taken as long as it had for degenerative changes to occur. (Ex. 61). He also opined that the thoracic injury of 1984 was not a significant traumatic event, and, because of the thoracic location, would not have been likely to cause cervical disc difficulty. He concluded that, in all probability, claimant has progressive degenerative disc disease without any of the accepted injuries being the major contributing cause. (Ex. 63).

We are more persuaded by the complete and well-reasoned opinion of Dr. Woolpert than that of Dr. Freeman. Dr. Freeman based his opinion of the cause of claimant's current condition solely on claimant's history of symptoms. He relied on the consistency of claimant's complaints of pain and the history of re-injury, rather than the medical records. He stated: "[I]nitial injury occurred in 1973 as per [claimant's] description and subsequent injuries continuing the damage, worsening the same most likely over a period of time." He also stated that "cervical degenerative disc disease in consequence to injuries over a period of time as related by [claimant] do not present themselves on regular x-rays and initially not as apparent on CT scans."

Dr. Freeman's generalized conclusion did not address the specific and significant medical issue raised by Drs. Woolpert and Jansen: That claimant's initial injuries were musculoligamentous and there was no objective evidence of spinal trauma that would lead to disc problems. Nor did Freeman explain the long hiatus between the 1973-1984 injuries, the development of disc disease and the eventual development of the current degenerative condition in 1991, an issue also raised by Dr. Woolpert.

Furthermore, Dr. Freeman indicated that each injury and claimant's heavy work were all part of the major cause of claimant's condition. Whether claimant experienced an occupational disease was not raised at hearing, so we decline to consider it on review. The specific issue is whether the 1973 injury is the major contributing cause of claimant's current degenerative condition. Dr. Freeman did not state that the 1973 injury was the major cause. We therefore conclude that claimant has failed to establish that his compensable 1973 head injury is the major contributing cause of his current cervical degenerative condition. Accordingly, claimant has not established the compensability of his degenerative cervical condition as a consequence of his compensable 1973 head injury. Albany General Hospital v. Gasperino, supra.

ORDER

The Referee's order dated November 30, 1992 is reversed. The SAIF Corporation's denial in WCB Case No. 92-01916, Claim No. 3462708 is reinstated and upheld. The attorney fee is reversed. The remainder of the order is affirmed.

October 5, 1993

Cite as 45 Van Natta 1997 (1993)

In the Matter of the Compensation of
ANTHONY FOSTER, Claimant
WCB Case No. 92-06071
ORDER ON RECONSIDERATION
Coons, Cole & Cary, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

On September 23, 1993, we withdrew our August 26, 1993 order that: (1) set aside the SAIF Corporation's denial of claimant's occupational disease claim for bilateral upper extremity conditions; and (2) awarded a \$10,000 carrier-paid attorney fee under ORS 656.386(1). We took this action to consider SAIF's motion for reconsideration regarding our attorney fee award. Having received claimant's reply and after completing our further consideration of this matter, we issue the following order.

To begin, SAIF did not submit a timely response to claimant's counsel's request for an attorney fee award. Thus, insofar as SAIF's motion for reconsideration pertains to specific objections to representations offered in claimant's counsel's attorney fee request, those objections shall not be

considered. See OAR 438-15-029(4). Nevertheless, since SAIF has timely requested reconsideration of our order and contended that the attorney fee award included in that decision is excessive, we have proceeded with a reexamination of our attorney fee award. In doing so, we emphasize that SAIF's untimely contentions regarding particular portions of claimant's counsel's request have not been considered.

As noted in our prior decision, in determining a reasonable attorney fee under ORS 656.386(1), we consider the factors recited in OAR 438-15-010(4). Those factors are as follows: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (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.

Our review of the record reveals the following information. The file consists of some 34 exhibits. Claimant's counsel generated one "check-the-box" response from claimant's attending physician. (Ex. 27-1). In addition, counsel participated in two depositions (one with claimant's supervisor and the other with claimant's attending physician). (Exs. 28 & 29). The former deposition consisted of 24 pages, while the latter included 40 pages. Both of these depositions were conducted after the hearing. The transcript of the hearing involved two witnesses and 64 pages.

On Board review, claimant's counsel submitted opening and reply briefs, as well as a citation to supplemental authorities. The appellate briefs provided a thorough argument regarding claimant's contention that his occupational disease claim was compensable. (Opening brief - 9 pages; Reply brief - 5). In doing so, claimant's counsel analyzed the medical opinions and an issue regarding claimant's reliability as a historian. In addition, claimant's counsel sought penalties for an unreasonable denial and unreasonable claim processing.

Including a list totalling 71.1 hours of attorney time and 2.4 hours of paralegal time, claimant's counsel sought an attorney fee of \$10,857. Counsel's statement further noted that he had been practicing law for 2 years, 100 percent of which was devoted to workers' compensation. The statement listed the following factors as important in determining a reasonable attorney fee: "complexity of issues; claimant's attorney fully litigated hearing, participated in two depositions and lengthy closing arguments, and drafted two Board review briefs; benefits secured for worker; danger of claimants' attorneys going uncompensated."¹

We draw the following conclusions from the foregoing findings. The value of this compensability issue is substantial in that claimant has undergone a number of surgeries for his bilateral upper extremity conditions. Likewise, the benefit secured for claimant is significant in that he will be receiving compensation for these conditions and treatments. Counsel persuasively advocated claimant's claim at hearing and on review, investing a great deal of time in that pursuit. However, these efforts were not entirely successful in that we affirmed those portions of the Referee's order which declined to assess penalties for an allegedly unreasonable denial and allegedly unreasonable claim processing.

The issues in dispute involved factual and medical matters of normal complexity consistent with compensability disputes that are generally presented for Board resolution. The events which transpired at the hearing level (64-page transcript, closing arguments, and two depositions) and on review are consistent with those which normally arise when the Board confronts a compensability dispute regarding a medical issue. Finally, there was a risk that counsel's efforts might have gone uncompensated.

After conducting our reconsideration of this matter, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$5,500. In reaching this conclusion, we have particularly considered the factors recited in claimant's counsel's statement of services. In doing so, we acknowledge the skill demonstrated by counsel's advocacy in securing this significant benefit for claimant. Nonetheless, we are unable to conclude that this record supports counsel's attorney fee request, particularly for a fee in excess of \$9,000 for services performed at the hearings level. As noted above, our review of the record establishes that the hearing level events were not unlike the majority of compensability disputes.

¹ Counsel's statement of services essentially mirrored the statement presented to the Referee. That statement sought \$9,417 for 61.5 hours of attorney time and 2.4 hours of paralegal time. Thus, for purposes of Board review, counsel is seeking \$1,440 for 9.6 hours of attorney time.

Accordingly, we republish our August 26, 1993 order with the following modification. In lieu of our prior attorney fee award, claimant's attorney is awarded \$5,500, to be paid by SAIF. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 5, 1993

Cite as 45 Van Natta 1999 (1993)

In the Matter of the Compensation of
TERRY E. GARRETT, Claimant
WCB Case Nos. 92-11779, 92-08695 & 92-08868
ORDER ON REVIEW
Dobbins, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Williams, et al., Defense Attorneys
Jamie Goldberg (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Liberty Northwest Insurance Corporation, on behalf of Sheldon Manufacturing (Sheldon), requests review of that portion of Referee Hoguet's order which: (1) set aside its denial of claimant's occupational disease claim for bilateral tendonitis, as it relates to a right arm condition; (2) upheld Liberty/Soloflex's denial of claimant's occupational disease claim for the same condition; and (3) upheld the SAIF Corporation's denial, on behalf of Seattle/Beaverton Packaging Corporation (SAIF/Beaverton), of claimant's aggravation claim for the same condition. In its brief, Sheldon contends that Beaverton previously accepted claimant's right arm condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

SAIF (Beaverton) did not accept claimant's right arm condition, which has been diagnosed as right wrist tendonitis. (Ex. 42).

Claimant did not seek treatment for his right arm condition prior to working for Sheldon.

CONCLUSIONS OF LAW AND OPINION

Claim Acceptance

The Referee concluded that there had been no prior accepted right upper extremity condition. We agree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9).

Here, claimant worked for Soloflex from May 1983 until January 17, 1990. He worked for SAIF/Beaverton from January 21, 1990 through August 1990, and for Sheldon from September 1990 until taken off work in March 1992.

Soloflex accepted a claim for left carpal tunnel syndrome, which was closed in February 1988. On September 21, 1990, SAIF/Beaverton accepted claimant's claim for "Bicepetial [sic] Tendonitis Left Epicondylitis." (Ex. 31). The SAIF/Beaverton claim was closed in December 1990. Claimant did not seek treatment for right arm symptoms until February 21, 1992, when he sought treatment with Dr. Hardin. Dr. Hardin initially diagnosed tendonitis of the right wrist.

In August and September 1990, claimant had been treating with Dr. Boyd for the left arm condition which SAIF/Beaverton accepted in September 1990. Sheldon argues that SAIF/Beaverton accepted claimant's right arm condition as well as the left arm condition because, at the time SAIF issued its September 21, 1990 acceptance, claimant was suffering from right upper extremity conditions. We do not agree that SAIF accepted a right arm claim.

On August 30, 1990, Dr. Boyd examined claimant for his left arm condition. (Ex. 25). Dr. Boyd's report of that examination states, parenthetically, that claimant mentioned some aching in his right shoulder due to overuse because of his injured left arm. (Ex. 25-2). Nevertheless, claimant neither sought nor received treatment for his right arm at that time.

On September 17, 1990, claimant returned for a recheck of his left arm condition. (Exs. 29, 30). At that time, Dr. Boyd noted right hand, arm and trapezius complaints, which he attributed to claimant's reaching with his arms while masking walls in preparation for painting. However, Dr. Boyd's examination focused on the left arm and shoulder and his diagnosis was "exacerbation of the overuse tendinitis of the upper extremity. * * * ." Moreover, in subsequent reports from Dr. Boyd, there is no further mention of right arm symptoms, and his diagnoses continue to relate to the left arm. Finally, Dr. Hardin's 1992 diagnosis of claimant's current right arm condition is wrist tendonitis. (See Exs. 42, 48). In light of such circumstances, we are not persuaded that SAIF/Beaverton accepted claimant's right arm condition when it accepted "bicepetial [sic] tendonitis left epicondylitis."

After his July 1990 left arm injury with SAIF/Beaverton, claimant received temporary partial disability from August 6, 1990 through September 26, 1990. Sheldon argues that SAIF had accepted claimant's right arm condition because the time loss resulted, in part, from upper extremity problems. Again, we disagree.

As previously discussed, although claimant received a diagnosis for his right upper extremity condition following the 1990 injury, we are not persuaded that he received treatment for a right arm condition during that period. Moreover, the record does not support a conclusion that claimant was off work due to a right arm condition in 1990. Rather, the record establishes that claimant's disability was due to his left arm condition. Finally, even if SAIF/Beaverton provided temporary disability for the unaccepted right arm condition, merely providing compensation is not considered acceptance of a claim or admission of liability. ORS 656.262(9); Richard J. Messmer, 45 Van Natta 874 (1993).

Responsibility

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which have not been previously accepted. Fred A. Nutter, 44 Van Natta 854 (1992). Under that rule, if a worker proves that an occupational disease was caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

The onset of disability is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Bazar, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition, or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986).

In light of our conclusion concerning SAIF/Beaverton's alleged acceptance, we conclude that the last injurious exposure rule is applicable. See Fred A. Nutter, 44 Van Natta 854 (1992). Here, claimant did not lose time from work as a result of this right upper extremity condition. Thus, the "date of disability" is the time claimant first sought medical treatment for his right arm, and responsibility is initially assigned to the carrier on the risk at that time.

Claimant first sought treatment for his right arm on February 21, 1992, while working for Sheldon. (Ex. 41). At that time, Dr. Hardin indicated that claimant had experienced right arm numbness and pain for two months. (Ex. 41). Accordingly, responsibility is initially assigned to Sheldon.

Sheldon can avoid responsibility by establishing that a prior employment exposure was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while Sheldon was on the risk to have caused his disability. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Claimant's work for Soloflex, Beaverton and Sheldon involved activities which were potential causes of his right arm condition. (Tr. 10-21). Moreover, Dr. Bergquist, claimant's first treating physician and surgeon, attributed claimant's arm symptoms to work activities at all three employers. (Ex. 57).

Accordingly, we conclude that Sheldon has failed to show that it was impossible for claimant's employment exposure at Sheldon to have caused his disability. Furthermore, as discussed above, because the right arm condition for which claimant sought treatment while working for Sheldon was a different condition than his prior upper extremity conditions, Sheldon has failed to prove that employment exposures at previous employers were the sole cause of his right arm condition. Consequently, responsibility for claimant's right arm condition remains with Sheldon.

Because compensability was at issue at hearing, it remained a potential issue on review. Therefore, 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 attorney fee for services on review, payable by Sheldon, the insurer who requested review and is 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 \$1,000 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 issues presented and the value of the interest involved.

ORDER

The Referee's order dated February 19, 1993 is affirmed. For services on Board review, claimant's attorney is awarded \$1,000, to be paid by Liberty Northwest/Sheldon.

October 5, 1993

Cite as 45 Van Natta 2001 (1993)

In the Matter of the Compensation of
MARIE M. LIBBETT, Claimant
WCB Case No. 90-21849
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Referee Herman's order finding that: (1) claimant's requests for hearing from a February 13, 1990 Determination Order and December 7, 1990 Notice of Closure were timely filed; (2) claimant was not medically stationary at the time of the February 13, 1990 Determination Order; and (3) claimant was permanently and totally disabled. On review, the issues are timeliness, premature closure, and permanent total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Timeliness and Premature Closure

The employer asserts that claimant did not timely request a hearing from the February 13, 1990 Determination Order and December 7, 1990 Notice of Closure. The employer also challenges the Referee's conclusion that claimant was not medically stationary when the February 13, 1990 Determination Order issued and, thus, the claim was prematurely closed. We affirm and adopt those portions of the Referee's order concerning these issues.

Permanent Total Disability

The employer further disputes the Referee's conclusion that claimant is permanently and totally disabled based on her medical condition and the "odd lot" doctrine. We agree that claimant failed to prove permanent total disability.

Claimant has an accepted right hip and leg condition. After the claim was initially closed in November 1987, claimant eventually was awarded 65 percent unscheduled permanent disability. Claimant then sustained a compensable aggravation in October 1989. A Notice of Closure, affirmed by an Order on Reconsideration, awarded additional temporary disability but did not increase claimant's permanent disability.

Permanent total disability is the loss 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." ORS 656.206(1)(a). Along with permanent physical incapacity, the worker may prove permanent total disability with the "odd lot" doctrine, under which a combination of medical and non-medical disabilities effectively foreclose the worker from performing gainful and suitable employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

First, we are not convinced that claimant is permanently and totally disabled based on physical incapacity alone. Following claimant's aggravation in October 1989, Dr. Jones, orthopedist and claimant's treating physician, released claimant to vocational training or receptionist work as of December 1, 1989. (Ex. 49-4). On February 15, 1990, however, Dr. Jones noted that claimant's condition was "no better" and released claimant from conducting a job search. (Ex. 56, 59-5).

In an April 17, 1990 chart note, Dr. Jones predicted "considerable difficulty in getting [claimant] back to work" and that she would not even be able to perform a job requiring prolonged sitting. (Ex. 61A). In February 1991, Dr. Jones wrote to claimant's attorney that claimant had "chronic nerve root irritation" and that this condition caused "rather severe symptomatology and functional disability." (Ex. 78-1). Dr. Jones also reported that claimant was "permanently incapable of regular and gainful employment." (Id. at 2).

Dr. Gurney, surgeon, treated claimant's preexisting and unrelated heart condition. He reported that claimant was disabled from her heart condition and had experienced progressive pain in her back. Based on these conditions, Dr. Gurney found that claimant was "permanently disabled from regular and gainful employment." (Ex. 78A).

The opinions of Dr. Jones and Dr. Gurney provide evidence that claimant is permanently and totally disabled. However, because we find that claimant is not credible, we conclude that these opinions are not reliable. Claimant testified at hearing that she could sit only for 15 to 20 minutes, (Tr. 23), could not walk more than a quarter of a mile, (Id.), did not perform any twisting movements, (Id. at 26), did not drive more than a half-mile to the grocery store, (Id. at 46-47), carried no more than a "couple loaves of bread," (Id. at 51), did very little grocery shopping, (Id. at 50), did not bend but squatted, (Id. at 52-53), and spent most of the day laying down, (Id. at 24, 57).

The employer submitted surveillance tapes and an investigator's testimony of claimant's activities during September 12, 13, 16, 23-25, October 21-22, and December 6, 1991. That evidence showed claimant fully bending to pick up a dog from the ground, (Tr. 92), driving to a grocery store nearly every day, (Id. at 98, 99, 105, 106, 110), carrying items such as a bag of groceries and a large lamp, (Id. at 98, 100), bending and twisting to place bags of groceries into her car, (Id. at 98, 106), and driving to the bank, post office, drug store and restaurants, (Id. at 104-05, 109, 110). On some days, claimant drove to several places during the same afternoon. (Id. at 104-05, 110). Furthermore, most locations were more than a half-mile from her home. In no instance did claimant exhibit pain behavior.

Based on this evidence, we find that claimant did not accurately depict her physical limitations at hearing. Neither Dr. Jones nor Dr. Gurney specifically delineated the extent of claimant's physical incapacity. However, claimant testified that she informed Dr. Jones of the same limitations that she described at hearing. (Tr. 51-52). We find that this statement, along with Dr. Jones' statement that claimant had severe functional disability, shows that Dr. Jones likely based his opinion on the same or

similar inaccurate and unreliable information regarding her physical capacity that claimant provided at hearing. There is no evidence that Dr. Gurney based his opinion on anything other than claimant's statements, especially in view of the fact that he did not treat her back condition. Consequently, we conclude that the opinions of Dr. Jones and Dr. Gurney are entitled to little or no weight. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Therefore, we conclude that claimant did not prove that she is permanently and totally disabled based on physical incapacity alone.

Relying on testimony from Byron McNaught, a vocational rehabilitation counselor, claimant also asserts that she is permanently and totally disabled based on the "odd lot" doctrine. Mr. McNaught testified that claimant was not employable because of her need to frequently change position and lay down during the day. (Tr. 69-71). In formulating his opinion, Mr. McNaught relied upon claimant's description of her physical limitations that were similar to her testimony at hearing. (See id. 76-78). Although, after viewing the videotape and listening to the investigator's testimony, Mr. McNaught conceded that claimant's description was not consistent with her actual activities, he testified that his opinion regarding claimant's employability would not change since the videotape did not prove that claimant could sustain a prolonged level of activity. (Id. at 120-21).

Mr. McNaught's testimony shows that, even after viewing the videotape, his opinion continued to be based on claimant's description of her physical capabilities. Thus, because we have found that claimant was not credible, we also find that Mr. McNaught's opinion is not reliable. See Miller v. Granite Construction Co., supra. Therefore, we conclude that claimant also failed to prove that she is permanently and totally disabled based on the "odd lot" doctrine.

Attorney Fees on Review

Inasmuch as the employer has requested Board review and since we have found that the Referee's permanent total disability award should be reversed, claimant is not entitled to an attorney fee award because her compensation has been disallowed. See ORS 656.382(2).

ORDER

The Referee's order dated October 7, 1992 is affirmed in part and reversed in part. That portion of the order finding claimant permanently and totally disabled is reversed. The December 7, 1990 Notice of Closure, as affirmed by the June 11, 1991 Order on Reconsideration, is reinstated and affirmed. The remainder of the order is affirmed.

October 5, 1993

Cite as 45 Van Natta 2003 (1993)

In the Matter of the Compensation of
ROY W. RIGGS, Claimant
WCB Case Nos. 91-05037, 91-01317 & 91-04951
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
E. Jay Perry, Defense Attorney
Paul L. Roess, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Referee McWilliams' order which: (1) set aside its denial, on behalf of Industrial Carbide Tooling (ICT), of claimant's psychological condition; and (2) upheld Sedgwick James' denial, on behalf of International Paper Company (IP), of the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's employment activities at ICT worsened claimant's psychological condition (for which IP had been responsible) and, thus, responsibility for the condition shifted to Liberty. We do not agree.

As used in ORS 656.308, the phrase "new compensable injury" also includes a new occupational disease. See Donald C. Moon, 43 Van Natta 2595 (1991). Accordingly, in the present case, IP (Sedgwick James), as the initially responsible carrier for claimant's psychological condition, remains responsible for claimant's continued or increased disability during his employment with a later carrier, unless claimant sustains a new injury or occupational disease involving the same condition during the subsequent coverage. See Ricardo Vasquez, 43 Van Natta 1678 (1991).

The evidence shows that, after Liberty (ICT) came on the risk, claimant's psychological condition did not result from a discrete incident or period of work activity. Thus, claimant did not sustain a new injury. Valtinson v. SAIF, 56 Or App 184 (1992). Accordingly, claimant must prove that his work activities at ICT after May 22, 1990, the date of the prior hearing,¹ are the major contributing cause of the worsening of his psychological condition. ORS 656.802(1), (2).

Claimant was off work at IP (Sedgwick James) beginning March 1985 for vocational rehabilitation and a subsequent lumbosacral fusion in January 1986 related to his compensable injury with IP. (Ex. 8-2). Claimant then participated in a program at Portland Pain Center. In August 1986, his intake psychological evaluation at the Pain Center indicated, inter alia, adjustment disorder with depressed and anxious mood and psychological factors affecting physical condition. (Ex. 8-3).

In May 1987, claimant began treating with Dr. Henderson, psychiatrist, for a psychological condition related to his low back injury. (Ex. 8, 11). By May 1989, Dr. Henderson opined that claimant was medically stationary, and that his psychiatric impairment was 45 percent. Id. Beginning in approximately April 1988, claimant participated in an on-the-job training program with ICT, and then returned to work full-time for ICT in April 1989.

Claimant continued to have back pain. In April 1990, Dr. Henderson reported that claimant's need for psychiatric treatment was directly associated with his 1982 compensable injury with IP. (Ex. 18). He stated that claimant's employment with ICT had not independently contributed to his need for treatment at that time.

By October 1990, Dr. Henderson noted increased depression associated with chronic low back pain and development of left radicular pain. He related chronic depression to claimant's 1982 back injury. (Ex. 24).

In January 1992, Dr. Henderson characterized claimant's back problem as failed back surgery syndrome. (Ex. 29). In February 1991, Dr. Henderson stated that claimant's mood had become increasingly depressed over the chronicity of his back pain and radicular pain, and he took claimant off work for an indefinite period of time. (Ex. 33).

Dr. Holland first examined claimant in September 1987 and again in March 1991. In 1991, he agreed that claimant had increased depression and related it in a major way to increased back pain from claimant's 1982 injury. (Ex. 35B-18).

We are persuaded by the uncontroverted evidence that claimant's increasing level of psychopathology after May 1990 was caused by continuing low back pain related to his 1982 injury with IP. Consequently, we are not persuaded that claimant's "post-May 22, 1990" work activities for ICT were the major contributing cause of a worsening of his psychological condition. Accordingly, we reverse that portion of the Referee's order which shifted responsibility for claimant's psychological condition to Liberty (ICT). IP continues to be responsible for the condition.

Sedgwick James (IP) issued a denial of responsibility only, contending that claimant's employment at ICT after June 1, 1990 was responsible for a worsening of his psychological condition. Liberty (ICT), however, denied the compensability of, as well as responsibility for, claimant's psychological condition. Under such circumstances, when claimant's compensation is placed at risk by the non-responsible insurer, that insurer is held responsible for an assessed attorney fee. SAIF v. Bates, 94 Or App 666 (1989); William J. Emery, 45 Van Natta 1777 (1993). Accordingly, Liberty remains responsible for the Referee's \$3,500 attorney fee for services at the hearing level.

¹ At the previous hearing, Referee Gruber found that claimant's employment activities at ICT did not independently contribute to a worsening of claimant's physical or mental condition. That order has become final as a matter of law.

Furthermore, because of our de novo review, claimant's compensation remained at risk on Board review. 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 also payable by Liberty. ORS 656.382(2); 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 attorney's services on review is \$500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 24, 1992 is reversed in part and affirmed in part. Liberty Northwest Insurance Corporation's denial of claimant's current psychological condition is reinstated and upheld. Sedgwick James' denial is set aside and the claim is remanded to Sedgwick James for processing according to law. The Referee's attorney fee award shall be paid by Liberty. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$500, payable by Liberty.

October 5, 1993

Cite as 45 Van Natta 2005 (1993)

In the Matter of the Compensation of
DOLORES M. SHEPHERD, Claimant
WCB Case No. 92-10085
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee McCullough's order that awarded no permanent disability, whereas an Order on Reconsideration had awarded 7 percent (22.4 degrees) unscheduled permanent disability for a cervical condition. In her brief, claimant argues that the Referee erred in relying on the treating doctor's opinion rather than that of the medical arbiter panel. On review, the issues are evidence and extent of permanent disability.

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

We do not adopt that portion of the Referee's order which discounts the medical arbiters' opinion because the arbiters did not address whether or not claimant's neck range of motion measurements were "genuine." (O&O p. 6, first full paragraph, second sentence). Instead, we rely on the opinion of Dr. Mihalec, treating physician, because we find no persuasive reason to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983); Givens v. SAIF, 61 Or App 490, 494 (1983) (The opinion of the treating doctor is entitled to greater weight because he has more firsthand exposure to and knowledge of claimant's condition).

ORDER

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

In the Matter of the Compensation of
VINCENT B. SWEENEY, Claimant
WCB Case No. 90-09754
ORDER ON REMAND
Dennis O'Malley, Claimant Attorney
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

This matter is before the Board on remand from the Court of Appeals. SAIF v. Sweeney, 115 Or App 506 (1992), mod 121 Or App 142 (1993). Following review of our decision in Vincent B. Sweeney, 43 Van Natta 344, on recon 43 Van Natta 829 (1991), the court has remanded for reconsideration of the extent of claimant's permanent disability. In accordance with the court's instructions, we proceed with our reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The parties do not dispute the factors for age (0), education (2), and adaptability (2.5). In regard to impairment, the parties also agree that claimant is entitled to a value of 5 percent pursuant to former OAR 436-35-350(2) for a lumbar laminectomy and 5 percent for a chronic condition limiting repetitive use of the low back pursuant to former OAR 436-35-320(4). Thus, the only dispute between the parties is the value to be assigned to claimant's impairment due to lost ranges of motion in the low back. In rating claimant's permanent disability, we apply the "standards" effective at the time of the April 30, 1990 Notice of Closure. (WCD Admin. Order 1-1989).

Dr. Ordonez, claimant's attending physician, and Dr. Martens of the Western Medical Consultants, have each provided range of motion findings. Dr. Ordonez' findings were based on a June 1989 examination. Dr. Martens' findings were based on a March 1990 examination. The hearing was convened on July 20, 1990.

The Referee acknowledged that Dr. Martens' findings were made closer in time to the date of hearing. Nevertheless, the Referee reasoned that the credible testimony of claimant and his wife concerning claimant's range of motion limitations was inconsistent with the findings of Dr. Martens. Concluding that claimant's range of motion loss was "half way between" the findings of Dr. Ordonez and the findings of Dr. Martens, the Referee found that claimant was entitled to 12 percent for reduced range of motion. We disagree with the Referee's reasoning.

We generally defer to claimant's attending physician in the absence of persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to rely on Dr. Ordonez' opinion. Dr. Ordonez measured claimant's range of motion in the low back in June 1989, whereas Dr. Martens' range of motion findings were made in March 1990. (Exs. 16; 19). Under the applicable law, disability is rated as of the date of hearing. See Gettman v. SAIF, 289 Or 609 (1980); Jannette A. Kelly, 44 Van Natta 1715 (1992); Glenda D. Kenna, 44 Van Natta 1238 (1992). Thus, since Dr. Ordonez' findings were made over a year prior to the July 20, 1990 hearing, we consider those observations to be less relevant to the rating of claimant's permanent disability than the more recent findings of Dr. Martens.

Claimant contends that Dr. Martens' findings are not persuasive because claimant testified that Dr. Martens pushed claimant beyond the ranges of motion in which he is able to function. However, since permanent disability must be based on objective findings of impairment under the standards, and Dr. Martens has made those determinations, we are not persuaded by claimant's testimony that Dr. Martens' findings are invalid. We give greater weight to the expert opinion of Dr. Martens concerning claimant's range of motion in the low back than we do to claimant's lay opinion concerning his limitations. See William O. Esselstrom, 42 Van Natta 1036 (1990). Finally, we find Dr. Martens' report to be thorough and well reasoned. See Somers v. SAIF, 77 Or App 259 (1986).

Accordingly, we rely on Dr. Martens' findings concerning claimant's low back ranges of motion. Based on Dr. Martens' finding of 78 degrees flexion, claimant is entitled to an impairment rating of 1 percent. Former OAR 436-35-360(6). Claimant's total impairment is 11 percent (5 percent for a lumbar laminectomy combined with 5 percent for a chronic condition and 1 percent for lost range of motion).

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 his education value 2, the sum is 2. When that value is multiplied by claimant's adaptability value 2.5, the product is 5. When that value is added to claimant's impairment value 11, the result is 16 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 16 percent.

The April 30, 1990 Notice of Closure awarded claimant 17 percent (54.4 degrees) unscheduled permanent partial disability. Inasmuch as SAIF does not seek a reduction of that award, we do not alter it.

ORDER

The Referee's order dated August 20, 1990 is reversed. The April 30, 1990 Notice of Closure is reinstated and affirmed.

October 7, 1993

Cite as 45 Van Natta 2007 (1993)

In the Matter of the Compensation of
MEHMET M. AHMET, Claimant

WCB Case No. 92-06513

ORDER ON REVIEW

Rasmussen & Henry, Claimant Attorneys

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Brown's order that upheld the insurer's partial denial of his right leg (knee) 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 insurer's denial denied both compensability of his right knee degenerative condition and a worsening of his condition. We disagree.

Claimant's injury was originally accepted as a right knee strain. Following a medical arbiter's exam, the insurer partially denied claimant's claim. Specifically, the insurer's denial provided that:

"A review of the medical information received indicates a diagnosis of degenerative osteoarthritis of the right knee and mild chondromalacia patellofemoral joint bilaterally. These conditions are felt to be preexisting degenerative conditions that were not materially worsened by the July 21, 1992 work incident. ****At this time, we would also like to reaffirm our acceptance of your original work incident of July 21, 1990 resulting with (sic) a removal of a loose foreign body of the right knee."

After reviewing the insurer's denial, we conclude that, because the denial reaffirmed compensability of the original injury, the only condition denied in this case was the preexisting degenerative condition. Under the circumstances, we agree with the Referee that claimant did not establish compensability of his condition pursuant to ORS 656.005(7)(a)(B). Textronix, Inc. v. Nazari, 117 Or App 409 (1992) on recon 120 Or App 590 (1993).

ORDER

The Referee's order dated January 4, 1993 is affirmed.

In the Matter of the Compensation of
MATTHEW P. KOHANES, Claimant
Own Motion No. 66-0316M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our September 9, 1993 Own Motion Order. In that order, we declined to authorize payment of a June 7, 1993 independent medical examination (IME) on the ground that the expense was incurred as a cost of litigating the compensability issue, not for the treatment of claimant's compensable injury. Walter Jones, 43 Van Natta 1717 (1991). On reconsideration, relying on our holdings in Carl Hight, 44 Van Natta 224 (1992), and Cordy A. Brickey, 44 Van Natta 220 (1992), SAIF contends that we should authorize payment of the IME. We find these cases distinguishable and continue to decline to authorize payment for the IME.

In Brickey, supra, and Hight, supra, we reconsidered our prior reasoning which had concluded that a medical report to determine compensability was not compensation as defined by ORS 656.005(8) and, thus, could not qualify as reimbursable compensation payable to injured workers under ORS 656.625. We made this reconsideration in light of Brooks v. D & R Timber, 55 Or App 688 (1982), in which the Court of Appeals held that diagnostic medical services are compensable when the services are reasonable and necessary in order to determine whether a causal relationship exists between a compensable condition and a current condition. Reasoning that such a policy encouraged the insurer to fully investigate and, therefore, properly process the claim, we applied the policy to claims in own motion status and found that a medical report to determine compensability was an integral part of a medical service provided to an injured worker. As such, we concluded that such a report would qualify as compensation under ORS 656.005(8) and ORS 656.625. Brickey, supra; Hight, supra.

We find Brickey, supra, and Hight, supra, distinguishable in that, in those cases, there was no indication that the report regarding compensability was sought after the carrier had recommended against reopening the claim and the claim was referred for a fact finding hearing, as is the case here. Instead, we continue to rely on the reasoning in Walter Jones, supra, in concluding that the IME in this case is not compensable because it was incurred as a cost of litigation. This reasoning is consistent with our holding in David M. Nelson, 42 Van Natta 2045 (1990).

In Nelson, the Board 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. Clara M. Peoples, 31 Van Natta 134 (1981). 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. Clara M. Peoples, supra; Welch v. Bannister Pipeline, 82 Or App 23 (1986)." 42 Van Natta at 2047.

In Nelson, since the claimant's attorney had requested the medical report from the claimant's attending physician in preparation for hearing regarding the claimant's appeal of a Determination Order, we found that the report was written for the purpose of litigation. We concluded that the cost of the report should be borne by the claimant, as the requester of the report, because the report was not sought for the purpose of treatment, but solely for the purpose of litigation. David M. Nelson, supra. This rationale is also consistent with our holding in disputes regarding the distribution of third party recoveries where we do not permit a Worker's Compensation carrier to receive reimbursement for expenses incurred from an IME where the examination is designed for claim evaluation or litigation purposes. See David G. Payne, 43 Van Natta 918 (1991).

For pre-1966 claims, the Board, in its own motion authority, has original jurisdiction to determine whether the claim for medical benefits is causally related to the pre-1966 injury, with limited exceptions not applicable here.¹ ORS 656.278(1)(b); OAR 438-12-037. Appeal of a Board's Own Motion

¹ A request for medical services for a compensable injury occurring from August 5, 1959 through December 31, 1996, and resulting in permanent total disability, is processed as a claim for medical services under ORS 656.245. Or Laws 1959, ch 589, §2; OAR 438-12-037(2). Because claimant's compensable injury occurred on January 22, 1959, that exception to the Board's jurisdiction over medical services regarding pre-1966 injuries does not apply. ORS 656.278(1)(b).

Order is to the Court of Appeals, with the claimant being allowed to appeal only if the order diminishes or terminates a former award and the carrier being allowed to appeal only if the order increases the award. ORS 656.278(3); OAR 438-12-065(1). Therefore, here, the first step to any possible litigation was the carrier's recommendation to deny reopening claimant's claim followed by the Board's action regarding that recommendation.

On December 21, 1992, SAIF recommended that claimant's pre-1966 claim not be reopened for provision of the proposed cervical surgery on the ground that it was "not related to the compensable condition." On April 21, 1993, the Board referred the matter to the Hearings Division for an evidentiary hearing and a recommendation as to: (1) whether claimant's current cervical condition is compensable; and (2) whether claimant was in the work force at the time of disability. OAR 438-12-040. The IME in question occurred on June 7, 1993. The IME report was primarily devoted to discussing the causal relationship, although it touched on treatment in that the examiner stated that he would not favor surgery. The fact finding hearing was held on July 13, 1993.

Here, the IME occurred well after SAIF recommended that claimant's pre-1966 claim not be reopened for medical services. Thus, SAIF opposed reopening claimant's claim but now requests authorization for reimbursement for costs expended in defending its opposition. Furthermore, the IME report primarily addressed the causal relationship between claimant's current condition and his compensable injury. Since the exam was conducted after SAIF's recommendation to deny reopening and the report generated in anticipation of the fact-finding hearing, we find that the IME/report were for the purposes of litigation. Therefore, we conclude that the IME/report are not compensable.

We do not find that this conclusion contradicts our holdings in Brickey, supra, and Hight, supra, because those cases did not involve situations where IMEs regarding causation occurred after the carrier recommended against reopening the claim. Furthermore, our decision in this case abides by the policy to encourage the carrier to fully investigate and properly process the claim. Here, if this same IME had been performed prior to SAIF's recommendation to the Board, it would likely have been compensable as reasonable and necessary for determining whether a causal relationship existed between the current condition and the compensable injury. Brooks v. D & R Timber, supra; Cordy A. Brickey, supra. Thus, our decision in this case will encourage a complete investigation before a carrier makes a recommendation. Here, however, because this report was not generated until after SAIF recommended against reopening the claim and in anticipation of a fact finding hearing concerning the compensability of claimant's current condition, the report was generated for litigation purposes and is not compensable.

We withdraw our September 9, 1993 Own Motion Order. 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
DANIEL E. NORTHWAY, Claimant
WCB Case No. 92-10684
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Black's order that awarded claimant 39 percent (58.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist), whereas an Order on Reconsideration awarded claimant 25 percent (37.5 degrees) scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings" except for the first sentence in the first complete paragraph on page two, and his finding concerning claimant's loss of strength on page three. In addition, we make the following findings.

Dr. Schächner, claimant's treating orthopedic surgeon, performed a closing examination on December 3, 1991. He reported that claimant had "no loss in respect to strength due to any muscle atrophy or nerve loss."

On June 29, 1992, Dr. Schachner noted that claimant had no neurological deficits and retained both median and ulnar innervation of the flexor extensors.

Dr. Fry performed an arbiter's examination on July 27, 1992. He recorded 5/5 strength in all muscle groups.

Dr. Schachner reexamined claimant on October 7, 1992, at which time he found that claimant retained good grip strength.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 39 percent scheduled permanent disability for partial loss of the right wrist, based on lost ranges of motion, three surgical fusions, a chronic condition limiting repetitive use, and loss of strength due to impairment of the median and ulnar nerves. On review, the insurer contests only that portion of the Referee's order that awarded claimant an impairment value for loss of strength. The insurer contends that claimant has no loss of strength, no injury-related damage to the peripheral nerves, no muscle atrophy, and no disruption of the right arm musculotendonous unit.

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" are those in effect at the time of the Determination Order (WCD Admin. Order 2-1991).

Under the standards, loss of strength must be determined on the basis of medical evidence which measures the loss using a 0 to 5 grading system, and identifies the spinal nerve root, peripheral nerve, or plexus which is responsible for the loss. Former OAR 436-35-007(14). An award may be made if the loss is attributable to peripheral nerve injury, loss of muscle, or disruption of the musculotendonous unit. Former OAR 436-35-110(2). Here, the preponderance of the medical evidence does not support a finding of permanent impairment due to loss of strength.

Dr. Schachner performed a closing examination on December 3, 1991. He reported that claimant had "no loss in respect to strength due to any muscle atrophy or nerve loss."

On June 29, 1992, Dr. Schachner spoke with claimant's counsel and later signed a statement memorializing that conversation. He reported:

"Telephone conference with [claimant's attorney] regarding grip strengths and [claimant's attorney] relates based on the numbers provided that compared to the norm for this individual he is approximately 30 per cent (sic) weak. That being the case, in using the evaluations from Workmen's Compensation on their system of rating it would place him at 4-/5. . . . There are no actual neurological deficits and the innervation to the flexors he was appraised is from both median and ulnar distributions." (Emphasis supplied).

Medical arbiter Fry examined claimant on July 27, 1992, and found 5/5 strength in all muscle groups. Dr. Schachner reexamined claimant on October 7, 1992, and again opined that claimant retained good grip strength.

Dr. Schachner's June 29, 1992 chart note is not evidence of loss of muscle strength. Dr. Schachner never measured claimant's muscle strength on a 0 to 5 grading scale. Rather, he merely acquiesced to claimant's counsel's representation that claimant has a 30 percent loss of muscle strength which equates with a 4/5 muscle strength rating. Moreover, Dr. Schachner has consistently opined that claimant has no loss of muscle strength. Finally, Dr. Fry, the only physician who tested claimant's right forearm strength against resistance, measured 5/5 muscle strength in all muscle groups. See former OAR 436-35-007(14).

On this record, we conclude that claimant has failed to prove loss of strength in his right arm attributable to nerve injury, loss of muscle, or disruption of the musculotendonous unit. Therefore, claimant is not entitled to a value for loss of strength. Former OAR 436-35-110(2)(a); Kent D. Anderson, 45 Van Natta 31 (1993).

Combining the uncontested values for lost ranges of motion (13), three surgical fusions (5,5,5), and a chronic condition limiting repetitive use (5), claimant's scheduled disability under the standards is 29 percent. Former OAR 436-35-010(6)(c); OAR 436-35-080(11); OAR 436-35-120(1). Consequently, we modify the Referee's order, reducing claimant's scheduled permanent disability award from 39 percent to 29 percent.

ORDER

The Referee's order dated February 5, 1993 is modified. In lieu of the Referee's award, and in addition to the 25 percent (37.5 degrees) scheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded an additional 4 percent (6 degrees) scheduled permanent disability, for a total award to date of 29 percent (43.5 degrees) scheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee is modified accordingly.

October 8, 1993

Cite as 45 Van Natta 2011 (1993)

In the Matter of the Compensation of
PHILIP F. DYE, Claimant
WCB Case No. 92-05239
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Davis, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of Referee Hazelett's order that set aside its denial of claimant's left elbow condylitis condition. On review, the issue is compensability.

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

After our review of the record, we find no material discrepancies in the testimony of the witnesses that would cause us to overturn the Referee's finding of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Timothy J. Swodeck, 39 Van Natta 341 (1987).

In addition, although the Referee found that the onset of claimant's pain that caused him to seek medical treatment was sudden, we conclude that, given the repetitive nature of claimant's work activities as a truck driver/unloader, claimant met his burden to prove that work activities were the major contributing cause of his left elbow epicondylitis condition. ORS 656.802(1)(c); ORS 656.802(2); 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).

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 March 3, 1993 is affirmed. Claimant's attorney is awarded \$1,500 for services on Board review, to be paid by the insurer.

October 8, 1993

Cite as 45 Van Natta 2012 (1993)

In the Matter of the Compensation of
WCB Case No. 92-14093

DARLA A. MONROE, Claimant

ORDER ON REVIEW

Whitehead & Klosterman, Claimant Attorneys

James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee Quillinan's order that upheld the SAIF Corporation's partial denial of claimant's current condition, specifically the preexisting degenerative disc disease, and current need for treatment. On review, the issue is compensability.

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

After review of the record, we find no evidence that SAIF accepted claimant's preexisting degenerative disc disease condition. The prior referee's finding of a mild disc bulge was cited as part of her reasoning relevant to supporting her conclusion that claimant's lumbosacral strain was compensable. Claimant's current need for treatment is for a different condition, *i.e.*, her preexisting degenerative disc disease. Consequently, SAIF's partial denial of claimant's current need for treatment is appropriate. Green Thumb, Inc. v. Basl, 106 Or App 98 (1991).

ORDER

The Referee's order dated February 2, 1993 is affirmed.

In the Matter of the Compensation of
DEBRA J. ADDOMS, Claimant
WCB Case No. 92-15188
ORDER ON REVIEW (REMANDING)
Dean Heiling, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Galton's order dismissing claimant's hearing request concerning the self-insured employer's denial of claimant's aggravation claim on jurisdictional grounds. We reinstate claimant's hearing request and remand to the Referee for further proceedings.

Claimant filed her hearing request in response to an aggravation denial issued by the self-insured employer. The employer moved for dismissal of the hearing request, contending that the Hearings Division was without jurisdiction as claimant's aggravation rights had expired. Claimant moved for a summary ruling denying the motion to dismiss, arguing that she had filed no less than four aggravation claims prior to the expiration of her aggravation rights.

The Referee granted the employer's motion to dismiss without admitting any documentary evidence into the record. The Referee apparently based the dismissal on a finding that claimant had not filed a timely aggravation claim. The Referee's order references correspondence from the parties that is included in the record, as well as other documentary evidence that is not in the record.

Our review is restricted to the record created by the Referee. Given the incomplete nature of the record, we cannot ascertain whether claimant did or did not file a timely aggravation claim. Accordingly, we conclude that this case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(3) and (5). We, therefore, vacate the Referee's order, reinstate claimant's hearing request and remand the case to Referee Galton.

The Referee is instructed to conduct further proceedings at which time the parties shall be permitted to present evidence concerning their respective positions. These proceedings may be conducted in any manner that will achieve substantial justice to all parties. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

October 12, 1993

Cite as 45 Van Natta 2013 (1993)

In the Matter of the Compensation of
MIGUEL A. CARDONA, Claimant
WCB Case No. 91-17381
ORDER ON RECONSIDERATION
Royce, Swanson, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our September 22, 1993 Order on Review. Specifically, SAIF points out that although we assessed a penalty for its unreasonable denial, we did not specify the amount of the penalty.

We found that SAIF did not have a legitimate doubt as to its liability and therefore found its denial unreasonable. While we concluded that a penalty, based on all amounts due at the time of the hearing, was warranted, we neglected to set the amount of the penalty. After considering the matter, we conclude that a penalty, equal to 25 percent of all amounts due at the time of the hearing as a result of the Referee's compensability decision is appropriate. The penalty shall be paid in equal shares to claimant and his attorney. ORS 656.262(10).

Accordingly, our September 22, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 22, 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
LINDA L. DEMANCHE, Claimant
WCB Case No. 92-10086
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 Menashe's order that: (1) declined to direct the insurer to pay claimant's scheduled disability award at the rate of \$305 per degree; (2) did not assess an additional penalty under ORS 656.268(4)(g) based on the Referee's increased permanent disability award; and (3) did not award an attorney fee under ORS 656.382(1) for allegedly unreasonable claims processing. The insurer cross-requests review of that portion of the order that increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 5 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 61 percent (117.12 degrees). In its brief, the insurer argues that the Referee impermissibly considered a post-closure medical report in rating claimant's permanent impairment. On review, the issues are evidence, extent and rate of scheduled permanent disability, and penalties and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the last sentence, with the following supplementation.

At the time of the April 9, 1992 Notice of Closure, the uncontroverted medical evidence indicated that claimant's unscheduled permanent disability was greater than 8 percent.

CONCLUSIONS OF LAW AND OPINION

Evidence/extent of scheduled permanent disability

The Referee increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 5 percent to 61 percent. In reaching this result, the Referee relied on a "post-reconsideration" questionnaire completed by Dr. Knox, treating physician. (See Ex. 44A).

The insurer contends that the Referee impermissibly admitted Knox's questionnaire and erred in relying on the questionnaire in rating claimant's scheduled permanent disability. We conclude that the "post-reconsideration" questionnaire was properly admitted.

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.

Thus, pursuant to Smith and Luciani, ORS 656.268(5) is not applicable to evidence submitted at hearing. Furthermore, no medical arbiter was either appointed or a report issued. (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report. See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993)). Since there is no other basis for preventing admission of this attending physician's "post-reconsideration" questionnaire, we conclude that it was properly admitted. However, after considering the entire record, we find the questionnaire unpersuasive, based on the following reasoning.

Claimant's initial injury claim was closed by a December 4, 1989 Determination Order which awarded 8 percent unscheduled permanent disability for claimant's cervical and lumbar conditions. (See Ex. 5). The claim was reopened and claimant underwent a scalene muscle resection in August 1990. On June 10, 1991, Dr. Knox recommended pain center treatment for claimant's continuing low back, cervical and thoracic outlet syndrome problems.

On March 3, 1992, after claimant's participation in an eight week pain treatment program, Dr. Morris reported claimant's "remarkable" progress and opined that she was medically stationary. (See Ex. 37). Morris recorded claimant's cervical, thoracic, lumbar, shoulder and hip ranges of motion and issued a closing report. He opined that claimant is capable of full-time employment in the "sedentary-light to light duty category" with restrictions against working above shoulder level and excessive reaching. (*Id.*)

Knox concurred with Morris' report in its entirety. (Ex. 39, 41). In addition, referring to the "rather complete and thorough closing report," Knox opined that the report "certainly can serve as a closing examination in that I have totally concurred with the report in its entirety." (Ex. 41-2). See OAR 436-35-007(8); Alex J. Como, 44 Van Natta 221 (1992); Dennis E. Connor, 43 Van Natta 2799 (1991).

The claim was closed by an April 9, 1992 Notice of Closure which awarded no additional permanent disability. (Ex. 40). Claimant requested reconsideration, seeking additional scheduled and unscheduled permanent disability and a penalty under ORS 656.268(4)(g). With the request, claimant submitted Knox's June 19, 1992 questionnaire, which was based on a May 7, 1992 examination. (Ex. 44A-26). In that document, Knox described numerous types of impairment which differ substantially from those described in Morris' closing examination. Knox also indicated that claimant's condition had not changed since April 9, 1992, when the claim was closed. Thereafter, an Order on Reconsideration granted 5 percent scheduled permanent disability for loss of use or function of the right arm, as well as an additional 21 percent unscheduled permanent disability.

Claimant argues that the questionnaire is necessary for complete evaluation of her permanent disability under the "standards," because Dr. Morris neglected areas of ratable impairment. We disagree.

In our view, Knox's June 19, 1992 questionnaire responses constitute an unexplained departure from his unequivocal pre-closure "total[] concur[rence]" with Morris' opinion concerning claimant's permanent disability. Under these circumstances, we do not find Knox's post-closure conclusions persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Karen L. Taylor, 45 Van Natta 1785 (1993).

Moreover, because we find Morris' evaluation of claimant's injury-related permanent disability to be thorough and complete, we consider those impairment findings to be most persuasive. See Somers v. SAIF, 77 Or App 269 (1986); see also OAR 436-35-007(8); Alex J. Como, *supra*. Accordingly, based on Morris' evaluation, we affirm the Order on Reconsideration award of 5 percent scheduled permanent disability for claimant's chronic right arm condition and reverse the Referee's additional award. (See Exs. 37-3, 46-4).

Rate of scheduled permanent disability

We adopt the Referee's opinion on this issue.

Penalty and attorney fee

Claimant's aggravation claim was closed by a Notice of Closure which awarded no permanent disability in addition to the prior award of 8 percent unscheduled disability. Claimant requested reconsideration and an Order on Reconsideration awarded a total of 29 percent unscheduled disability and 5 percent scheduled disability.¹ In addition, the Order on Reconsideration awarded a penalty, based on the increased award. (Ex. 46).

¹ We note that the portion of the Order on Reconsideration which awarded an additional 21 percent unscheduled permanent disability is not contested on review.

The Referee declined to assess a penalty under ORS 656.268(4)(g), which provides for a penalty "upon reconsideration," when a worker is at least 20 percent disabled and the Order on Reconsideration increases her permanent disability by at least 25 percent. In reaching this result, the Referee noted that the Order on Reconsideration had already assessed a penalty under the statute based on claimant's increased un-scheduled disability award.

Claimant requests an increased penalty, based on the Referee's increased scheduled permanent disability award. However, because we have determined that claimant is not entitled to scheduled disability beyond that awarded by the Order on Reconsideration, the basis for claimant's requested penalty has been eliminated. See ORS 656.268(4)(g).

Finally, claimant seeks an attorney fee under ORS 656.382(1), for the insurer's unreasonable resistance to the payment of compensation. Specifically, claimant asserts that the insurer failed to award that permanent disability which was subsequently granted by the Order on Reconsideration.

Since the Referee's order we have held that imposition of a penalty under ORS 656.268(4)(g) by itself does not constitute grounds for awarding an attorney fee under ORS 656.382(1). See Jesus R. Corona, 45 Van Natta 886 (1993). Such a fee is awarded if claimant establishes an unreasonable resistance to the payment of compensation. Id.

In this case, the medical evidence regarding claimant's back condition, at the time of the Notice of Closure, clearly indicated disability greater than that compensated by the prior Determination Order (8 percent). In reaching this conclusion, we rely on Morris' closing examination which supports the Order on Reconsideration award of 29 percent un-scheduled disability for claimant's injury-related back and right shoulder conditions. (See Exs. 37, 46; compare Ex. 40). Moreover, because the evidence regarding claimant's un-scheduled permanent disability was uncontroverted when the Notice of Closure issued, we conclude that the insurer's failure to increase claimant's un-scheduled award amounted to unreasonable resistance to the payment of compensation. Consequently, claimant's counsel is entitled to an attorney fee for this unreasonable conduct. See ORS 656.382(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 concerning this unreasonable conduct 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 the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 10, 1992 is reversed in part, modified in part and affirmed in part. That portion of the order that increased claimant's scheduled permanent disability award from 5 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 61 percent (117.12 degrees) is reversed. The Order on Reconsideration is reinstated and affirmed. For the insurer's unreasonable claims processing, claimant's attorney is awarded an attorney fee of \$750 under ORS 656.382(1), payable by the insurer. The remainder of the order is affirmed.

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

The insurer requested reconsideration of our July 19, 1993 Order on Review which found that claimant was entitled to an 11 percent award of scheduled permanent disability for a left knee injury. On August 16, 1993, in order to fully consider the matter, we abated our prior order and granted claimant an opportunity to respond. To date, no response from claimant has been received. After further considering the matter, we make the following conclusions.

On reconsideration, the insurer relies on the Court of Appeals recent decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) and contends that we erred in concluding that Exhibits 28, 29, 30, and 31 could not be considered in evaluating the extent of claimant's permanent disability.

In Smith, the court 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, supra. We have 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.

While we agree with the employer that ORS 656.268(5) does not preclude consideration of the disputed exhibits, the inquiry does not end there. Exhibits 28 and 29 (reports from Dr. Butler and Vigeland) are not from the attending physician, nor has the attending physician (Dr. Tennant) concurred with those reports. Thus, pursuant to ORS 656.245(3)(b)(B), neither report can be considered in evaluating the extent of claimant's disability. Dennis E. Connor, 43 Van Natta 1799 (1991); Timothy L. Smith, 44 Van Natta 2246 (1992).

Exhibits 30 and 31 are reports from Dr. Tennant, the attending physician. Since Dr. Tennant is the attending physician, his reports satisfy the requirements of ORS 656.245(3)(b)(B). However, there is some question whether Dr. Tennant's report can be considered inasmuch as the Director appointed a medical arbiter. ORS 656.268(7) provides that the findings of a medical arbiter shall be submitted to the department for reconsideration purposes and "no subsequent medical evidence of the worker's impairment is admissible before the department the board or the courts for purposes of making findings of impairment on the claim closure." See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993) (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself).

We do not need to decide whether Exhibits 30 and 31 are inadmissible under ORS 656.268(7), however, as we would still reach the same conclusion if those exhibits were considered. As noted in our prior order, we do not find Dr. Tennant's opinion persuasive. 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.

Exhibits 30 and 31 suffer from the same defects. Neither exhibit indicates that Dr. Tennant had recently examined claimant. Moreover, in Exhibit 31, Dr. Tennant agreed that he had not examined claimant since June 16, 1991. Under these circumstances, we continue to rely on Dr. Gritzka, the medical arbiter, and conclude that claimant has an 11 percent loss of use or function of the left leg (knee) due to her compensable injury.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BETTY J. LINCOLN, Claimant
WCB Case No. 91-10378
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Referee Hazelett's order that upheld the insurer's partial denial of her osteoarthritic condition in her back, shoulders and arms. The insurer cross-requests review of that portion of the Referee's order that set aside its partial denial of claimant's right knee condition. Prior to conducting our review, the insurer has withdrawn its cross-request for review. On review, the sole issue is compensability of claimant's osteoarthritic condition in her back, shoulders and arms. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Relying on ORS 656.005(7)(a)(B), the Referee found that the major cause of claimant's current condition was her preexisting osteoarthritis. Therefore, the Referee upheld the insurer's denial of that condition. We disagree.

At the outset, we note that ORS 656.005(7)(a)(B) is not applicable. Claimant's osteoarthritis condition was accepted by the insurer as a compensable occupational disease. We have previously held that ORS 656.005(7)(a)(B) does not apply to accepted occupational disease claims. See Lizbeth Meeker, 44 Van Natta 2069, 2071 (1992). Accordingly, we do not decide this case based on ORS 656.005(7)(a)(B). Rather, we find that the insurer is precluded from denying claimant's osteoarthritis condition based on the following reasoning.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988).

In July 1988, claimant filed a claim against the insurer for an osteoarthritis condition in her back, arms, shoulders and knees. The insurer denied all conditions for which claimant had submitted a claim. Claimant requested a hearing and, by a May 4, 1989 Referee's order, the insurer's denial was set aside in its entirety. By order of August 31, 1990, the Board affirmed the Referee's order. Betty J. Lincoln, 42 Van Natta 1887 (1990). The insurer requested judicial review, however, it subsequently withdrew its appeal, making the August 31, 1990 Order on Review final.

As noted above, claimant's claim in 1988 was for osteoarthritis in the back, arms and shoulders. In June 1989, Dr. Rabie, claimant's attending physician, reported that claimant continued to have the same symptoms which were attributable to her underlying osteoarthritic condition. (Ex. 89). Rabie further noted that claimant's osteoarthritic condition had been diagnosed on numerous occasions. (Ex. 89). Based on Dr. Rabie's report, the insurer issued its October 1991 denial which denied claimant's osteoarthritic condition after June 1989. (Ex. 101).

In light of Dr. Rabie's opinion we are persuaded that claimant's current osteoarthritis condition is the "same condition" that was found compensable by the earlier Referee and Board orders. Thus, under the doctrine of issue preclusion, the August 31, 1990 Board order establishes as a matter of law that claimant's osteoarthritis condition is compensable. Therefore, the insurer is precluded from subsequently denying that the same condition is not compensable. Inasmuch as the insurer's denial is based on the premise that claimant's osteoarthritis condition is not compensable, it must be set aside under the res judicata doctrine of issue preclusion. See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993); Weyerhaeuser Company v. Pitzer, 123 Or App 1 (1993).

In reaching this conclusion, we are aware of the insurer's argument that it was ordered to accept only claimant's osteoarthritis symptoms. We disagree. Claimant's occupational disease claim was for her osteoarthritis condition. While it is true that the compensability decision of that condition was based on a worsening of symptoms under our decision in Donna E. Aschbacher, 41 Van Natta 1242 (1989), our reference to a worsening of symptoms only set forth the standard of proof for establishing compensability of the claim for the condition. It did not limit claimant's claim or the insurer's responsibility for that claim. Moreover, the insurer may not relitigate the compensability of a condition previously found compensable under a different legal standard. See Cox v. SAIF, 121 Or App 568 (1993) (Carrier precluded from contesting compensability of consequential conditions under ORS 656.005(7)(a)(A) because conditions had previously been found compensable under the law in existence prior to statutory amendments).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's osteoarthritis condition in her back, arms and shoulders is \$3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 18, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the insurer's denial of claimant's osteoarthritis condition in her back, arms and shoulder is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$3,000, payable by the insurer. This attorney fee award is in addition to that previously granted by the Referee. The remainder of the order is affirmed.

October 12, 1993

Cite as 45 Van Natta 2019 (1993)

In the Matter of the Compensation of
SHELLY L. MILLER, Claimant
 WCB Case No. 92-13183
 ORDER ON REVIEW
 Vick & Gutzler, Claimant Attorneys
 Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests that portion of Referee Spangler's order that upheld the insurer's denial of her occupational disease claim for a right knee 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 has a preexisting anatomical deformity (external rotation deformity of the right tibia) which predisposed her to the development of the right knee condition resulting in disability and the need for treatment. Claimant's work activities of constantly walking up and down stairs were the major contributing cause of the condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's current knee condition is not compensable because she had not sustained her burden of proving that work activities caused a pathological worsening of her preexisting knee condition (external rotation deformity). We disagree with the Referee's analysis.

In order to establish her occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that her work activities were the major contributing cause of her disease or its worsening. ORS 656.802(1)(c), (2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). "Major 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).

We do not consider a "predisposition" to be a disease or preexisting condition for purposes of establishing an occupational disease, nor do we consider the "predisposition" in applying the major contributing cause standard. See Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991); Preston v. Wonder Bread, 96 Or App 613, *rev den* 308 Or 405 (1989); John W. Walters, 45 Van Natta 55 (1993); Rodney T. Buckallew, 44 Van Natta 358 (1992). A "predisposition" is a condition of special susceptibility to a disease, not a disease in and of itself. Preston v. Wonder Bread, *supra*.

Here, we find that claimant's preexisting deformity is a predisposition. Dr. Carroll, the treating orthopedist, explained that claimant "has an underlying congenital deformity of the right leg which would predispose her to pain at the area of the kneecap if she were to do a lot of climbing of stairs and especially carrying weighted objects with her." (Ex. 13). Dr. Logan, the examining orthopedic surgeon, stated that claimant "has an external rotation deformity of her leg on the right compared to her left, and her running up and down stairs is irritating her patellofemoral joint area." (Ex. 7-4). Hence, both physicians agree that claimant's leg deformity predisposes her knee to pain when climbing stairs. Accordingly, we do not consider the preexisting deformity in determining whether claimant has established an occupational disease.

The physicians had different diagnoses for claimant's knee condition. Dr. Carroll diagnosed chondromalacia of the patella, while Dr. Logan diagnosed overuse syndrome. Under either diagnosis, however, we find the condition is established with medical evidence supported by objective findings.

Further, we find that the medical record sustains claimant's burden of proving causation. Both doctors essentially agreed that claimant's work activities resulted in the condition. Dr. Carroll opined that work activities were the major contributing cause of the condition. (Ex. 13). Dr. Logan opined that the leg deformity was the major cause, but he added that symptoms were "due to the increased work activity." (Ex. 7-5). Thus, when the leg deformity is excluded from consideration, we find that claimant's work activities were the major contributing cause of the knee condition. We conclude that claimant has established her occupational disease claim for the right knee condition.

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

ORDER

The Referee's order dated February 10, 1993, as reconsidered February 11, 1993, is reversed in part and affirmed in part. The insurer's denial of claimant's occupational disease claim for the right knee condition is set aside, and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded \$3,500 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
BRIAN A. CHAMBERS, Claimant
Own Motion No. 93-0250M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On September 28, 1993, the SAIF Corporation requested reconsideration of our June 2, 1993 Own Motion Order. In that order, we concluded that claimant was entitled to own motion relief because his right ankle and foot condition had worsened requiring surgery. We authorized the reopening of claimant's claim to provide temporary disability benefits beginning the date he was hospitalized for the proposed surgery. SAIF contends that the claim should not be reopened at this time because claimant's physician has subsequently withdrawn the request for surgery.

Pursuant to OAR 438-12-065(2), SAIF had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if SAIF could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. OAR 438-12-065(2). Under the particular circumstances of this case, we conclude that an exception to the deadline is appropriate. We withdraw our prior order for purposes of reconsideration and issue the following order in its place.

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.*

With its request for reconsideration, SAIF submitted a September 7, 1993 report from Dr. Rolfe, claimant's treating orthopedist, who stated that claimant has a significant problem involving the subtalar joint in his foot, and "will require fusion at some point." Dr. Rolfe also stated that "[a]t this time, however, [claimant] is very successful working and is able to function at a very high level," and that "I believe that surgery will be needed at some point in the future due to the likely progression of his symptoms." As noted above, we initially reopened claimant's claim for own motion relief based on his proposed surgery. ORS 656.278(1)(a). However, because claimant's physician is not recommending surgery or hospitalization at this time, he no longer qualifies to have his claim reopened pursuant to ORS 656.278(1)(a). In other words, he does not require inpatient or outpatient surgery or other treatment requiring hospitalization. *Id.* As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, the request for own motion relief is denied. Should claimant require the proposed surgery at a future time, he may request reopening of his claim to provide temporary compensation benefits at that time. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation
VIRGINIA M. BOJE, Claimant
WCB Case Nos. 92-07053 & 92-05651
ORDER ON REVIEW
Nick Chaivoe, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Bethlahmy's order which upheld the self-insured employer's denial of her occupational disease claim for left carpal tunnel syndrome (CTS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the finding that claimant's left carpal tunnel syndrome is not compensable. We add the following findings.

Claimant's work activities involved rapid and repetitive fine movement involving thumbs, index fingers and wrists. Claimant used her left hand approximately 70 percent of the time to perform those activities. She had been performing the same work for approximately twelve years. (Ex. 24).

The onset of CTS can be very insidious and varied in its presentation. (Ex. 29-18).

CONCLUSIONS OF LAW AND OPINION

In determining that claimant's CTS was not compensable, the Referee relied on the opinion of independent examiner, Dr. Button, hand surgeon, rather than claimant's treating physician (Dr. Ushman). We disagree.

When the medical evidence is divided, we give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no such reasons.

During claimant's initial visit to Kaiser Permanente on January 27, 1992, claimant provided a history of left forearm and upper arm numbness or tingling, which had been occurring for seven to ten days. (Ex. OD). The physician reported that claimant could not relate the symptoms to her job. Id. Based on claimant's description of her arm symptoms, the initial diagnosis was uncertain, but the physician considered both CTS and cervical spine radicular symptoms. Id. Accordingly, claimant was referred for radiographic studies of her cervical spine, which revealed no significant findings. (Ex. OE).

Claimant first saw her treating physician, Dr. Ushman, occupational medicine specialist, on February 14, 1992. Claimant gave Dr. Ushman a history of feeling a pain in her left shoulder and arm when opening the door of a machine at work. After his examination, Dr. Ushman diagnosed left biceps strain.

On February 20, 1992, Dr. Ushman referred claimant to physical therapy. The therapist obtained a history from claimant of "lowering window on machine over time," with symptoms of left arm tingling and numbness. (Ex. 8). During the first physical therapy visit, the therapist noted palpable tenderness of the flexor muscle group of the forearm, but no tenderness of the biceps. Id.

Subsequent visits to physical therapy revealed no biceps pain. However, claimant continued to complain of various symptoms including pain in the mid-trapezius and glenohumeral area. (Ex. 10).

Nerve conduction studies of claimant's left arm were completed on March 10, 1992. The studies revealed moderately severe left median motor sensory compression neuropathy in the left carpal tunnel. (Ex. 13).

Dr. Ushman diagnosed CTS which he felt was probably related to work. He admitted, however, that the history of claimant's injury with the door of the machine at work was not as clear as he would like and, thus, stated that it was not clear to him whether the work incident was related to her CTS symptoms. Dr. Button, however, later admitted that the onset of CTS can be very insidious and varied in its presentation. (Ex. 29-18).

Dr. Ushman subsequently obtained a thorough history of claimant's work and off-work activities. (Ex. 24-1). Claimant demonstrated the hand movements she performed in her work, and Dr. Ushman reported rapid and repetitive fine movement involving her wrist and hands, with the left hand being used 70 percent of the time. Claimant had been performing similar work for 12 years. Id. Dr. Ushman opined that claimant's work activities were the major contributing cause of her CTS. (Exs. 25, 26).

Dr. Button conducted an independent medical examination on July 24, 1992. Relying on a videotape of claimant's alleged work activities, Dr. Button stated that claimant's CTS was not work related because there was "nothing whatsoever strenuous, repetitious, or hand intensive in this operation." Rather, he concluded that claimant's CTS was idiopathic in nature. (Ex. 27-4).

When later questioned about his reliance on the videotape to make his diagnosis, Dr. Button stated that he relied on the video to a significant degree. (Ex. 29-6). Subsequently, at hearing, it was established that the videotape that Dr. Button reviewed showed claimant's work activities as they were after the process had been automated. (Tr. 64, 198). Dr. Button had not viewed the job as claimant had performed it manually for several years.

Where the opinion of any physician is based on an incomplete and inaccurate history, we do not find it persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Here, because Dr. Button relied significantly on a videotape which did not accurately depict claimant's work activities, we do not find his opinion persuasive.

Thus, after considering the entire record, we are persuaded by the opinion of Dr. Ushman that it is more likely than not that claimant's work activities are the major contributing cause of her left CTS. ORS 656.802(1), (2). Consequently, we set aside the employer's denial of claimant's occupational disease claim.

Claimant is entitled to an assessed attorney fee for prevailing on the issue of compensability of left CTS. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is \$2,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved. We further note that claimant's counsel has previously been awarded \$2,500 for prevailing at hearing over the employer's denial of claimant's left elbow and shoulder claim.

ORDER

The Referee's order dated December 4, 1992 is reversed in part and affirmed in part. That portion which upheld the self-insured employer's denial of left carpal tunnel syndrome is reversed. The denial is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of \$2,000 to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DAVID F. CAMPBELL, Claimant
WCB Case No. 92-11918
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerland and Gunn.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of a "dry eye" condition; and (2) found that claimant was not entitled to be paid scheduled permanent disability at the rate of \$305 per degree. On review, the issues are compensability and rate of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last three paragraphs.

CONCLUSIONS OF LAW AND OPINION

In 1989, a claim was accepted for injuries to both of claimant's eyes after a bullet exploded in his face. On reconsideration, claimant was awarded 10 percent scheduled permanent disability, payable at \$145 per degree. SAIF subsequently denied a claim for a "dry eye" condition.

The Referee upheld the denial and found that the scheduled permanent disability award was properly paid at \$145 per degree. Claimant contends that he proved compensability, and requests an order providing that he is entitled to be paid at the rate of \$305 per degree if the Supreme Court allows review of, and overturns, SAIF v. Herron, 114 Or App 64 (1992).

Compensability

The record contains two opinions regarding compensability of claimant's eye condition. Claimant's treating doctor, Dr. McLaughlin, O.D., indicated that "[i]njury to cornea from explosive particle has resulted in a chronically dry cornea which may later cause more severe problems." (Ex. 6A-1).

Dr. MacRae, ophthalmologist, examined claimant at SAIF's request. He diagnosed keratitis sicca, or dry eyes, finding that it was probably not caused by the industrial accident. (Exs. 7-2, 8-1, 15-1). Dr. MacRae further found, however, that the accident caused an irregular corneal surface, causing the tears in the eyes to evaporate more quickly, which in turn made claimant's dry eye condition symptomatic. (Ex. 15-1).

We agree with the Referee that Dr. MacRae provided the more persuasive opinion. In comparison, Dr. McLaughlin's opinion is conclusory and lacks any supporting explanation. See Somers v. SAIF, 77 Or App 259 (1986).

Nonetheless, we disagree with the Referee's application of ORS 656.005(7)(a)(A) to the question of compensability. We understand Dr. MacRae to opine that claimant had a latent asymptomatic dry eye condition which preexisted his accidental injury, and that the dry eye condition "combined" with the injury, resulting in the need for treatment. Thus, the appropriate statute for analyzing compensability is ORS 656.005(7)(a)(B). To establish compensability, claimant must show by a preponderance of the evidence that his compensable injury is the major contributing cause of his need for medical treatment.

Based on Dr. MacRae's opinion, we conclude that claimant carried his burden of proof. Dr. MacRae indicated that claimant's dry eye condition became symptomatic as a result of his injury. Inasmuch as these symptoms prompted claimant's need for medical treatment, claimant has proved the compensability of his claim. See U-Haul of Oregon v. Burtis, 120 Or App 353, 358-59 (1993).

Claimant's attorney is entitled to an attorney fee for services at hearing and on review regarding the issue of compensability. 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 is \$3,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the transcript and claimant's appellant's brief), the complexity of the issue and the value of interest involved.

Rate of Scheduled Permanent Disability

We affirm and adopt that portion of the Referee's order concerning this issue. SAIF v. Herron, 114 Or App 64, rev den 315 Or 271 (1992).

ORDER

The Referee's order dated January 6, 1993 is reversed in part and affirmed in part. That portion of the order upholding the SAIF Corporation's denial of claimant's dry eye condition is reversed. SAIF's denial is reversed and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded an assessed fee of \$3,000, to be paid by SAIF, for services at hearing and on review regarding compensability. The remainder of the order is affirmed.

October 14, 1993

Cite as 45 Van Natta 2025 (1993)

In the Matter of the Compensation of
ALLEN G. HALL, Claimant
WCB Case No. 91-10305
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Baker's order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. Alternatively, claimant requests review of that portion of the order that increased his unscheduled permanent disability for a low back condition from 9 percent (28.8 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees). On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his back in July 1990 while working in a plywood plant. On June 6, 1991, the claim closed and claimant was awarded 8 percent unscheduled permanent disability. A July 16, 1991 Order on Reconsideration increased the permanent disability award to 9 percent. In October 1991, claimant sought further treatment from Dr. Erkkila, his treating orthopedic surgeon. Claimant then filed a claim for aggravation.

The Referee concluded that claimant had failed to prove a compensable aggravation because he had not shown "temporary disability [or] increased permanent disability subsequent to reconsideration[.]" We disagree.

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. 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). Finally, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. See ORS 656.273(8).

We agree with claimant that he demonstrated a symptomatic worsening subsequent to claim closure. Dr. Erkkila reported that, when he saw claimant in October 1991, he found increased tenderness and decreased lumbosacral flexion in comparison to claimant's condition in July 1991. He stated that such findings were indicative of at least a transient worsening of claimant's condition. (Ex. 25).

Furthermore, we conclude that claimant proved that his worsened condition resulted in diminished earning capacity. Dr. Erkkila concurred with a May 1991 independent medical examination report prior to the issuance of the June 1991 Notice of Closure, (Ex. 17), and again before the issuance of the July 1991 Order on Reconsideration, (Exs. 19, 20). That report recommended no further treatment, finding that claimant was "physically capable and able to return to employment at the plywood mill" and that a work-hardening program was not necessary since he was in "excellent physical condition[.]" (Ex. 15-4).

Moreover, in August 1991, Dr. Erkkila reiterated that claimant was "stable and stationary" and could "return to his regular work as of the date July 9, 1991." (Ex. 22-1). Dr. Erkkila added that "[a]ny restrictions that I would place on the work capacities' evaluation would be those that would be placed on any individual his size." (Id.)

After examining claimant in October 1991, however, Dr. Erkkila requested that the claim be "reopened for medical treatment", stating that claimant's pain had progressively worsened and that he was unable to "continue in his current form of employment because of the pain." (Ex. 27). Although Dr. Erkkila also stated that he "did not specifically authorize time loss" at that time, he later explained during a deposition that he was of the opinion that claimant was not capable of performing his regular work at the mill and recommended vocational assistance. (Ex. 33-30, 33-20). Dr. Erkkila further stated that claimant was capable of performing his regular work in July 1991 but that he would not have given claimant such a release in October 1991. (Id. at 38, 39-41).

Finally, Dr. Becker, physical medicine and rehabilitation specialist, examined claimant on referral from Dr. Erkkila in April 1992. Dr. Becker recommended that claimant work only in a light duty capacity. (Ex. 28A-5).

Although Dr. Erkkila stated that the release to regular work was only to allow claimant an opportunity to attempt his regular work rather than an indicator of claimant's actual physical capabilities, (Ex. 33-38, 33-48), Dr. Erkkila based such statements on the fact that, when claimant returned to work, he experienced a worsening of his condition, (Id. at 49). As previously discussed, however, prior to the worsening, Dr. Erkkila concurred with the IME report and personally reported that he was stable. We find that such evidence shows that claimant was capable of performing regular work in June and July 1991.

Furthermore, we find that the record sufficiently shows that claimant's physical capabilities were more limited in October 1991 in comparison to his condition in June and July 1991. Finally, we find no evidence that the previous award contemplated a waxing and waning of symptoms of claimant's condition. Consequently, we conclude that claimant proved his claim for aggravation.

Claimant is entitled to an assessed attorney fee for prevailing against the employer's denial. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services at hearing and on review regarding this issue is \$3,750, 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, claimant's appellate briefs and claimant's counsel's statement of services for services on Board review), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated October 22, 1992 is reversed. The employer's denial of claimant's aggravation claim is set aside and the claim is remanded to the self-insured employer for processing. For services at hearing and on review regarding the aggravation claim, claimant's attorney is awarded an assessed fee of \$3,750, to be paid by the self-insured employer.

In the Matter of the Compensation of
MATTHEW J. HILGER, Claimant
WCB Case Nos. 92-10088 & 92-04229
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of those portions of Referee Thy's order that: (1) awarded claimant's counsel an \$1,150 assessed attorney fee for services concerning SAIF's "de facto" denial of claimant's L4-5 and L5-S1 low back condition; and (2) awarded a penalty-related attorney fee for SAIF's allegedly unreasonable claims processing. In his brief, claimant contends his counsel is entitled to an increased attorney fee for services concerning SAIF's "de facto" denial. On review, the issues are 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

Assessed Attorney Fee

We adopt the Referee's conclusions and reasoning concerning the \$1,150 assessed attorney fee.

Penalty-Related Attorney Fee

The Referee awarded a \$500 penalty-related attorney fee for SAIF's allegedly unreasonable claims processing. Although noting that there were no amounts on which to base a penalty (since SAIF had accepted the claim and paid all benefits), the Referee relied on Charles V. Condon, 44 Van Natta 726 (1992) to award the attorney fee.

Subsequent to the Referee's order, the Court of Appeals issued its decision in SAIF v. Condon, 119 Or App 194 (1993). In Charles V. Condon, supra, the Board had awarded an assessed attorney fee pursuant to ORS 656.382(1) finding that, although the carrier had paid all outstanding medical billings, its failure to timely accept or deny the claim constituted unreasonable resistance to the payment of compensation. The court reversed, holding that, as a matter of law, a carrier cannot unreasonably resist the payment of compensation that has already been paid. SAIF v. Condon, supra at 196.

In accordance with the Condon rationale, we reverse the Referee's award of a \$500 penalty-related attorney fee. Id.

Finally, claimant requested an assessed attorney fee for services on review. However, 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 January 12, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which awarded a \$500 penalty-related attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
THOMAS A. HUTCHESON, Claimant
WCB Case No. 91-16385
SECOND ORDER DENYING RECONSIDERATION
W. Todd Westmoreland, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant has requested reconsideration of our October 19, 1992, November 18, 1992, and December 4, 1992 orders. Pursuant to those orders, we reversed a Referee's order which had set aside the insurer's denial of claimant's low back condition. Contending that the Board "misconstrued" the medical opinion of claimant's attending physician, claimant asserts that this misinterpretation has resulted in a recent referee's decision to ignore opinions from the attending physician and a consulting physician concerning whether claimant's compensable condition is medically stationary. Consequently, claimant seeks withdrawal of our prior decisions for reconsideration.

Claimant has previously petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider the Board's order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. See Carole A. Vanlanen, 45 Van Natta 178 (1993); Ronald D. Chaffee, 39 Van Natta 1135 (1987).

In our prior decisions, we found that claimant had failed to establish that his October / December 1990 compensable back injuries were the major contributing cause of his need for medical treatment / disability for his current "resultant" condition. See ORS 656.005(7)(a)(B). We were persuaded by opinions from several independent medical examiners. We declined to rely on the opinion offered by Dr. Nash, claimant's attending physician. We reasoned that Dr. Nash had not offered an opinion explaining the relative contribution to claimant's current condition (diagnosed by Dr. Nash as a herniated disc / nerve root entrapment) from claimant's preexisting degenerative disease, his congenital anomaly, and his compensable injury.

We also denied claimant's motion to remand to the Referee for the introduction of additional evidence. (Dr. Nash's post-hearing surgery report, Dr. Misko's consulting report, Dr. Nash's request for a second surgery, and the insurer's surgery denial). We reasoned that, although the proffered evidence may confirm Dr. Nash's diagnosis of a nerve root entrapment, the evidence continued to lack an explanation regarding the relationship between claimant's compensable injuries and his current condition. In addition, we determined that the evidence concerning claimant's second proposed surgery was not relevant to claimant's disputed condition at the time of hearing regarding this case.

Following our October 19, 1992 order which reinstated the insurer's denial of claimant's treatment for his current low back condition, the insurer issued a November 3, 1992 Notice of Closure. Finding him medically stationary as of December 5, 1991, the notice granted claimant 15 percent unscheduled permanent disability. In December 1992, after issuance of our decisions republishing our prior order and denying claimant's motion for remand, Drs. Nash and Misko each offered opinions concluding that claimant was suffering from a recurrent L4-5 disc, the major contributing cause of which was claimant's work injury.

Thereafter, in response to claimant's request for reconsideration of the closure notice, Dr. Stanford performed a medical arbiter examination. Stanford concluded that any permanent impairment that claimant had suffered was attributable to his preexisting problems and surgery, rather than to his work-related low back strain. A February 1993 Order on Reconsideration reduced the Notice of Closure award from 15 percent to zero. Otherwise, the closure notice was affirmed.

Claimant requested a hearing from the Order on Reconsideration. He contended that his claim was prematurely closed or, alternatively, that he was permanently and totally disabled. The Referee acknowledged that Dr. Nash's opinion supported a conclusion that claimant's condition was not medically stationary. However, the Referee found that opinion unpersuasive because Dr. Nash considered claimant's prior surgery to be related to the compensable injury (a conclusion which was contrary to the Board's prior decisions). Consequently, relying on the opinions of several independent medical examiners, the Referee found that claimant's compensable condition was medically stationary at

the time of claim closure. Finally, in light of Dr. Stanford's opinion concerning the lack of permanent impairment attributable to the compensable injury, the Referee declined claimant's request for permanent total disability.

Asserting that the subsequent opinions from Drs. Nash and Misko "establish beyond doubt that claimant's low back condition was, always has been and remains the result of his compensable back injuries," claimant seeks withdrawal of our prior decisions for reconsideration. Since the subsequent opinions from Dr. Nash and Dr. Misko were generated after our decision, they obviously were not admitted as evidence at the hearing. Consequently, we interpret claimant's request as a motion to remand this case to the Referee for consideration of this additional evidence.

As recited in our prior decision denying claimant's motion to remand, 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). 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).

Here, since the reports from Drs. Nash and Misko were not generated until after the hearing, they were unobtainable at the time of hearing. Nevertheless, we are not persuaded that the substantive matters discussed in those reports (whether claimant's compensable injury was and remained the major contributing cause of his current need for medical treatment/disability) was unobtainable. Finally, as noted in our previous denial of claimant's remand motion, these subsequent opinions also primarily pertain to his "post-hearing" condition and his second surgery request for removal of a recurrent L4-5 disc. In light of such circumstances, and particularly considering the countervailing evidence from the independent medical examiners, we are unable to conclude that it is reasonably likely that the subsequent opinions from Drs. Nash and Misko would affect the outcome of this case.

Based on the foregoing reasoning, claimant's motion for reconsideration and remand is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 545 (1985).

IT IS SO ORDERED.

October 14, 1993

Cite as 45 Van Natta 2029 (1993)

In the Matter of the Compensation of
RYAN D. KIVETT, Claimant
WCB Case No. 92-13026
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Jaime Goldberg (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's claim for his left elbow injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the sentence stating that claimant had no objective findings. We also do not adopt the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant did not prove a compensable industrial injury because there were no objective findings to support his claim, as required by ORS 656.005(7)(a). We disagree.

A "compensable injury" is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. Additionally, the injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a).

In Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992), the Court of Appeals agreed with our analysis of "objective findings" in Suzanne Robertson, 43 Van Natta 1505 (1992), in which we held that findings based on a doctor's objective evaluation of a claimant's subjective complaints are sufficient to constitute "objective findings" pursuant to ORS 656.005(7)(a) and 656.005(19).¹

Here, claimant first reported to Dr. Telford, M.D., that he had been working two jobs and had noted an onset of pain in his left elbow. Dr. Telford diagnosed left elbow strain and prescribed Anaprox. Claimant was released to modified work.

On his Form 827, claimant described the injury as a strain of the left elbow from lifting and carrying heavy loads of lumber. On that same form, Dr. Seymour, M.D., diagnosed left elbow pain, resolved. In a chart note, Dr. Seymour stated that claimant had initially been diagnosed with elbow strain and was told to wear an arm sling for ten days with no work. Dr. Seymour released claimant for work but advised him to continue to take Anaprox only on an "as needed" basis and to stop lifting if he developed elbow pain.

Finally, on November 4, 1992, Dr. Telford reported that, although claimant had no physical deformity and a normal x-ray, all elbow movements "were painful." Dr. Telford stated that, in her opinion, claimant suffered "a strain of his left elbow which was a direct result of an overuse injury sustained during his job (with the employer)."

Under the circumstances, we find that Dr. Telford's report does not merely recite claimant's complaints of pain, but rather, indicates that claimant did, in fact, experience such symptoms. See Norma J. Hodges, 45 Van Natta 1127 (1993) (Doctors all believed the claimant's reports of increased pain and subsequently diagnosed a strain. Such medical reports satisfied the objective findings requirement of ORS 656.005(7)(a)). Consequently, we agree with claimant that he has proven that he incurred a work-related injury which is established by medical evidence supported by objective findings.

Finally, there is no evidence to suggest that claimant's injury occurred outside the course or scope of employment. Furthermore, SAIF has only contested this case on the basis of no "objective findings." Under the circumstances, we conclude that claimant has proven compensability of his left elbow strain. The Referee's order is reversed.

Claimant is entitled to an assessed attorney fee for services at hearing and on review concerning the issue of compensability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$3,500 is a reasonable assessed fee for claimant's counsel's efforts at hearing and on review, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellant and reply briefs and statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated January 15, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of \$3,500, to be paid by SAIF.

¹ Although a signatory to this order, Member Neidig directs the parties to her specially concurring opinion in Todd N. Hellman, 44 Van Natta 1082 (1992).

In the Matter of the Compensation of
JOSEPHINE M. KNIGHT, Claimant
WCB Case No. 92-06409
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Podnar's order that: (1) declined to award additional temporary disability; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees.

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

Following her compensable injury, claimant returned to work for her employer performing modified duties. Inasmuch as claimant's wage for such duties equaled her pre-injury wage, her temporary partial disability benefits were zero. See OAR 436-60-030(2); Robert L. Parrish, 45 Van Natta 1036 (1993). Thereafter, claimant was terminated from her employment for allegedly violating her employer's "confidentiality" rules. When the insurer did not pay temporary disability, claimant requested a hearing.

The Referee found that claimant was terminated from her employment for reasons unrelated to her compensable injury. Since claimant was receiving her pre-injury wage at the time of her termination, the Referee concluded that the insurer properly calculated claimant's temporary partial disability at zero. See Stone v. Whittier Wood Products, 116 Or App 427, 429 (1992); Safeway Stores v. Owsley, 91 Or App 475 (1988).

Claimant does not contest the application of the Owsley/Stone holding to cases where the claimant is terminated for reasons unrelated to the compensable injury. Instead, contending that she was terminated for reasons connected to her compensable injury, claimant asserts her entitlement to temporary disability.

To support her contention, claimant argues that the employer failed to comply with its personnel rules regarding breaches of its "confidentiality" standards. Specifically, she argues that the employer failed to provide a written/verbal warning of an alleged impropriety before her termination. Reasoning that the employer's failure to abide by its personnel policy constitutes a "contrived termination," claimant asserts that the insurer improperly refused to pay temporary disability.

We are not persuaded by claimant's argument. In essence, she is contending that because her termination was unjustified, she must have been terminated for reasons related to her compensable injury. It is well-settled that our statutory authority does not extend to a determination concerning the justification for a worker's termination from employment. See Stone v. Whittier Wood Products, *supra*; Penny N. Kester, 45 Van Natta 1763 (1993). Thus, resolution of that employment dispute rests with another forum. See ORS 659.410.

Moreover, even if we were authorized to determine the legality of the procedures surrounding claimant's termination and even if we found her termination to have been unjustified, such a determination would not lead to a conclusion that she was terminated for a reason related to her compensable injury. In other words, an unjustified termination does not automatically mean that a claimant's discharge was due to a compensable injury. Here, other than a bald accusation that her termination was "contrived," claimant offers no persuasive evidence which would lead us to a conclusion that she was discharged because of her compensable injury.¹ In light of such circumstances, claimant has not established her entitlement to temporary disability.

ORDER

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

¹ Although member Gunn is sympathetic to claimant's assertions, the record is un rebutted that the supervisor terminated, in less than a year, 20 to 30 employees, giving a whole new meaning to the term "at will" employment.

In the Matter of the Compensation of
JAMES R. MORSE, Claimant
WCB Case No. 92-10119
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Gruber's order that: (1) upheld the insurer's partial denial of claimant's current psychiatric condition as a consequence of his compensable low back injury; and (2) upheld the insurer's denial of claimant's aggravation claim for a low back condition. On review, the issues are compensability and aggravation.

We affirm and adopt the Referee's order, with the following comments concerning the compensability issue.

On review, claimant contends that the Referee should have relied on the "clear" opinions of neurologist Lockfeld and psychotherapist Lechnyr, over the conclusory opinion of psychiatrist Turco. To begin, claimant argues that Lockfeld offered more than a qualified opinion regarding the causation of claimant's conversion disorder. Claimant is correct. Although Lockfeld initially noted only that claimant's conversion disorder "may be related" to his compensable back injury, he later opined that claimant's condition is related to the stress of the compensable injury, disc herniation, and lumbar surgery. However, Dr. Lockfeld's opinion was based largely upon a lack of any preexisting psychiatric disease or prior conversion reactions. Such a causation analysis is not sufficient to prove compensability. ORS 656.266. See Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977). Moreover, Dr. Lockfeld himself noted that he was "not the best qualified individual to assess the psychiatric or psychological aspects" of the claim, and recommended that claimant be referred to a psychiatrist for evaluation.

Claimant also asserts that the Referee's "dismissal" of Dr. Lechnyr's "check-the-box" report was inappropriate. We agree with the Referee that Dr. Lechnyr's opinion is not supported by any underlying reasoning, nor does it contain any indication that the doctor has any knowledge of claimant's other nonwork-related stressors. See Kenneth C. Snow, 39 Van Natta 743 (1987) ("check-the-box" opinions generally are not persuasive). In fact, in an earlier report, Dr. Lechnyr explained that he did not wish to join the debate over whether claimant's conversion reaction was caused by his marital difficulties or the compensable injury. Rather, he believed it better to focus on rehabilitation and restoring claimant's ability to function.

Finally, as did the Referee, we find that Dr. Turco had the most thorough understanding of claimant's multiple stressors and carefully weighed the injury and noninjury-related factors in reaching his conclusion. Therefore, we find his opinion to be the most persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

ORDER

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

In the Matter of the Compensation of
ROBERT H. PARRISH, Claimant
WCB Case No. 92-11108
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of those portions of Referee Livesley's order that: (1) found that the temporary total disability issue had been withdrawn at hearing; (2) affirmed the August 20, 1992 Determination award of temporary total disability benefits; and (3) set aside the August 26, 1992 Determination Order as procedurally invalid. Claimant cross-requests review of that portion of the Referee's order that declined to award claimant's counsel an attorney fee payable out of temporary total disability benefits. On review, the issues are the procedural validity of a corrective determination order, temporary total disability 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

Validity of August 26, 1992 Determination Order

We affirm and adopt the Referee's order insofar as it found that the August 26, 1992 Determination Order was procedurally invalid. Like the Referee, we find that the August 26, 1992 Determination Order was invalid because it did not issue prior to claimant's filing of his hearing request on the August 20, 1992 Determination Order.¹ See former OAR 436-30-008(1) (effective prior to July 1, 1990).

Temporary Total Disability

The Referee concluded that claimant had withdrawn the issue of his substantive entitlement to temporary total disability benefits awarded by the August 20, 1992 Determination Order. We disagree.

The August 20, 1992 Determination Order awarded, among other benefits, temporary total disability benefits from July 1, 1991 through August 4, 1992. Claimant timely filed a hearing request from that order, challenging its award of temporary total disability. Subsequently, on August 26, 1992, the Department issued a second Determination Order which "corrected" the August 20 order by terminating the award of temporary total disability benefits as of June 30, 1992. Claimant filed a supplemental hearing request to contest the August 26 Determination Order. Thereafter, SAIF responded that the temporary total disability award should be affirmed.

The parties declined to present testimony and, instead, agreed to have the case decided on the written record. In closing argument, claimant contended that the August 26 Determination Order was invalid and that the temporary total disability awarded by the August 20 Determination Order should not be disturbed. In response, SAIF argued that the August 26 Determination Order should be affirmed.

We find no evidence in the record that claimant withdrew the temporary total disability issue. On the contrary, we find that the issue of claimant's substantive entitlement to temporary total disability benefits was litigated by the parties. The issue was generally framed in terms of whether or not the August 26 Determination Order was validly issued. Claimant argued that he was entitled to temporary total disability benefits through August 4, 1992, because the August 26 Determination Order was invalidly issued. SAIF, on the other hand, argued that the August 26, 1992 Determination Order validly terminated claimant's entitlement to temporary total disability benefits as of June 30, 1992. Hence, claimant's entitlement to temporary total disability benefits remained in dispute and was not withdrawn as an issue at hearing.

On the merits, we find that claimant's authorized training program was completed as of June 30, 1992. (Ex. 11). Therefore, claimant was is not entitled to receive temporary total disability benefits

¹ Because claimant became medically stationary before July 1, 1990, he was not required to seek a reconsideration order prior to requesting a hearing concerning the Determination Order. See Or Laws 1990 (Special Session), ch 2, §54(3).

beyond that date. See OAR 436-120-230(2). We modify the August 20, 1992 Determination Order accordingly.

Given our conclusion that claimant is not entitled to temporary total disability benefits beyond June 30, 1992, we need not address the attorney fee issue.

ORDER

The Referee's order dated January 15, 1993 is modified in part and affirmed in part. The August 20, 1992 Determination Order is modified to award temporary total disability benefits from July 1, 1991 through June 30, 1992. The remainder of the Referee's order is affirmed.

October 14, 1993

Cite as 45 Van Natta 2034 (1993)

In the Matter of the Compensation of
LEWIS E. TAYLOR, Deceased, Claimant
 WCB Case No. 90-21558
ORDER ON REVIEW
 Karen M. Werner, Claimant Attorney
 Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant's beneficiary requests review of Referee McWilliams' order that upheld the SAIF Corporation's denial of her claim for death benefits. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Reasoning," with the exception of the last three paragraphs in that section. In place of that portion of the Referee's order, we substitute the following supplementation.

On review, claimant's beneficiary (hereafter, "claimant" refers to both the worker and his beneficiary) contends that the myocardial infarction was caused by work-related stress. In SAIF v. Hukari, 113 Or App 475 (1992), the court held that any claim that a condition is independently compensable because it was caused by on-the-job stress, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802. Accordingly, claimant must prove that employment conditions were the major contributing cause of the infarction.

Claimant contends that Dr. Cookson's medical opinion establishes that work was the major cause of the infarction. We disagree. At hearing, Dr. Cookson testified that, if the union meeting attended by claimant had been stressful, the stress would have been the major cause of claimant's infarction. However, Dr. Cookson was unable to state how much stress it would take for an individual such as claimant to increase his adrenaline or blood pressure to a significant level. Additionally, Dr. Cookson testified that if the meeting had gone well and had not triggered a fight/flight mechanism, the major cause of claimant's condition would be due to an obstruction of the blood vessel on some other basis, such as a thrombosis or clot formation.

After reviewing the record and the witness' testimony regarding the union meeting, we are unable to conclude that Dr. Cookson's opinion supports claimant's contention that work stress was the major cause of the infarction. The witnesses all testified that although claimant was serious or business-like during the meeting, there was no yelling, raised voices or heated discussion. Furthermore, once informed that claimant had smoked a cigarette on his break immediately before the heart attack, Dr. Cookson agreed that, if the meeting was not stressful, another factor would have caused the coronary artery spasm to have occurred, and nicotine was "well known" to do that.

Under the circumstances, we conclude that claimant has not shown that work was the major cause of the myocardial infarction. We, therefore, affirm the Referee's order.

ORDER

The Referee's order dated December 7, 1992 is affirmed.

In the Matter of the Compensation of
ERWIN F. HALL, Claimant
WCB Case No. 92-14104
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

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

FINDINGS OF FACT

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

We find that the September 21, 1992 work incident was a material contributing cause of his disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that on September 21, 1992, claimant felt immediate and severe low back pain while turning a crane at work. The Referee also found that a low back injury was established by medical evidence supported by objective findings. However, because there was no medical opinion establishing a causal relationship to the work incident, the Referee concluded that the injury claim is not compensable. We reverse.

In order to establish a compensable injury claim, claimant must prove that a work-related injury was a material contributing cause of his disability or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). If claimant's injury is of such a nature as to require skilled and professional persons to establish causation, expert medical evidence is necessary to meet his burden of proof. See Madewell v. Salvation Army, 49 Or App 713, 717 (1980).

On review, claimant contends that the causation issue is not complex and, therefore, should not require expert medical evidence to resolve it. We agree. In determining whether expert medical evidence of causation is required, we consider the following factors: (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 evidence that the alleged precipitating event could not have been the cause of the injury. Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

Here, we agree with and adopt the Referee's finding that claimant was a credible and reliable witness. Based on his credible testimony, we do not find that the causation issue in this case is complicated. Claimant testified that when he turned the crane at work, he immediately felt a shooting pain from his low back to the foot of his right leg. (Tr. 15). Although he continued to work and did not promptly report the occurrence to his supervisor, he explained that he assumed the pain would "go away," as it had done after previous back sprains. (Tr. 17). He added that he does not like to see doctors and does not like complaining. (Id.) When the pain persisted, however, he reported it to the employer and filed his claim. (Ex. 2).

Further, claimant testified that, although he previously experienced back sprains, he had never felt shooting pain to his feet and had not sought treatment for the sprains. (Tr. 25). Finally, there is no expert medical evidence that the September 21, 1992 incident could not have been the cause of his injury. For these reasons, we do not find that the causation issue in this case must be determined by expert medical evidence. See Uris v. Compensation Department, *supra*; Barnett v. SAIF, *supra*. Rather, we rely on claimant's credible testimony in finding that the September 21, 1992 incident was a material contributing cause of his disability and need for treatment. We also adopt the Referee's conclusion that the claimant's injury was established by medical evidence supported by objective findings.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$3,000, to be paid by the insurer. In reaching this conclusion, we have considered the time devoted to the case (as represented by claimant's appellate brief, claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved. In particular, we have considered the fact that, among the documents submitted by claimant's counsel, there was no medical report attributing claimant's injury to his employment.

ORDER

The Referee's order dated January 29, 1993 is reversed. The insurer's denial of claimant's low back injury claim is set aside, and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded \$3,000 for services at hearing and on Board review, to be paid by the insurer.

October 18, 1993

Cite as 45 Van Natta 2036 (1993)

In the Matter of the Compensation of
ROBERT P. HOLLOWAY, SR., Claimant
WCB Case No. 92-05993
ORDER ON REVIEW
Tooze, Shenker, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) dismissed claimant's hearing request for lack of jurisdiction over claimant's claim for home health care services following the July 9, 1991 surgery; (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable conduct in failing to process the claim; and (3) declined to award an attorney fee under ORS 656.386(1) for prevailing over a denied claim. On review, the issues are jurisdiction, medical services, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

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

On June 20, 1991, claimant submitted to SAIF a copy of Dr. Butters' June 17, 1991 recommendation for home health care following claimant's July 9, 1991 surgery. (Ex. 65) According to claimant's July 12, 1991 hospital discharge summary, Dr. Butters assumed that home health care would be provided on a daily basis. (Ex. 47C). SAIF received a copy of the discharge summary, as well as was notified by phone of claimant's home health care request. According to a July 12, 1991 phone record, SAIF did not authorize claimant's home health care. (Ex. 49).

SAIF did not issue a formal acceptance or denial of claimant's home health care within 90 days after it received notice of the claim.

Neither the parties nor the Director requested Director review of the claim for home health care pursuant to ORS 656.327(1).

CONCLUSIONS OF LAW AND OPINION

Preliminary matters

As a preliminary matter, we find the issue of medical services has been raised on Board review. In his brief, claimant states, "[f]or purposes of this appeal, claimant does not dispute the Board's opinions in Panek, Hadley, and Stanley Meyers, 43 Van Natta 2643 (1991)," which addressed the issue of jurisdiction over medical services. Further, claimant's brief did not address the compensability issue. Nonetheless, the issue is raised in claimant's March 3, 1993 request for Board review, as well as

claimant's appellant's brief under specification of issues, "1. Did the referee err in granting the SAIF's motion to dismiss for lack of jurisdiction." Moreover, the conclusion portion of the brief asks the Board to "enter an Order finding (1) the Hearings Division has jurisdiction to hear this matter..." (See claimant's appellate's brief pages 1 & 6). Finally, jurisdictional issues are not dependent on whether a party has raised the issue. See Southwest Forest Industries v. Anders, 299 Or 205 (1985).

Jurisdiction

The Referee found that the compensability of claimant's home health care was a medical services dispute which is properly resolved by the proceeding contemplated by ORS 656.327(1). The Referee concluded that the Hearings Division lacked jurisdiction over this medical services dispute. In so holding, the Referee relied on Mark L. Hadley, 44 Van Natta 690 (1992) and Pamela J. Panek, 44 Van Natta 1625 (1992). These decisions, in turn, relied on our decision in Stanley Meyers, 43 Van Natta 2643 (1991).

In Meyers, the claimant filed a claim for chiropractic treatment in excess of two visits per month. The claim was denied by the insurer and the claimant requested a hearing. The Referee found the denial procedurally improper under ORS 656.327(1) in that the insurer was required to request Director review and set aside the denial. The claimant requested Board review. On Board review we held that under ORS 656.704(3), "matters concerning a claim" over which the Hearings Division has original jurisdiction, do not include any dispute regarding medical treatment that is challenged on one of the grounds listed in ORS 656.327(1), i.e., "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services." We reasoned that the 1990 amendments to 656.704(3) made review of treatment disputes by the Director a mandatory rather than discretionary procedure.

The court has recently reversed our decision in Meyers. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). The court held that the 1990 amendments to ORS 656.327(1) does not require the parties or the Director to invoke the Director review process. The court reasoned that the 1990 amendments left untouched the parties' discretion to request Director review and to argue the claimant's entitlement to compensation for medical services before the Board. Relying on ORS 656.327(1), the court determined that if a party or the Director "wishes review of the treatment by the director," and gives notice, the statute provides the procedure for a proceeding, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. Without a "wish" for Director review and a notice filed with the Director, the court further concluded that there is no "proceeding" before the Director. Reasoning that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create the jurisdiction occur, the court held that those conditions did not occur in Stanley Meyers. Accordingly, the court found that the medical treatment dispute remained within the Board's jurisdiction. Relying on Meyers, the court has also reversed our decisions in Hadley and Panek. Hadley v. Silverton Forest Products, 123 Or App 629 (1993); Panek v. Oregon Health Sciences University, 123 Or App 623 (1991).

Here, there is no evidence that either the parties or the Director "wished" for Director review or filed notice with the Director for such a review. Instead, claimant filed a request for hearing from SAIF's "de facto" denial of his home health care claim. Under such circumstances, we conclude that the Director did not have exclusive jurisdiction over this matter and that the Referee was authorized to consider the dispute. See Meyers v. Darigold, Inc., *supra*.

Inasmuch as exhibits were admitted and testimony taken at the hearing, we consider the record to be fully developed. Consequently, remand is unnecessary and we proceed to the merits of the claim. (See Tr. 4-5).

Medical services

Claimant asserts entitlement to home health care services under ORS 656.245(1). Previously we have held that such services are "other related" medical services for purposes of the statute. See James M. Frear, 40 Van Natta 1988 (1988); Albert Huntley, 39 Van Natta 120 (1987); William H. Brown, 38 Van Natta 1466 (1986). We have also held, however, that "housekeeping services" do not fall within the definition of ORS 656.245(1). See Maxine V. McInnis, 42 Van Natta 81 (1990) (Relying on the court's decision in Lorenzen v. SAIF, 79 Or App 751 (1986) that held child care services were not "other related services" within the meaning of the statute).

After considering the evidence, we conclude that the services at issue here transcend mere housekeeping tasks. The services requested by claimant's attending physician and surgeon were expressly intended to assist claimant in his recovery from surgery. The services were to consist of CNA services similar to the type claimant had previously received in 1990 and included assisting him with personal hygiene, housekeeping, changing bandages, taking medication, use of physical therapy/mobility devices, and transporting claimant to medical appointments. (See Exs. 47C, 59-64, see also 58a). We find these services are properly considered "other related" medical services pursuant to ORS 656.245(1). See also OAR 436-10-040(3)(a).

It is claimant's burden to prove that the home health care he seeks are for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires. See ORS 656.245(1)(a); OAR 436-10-040(1)(a); Roseburg Forest Products v. Ferguson, 117 Or App 601 (1993). It was the medical opinion of the treating physician and surgeon, Dr. Butters, that after the July 9, 1991 surgery claimant would require home health care. Dr. Butters indicated this need for medical services both prior to and after the July 9, 1991 surgery.

In contrast, it was the opinion of SAIF's nurse consultant, Ms. Freadman, that home health care was not necessary. Her opinion was based on telephone conversations which took place following surgery with a social worker, physical therapist, and another nurse consultant. (Tr. 67). She did not, however, seek out the opinion of Dr. Butters.

In weighing the respective medical opinions we give more weight to the opinion of Dr. Butters. As the attending physician and surgeon he was in the best position to evaluate the need for care following surgery. See Weiland v. SAIF, 64 Or App 610 (1982). In addition, we are impressed by the fact that the nurse consultant did not have the benefit of Dr. Butters' opinion in forming her own opinion that home health care was not necessary. We also find claimant's credible testimony supportive of a need for home health care.

Based on this evidence we find that claimant has carried his burden of proof establishing that the home health care was necessary and appropriate medical services resulting from the compensable injury and surgery. We find the claim compensable.

Penalties and attorney fees

Claimant also asserts that SAIF's failure to accept, deny, or request Director review of the claim for home health care services was unreasonable claim processing for which SAIF should be assessed penalties and/or attorney fees. We consider SAIF's conduct to have been unreasonable. However, since there are no unpaid bills for such services in the record, there are no "amounts then due" on which to assess a penalty. Although a penalty is not appropriate under these circumstances, we award an attorney fee for SAIF's unreasonable resistance to claimant's attending physician's clear request for compensation. We base our conclusions on the following reasoning.

If the insurer or employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or employer shall be liable for an additional amount up to 25 percent of the amounts then due. ORS 656.262(10). ORS 656.382(1) allows for an assessed attorney fee for an unreasonable resistance to the payment of compensation provided there are no amounts then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10). See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Prior to the compensable neck surgery, claimant's attending physician and surgeon, Dr. Butters, sent claimant a letter indicating the need for home health care services after surgery. (Ex. 46). Claimant notified the responsible claim adjuster by telephone of the need for medical services. In addition, on June 20, 1991, claimant sent to the claim adjuster a copy of Dr. Butters' June 17, 1991 letter. (Exs. 46, 65). The testimonial evidence indicates this letter was received by SAIF on June 24, 1991. (See Tr. 19, 59). After the July 9, 1991 surgery, Dr. Butters reiterated on the hospital discharge summary the need for home care. (Ex. 47C). SAIF was in receipt of this document as well. Shortly thereafter, it was decided by SAIF to deny these services. Based on this evidence we find that SAIF was provided notice of a claim for medical services. See ORS 656.005(6); 656.245(1).

Written notice of acceptance or denial of a claim shall be furnished to claimant by the insurer or employer within 90 days after the insurer or employer has notice or knowledge of the claim. ORS 656.262(6). In the event that the volunteer home care had already begun, SAIF also had the option to request Director review pursuant to ORS 656.327(1). See Meyers v. Darigold, Inc., *supra*; Jefferson v. Sam's Cafe, 123 Or App 464 (1993). Thus, SAIF was required to accept or deny the claim within 90 days of receipt of the claim or to file notice that it was requesting Director review. In this case neither of these claims processing actions were accomplished. Therefore, we find the claim was "de facto" denied and SAIF's claims processing unreasonable.¹ See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992); Barr v. EBI Companies, 88 Or App 132 (1987).

This order has found that claimant's home health care constitutes compensable medical services. Therefore, we find that SAIF has unreasonably resisted the payment of compensation. The issue now becomes whether there are any "amounts then due" upon which to base a penalty under ORS 656.262(10). Here, although a claim was made, no bill or expense voucher was submitted to SAIF for home health care. Claimant testified that instead of professional assistance he relied upon his friends to help him out while he recovered from the surgery. Since claimant apparently received volunteer services, there are no "amounts then due" upon which to base a penalty.

Despite claimant's fortunate receipt of amateur assistance, the fact remains that his treating physician had requested professional home health care services from a specific provider. Considering such circumstances, we find that SAIF's refusal to timely respond to claimant's physician's request constitutes unreasonable resistance to the payment of compensation. See ORS 656.382(1).

Where there has been an unreasonable resistance to the payment of compensation, but there are no amounts then due upon which to base a penalty and the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10), claimant is entitled to an assessed attorney fee under ORS 656.382(1). See Martinez v. Dallas Nursing Home, *supra*.

After considering claimant's counsel's statement of services as well as 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 concerning the unreasonable conduct issue is \$750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Assessed attorney fee

Claimant is entitled to an assessed attorney fee under ORS 656.386(1). After considering claimant's counsel's statement of services as well as 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 for prevailing over the "de facto" denial is \$3,250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearings record, claimant's appellate briefs, and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated February 25, 1993 is reversed. SAIF's "de facto" denial is set aside and the claim for home health care is remanded to SAIF for processing in accordance with law. Claimant is awarded an assessed attorney fee of \$750 for SAIF's unreasonable resistance to the payment of compensation pursuant to ORS 656.382(1), payable by SAIF. For services at hearing and on review concerning the "de facto" denial, claimant's counsel is awarded an assessed attorney fee of \$3,250, payable by SAIF.

¹ In so finding we are mindful of the fact that at the time these claim processing decisions were made, our decision in Stanley Meyers had issued which held that in matters involving medical services challenged on one of the grounds listed in ORS 656.327(1), i.e., "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services," the Director had exclusive jurisdiction. However, in Meyers we also stated that under similar circumstances failure to pay the bills or initiate Director review will, by that fact alone, ordinarily constitute unreasonable resistance for which penalties or fees would be assessed. Stanley Meyers, *supra* at 2646.

In the Matter of the Compensation of
VICTOR D. LOPEZ, Claimant
WCB Case No. 92-13176
ORDER ON REVIEW
Max Rae, Claimant Attorney
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Garayenta's order that dismissed claimant's request for hearing concerning an aggravation denial as untimely. On review, the issue is dismissal.

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

Claimant's citation to Dennis S. Jacobsen, 43 Van Natta 439, 441 (1991), for the proposition that a carrier cannot deny benefits under ORS 656.325(2), but only seek the Director's approval to suspend, is inapposite. In Jacobsen the issue was the compensability of the claim, not, as here, whether a request for hearing on a denial was made timely. Furthermore, a "good cause" argument, which appears to be raised by the discussion of claimant's language difficulties, is not valid after passage of the 180 day period allowed to request a hearing pursuant to ORS 656.319(1). Wright v. Bekins Moving and Storage Co., 97 Or App 45 (1989).

ORDER

The Referee's order dated January 11, 1993 is affirmed.

October 18, 1993

Cite as 45 Van Natta 2040 (1993)

In the Matter of the Compensation of
ELMER L. WILLE, Claimant
WCB Case No. 92-04816
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

The SAIF Corporation requests review of that portion of Referee Barber's order that set aside its denial of claimant's claim for a low back condition. Claimant cross-requests review of that portion of the order that declined to assess a penalty or related attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are compensability, 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 current low back condition is compensably related to the accepted 1986 injury. He analyzed claimant's low back condition in two parts: (1) the L5-S1 level; and (2) L4-5 level. Regarding the L5-S1 condition, he found that, although SAIF's acceptance purported to accept only a low back sprain/strain in 1986, its subsequent processing of the claim and payment of compensation constituted an acceptance of the current L5-S1 condition. We disagree with that portion of the Referee's opinion.

By Notice of Claim Acceptance dated December 5, 1986, SAIF specifically accepted claimant's claim for a "low back sprain/strain." (Ex. 5). Subsequently, in July 1987, Dr. Misko surgically removed the L5-S1 disc, left, with decompression of the L5 and S1 roots, and exploration of L4-5. (Ex. 15). SAIF

paid for that surgery, as well as related diagnostic procedures. The claim was closed by Determination Order in August 1988 with awards of 31 percent unscheduled permanent disability for the low back and 10 percent scheduled permanent disability for the loss of use or function of the left foot. (Ex. 29). Pursuant to a February 1989 Stipulation, SAIF agreed to pay claimant an additional 10 percent unscheduled permanent disability for the low back. (Ex. 30).

Unlike the Referee, we do not regard SAIF's voluntary payment of medical benefits and permanent disability benefits as an acceptance of claimant's current condition. ORS 656.262(9) provides that "[m]erely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability." Further, the Supreme Court has held that the scope of a claim acceptance encompasses only those conditions "specifically" or "officially" accepted by the insurer. Johnson v. Spectra Physics, 303 Or 49, 55 (1987). Here, SAIF has not specifically or officially accepted claimant's current low back condition; it has accepted only a sprain/strain.

Nevertheless, we agree with the Referee's conclusion that the current low back condition is compensably related to the accepted 1986 injury. Claimant has degenerative disc disease which preexisted the 1986 injury. He also had previous back surgery in 1979 for laminectomy and discectomy at L4-5. (See Ex. 47-8). We find that those preexisting conditions combined with the 1986 back strain to cause claimant's current condition and need for treatment. Therefore, claimant must prove that the 1986 injury is the major contributing cause of claimant's current resultant disability or need for medical treatment. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993).

We adopt the Referee's analysis of the medical evidence. He correctly relied on the better-reasoned opinion of Dr. Misko, claimant's treating neurosurgeon, who stated that the "current requirement for treatment is more than 50 percent due to his injury in 1986." (Exs. 35, 44). Because Dr. Misko performed the 1987 surgery, we are persuaded that he had a better opportunity to evaluate the nature and causation of claimant's condition. By contrast, the independent medical examiners, Drs. Gambee, Reimer, Tesar and Englander, saw claimant only once before issuing their opinions. (See Exs. 39, 47).

Dr. Misko explained that the 1986 injury caused the two-level laminectomy (in 1987) which caused the collapse of the interspaces with severe foraminal stenosis. (Ex. 44). Dr. Misko's opinion is consistent with the medical record, which shows that, whereas claimant recovered from the 1979 surgery and was able to work until the 1986 injury, he has had chronic pain with occasional exacerbations since the 1987 surgery. (See Exs. 9, 18-3, 31, 32). Based on Dr. Misko's opinion, therefore, we conclude that claimant has proved by a preponderance of the evidence that the accepted 1986 injury is the major contributing cause of the current condition.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$1,200, 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 January 19, 1993 is affirmed. Claimant's attorney is awarded \$1,200 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MARC D. PETSCHÉ, Claimant
WCB Case No. 92-13927
ORDER ON REVIEW
Galton, Scott & Colett, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Neal's order that: (1) admitted a medical report submitted by the self-insured employer; (2) upheld the employer's denial of claimant's herniated disc; and (3) declined to award a penalty and related attorney fee for an allegedly unreasonable denial. On review, the issues are evidence, compensability, and penalties. We affirm.

FINDINGS OF FACT

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

At hearing, the employer submitted Exhibit 22, a letter drafted by the employer's attorney summarizing a conversation between Dr. Coit, a physician at Good Samaritan Hospital in Portland, and counsel, with Dr. Coit's signature indicating his concurrence with the contents of the letter. The Referee admitted the document, subject to allowing claimant an opportunity to cross-examine Dr. Coit. (Tr. 7). At the end of hearing, the Referee offered to leave the record open to depose Dr. Coit. (Id. at 36-37). Claimant's attorney declined, stating that he would not depose Dr. Coit. (Id. at 37).

CONCLUSIONS OF LAW AND OPINION

Evidence

Relying on Harold T. Bird, 43 Van Natta 1732 (1991); aff'd mem Bird v. Bohemia, Inc., 113 Or App 233 (1992); claimant first asserts that the Referee abused her discretion in admitting Exhibit 22 because Dr. Coit neither examined nor treated claimant.

In Harold T. Bird, supra, the Board considered the admissibility of a medical report from an out-of-state expert who neither treated nor examined the claimant. Pursuant to ORS 656.310(2), the Board found the report inadmissible. The Board later clarified the holding in Bird as providing that medical or surgical reports are admissible under ORS 656.310(2) as long as the physician rendering the report consents to submit to cross-examination. Melvin O. Roberts, 43 Van Natta 2771 (1991), on recon 44 Van Natta 33 (1992). In Roberts, the Board found that a letter prepared by the insurer's counsel and signed by a physician was admissible under ORS 656.310(2) in view of the fact that claimant's attorney declined the opportunity to cross-examine the physician.

We further clarify the holding in Bird. ORS 656.310(2) provides that the:

"contents of medical, surgical and hospital reports shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination. This subsection shall also apply to medical or surgical reports from any treating or examining doctor who is not a resident of Oregon, provided that the [parties] shall have a reasonable time * * * to cross-examine such doctor by deposition or by written interrogatories to be settled by the referee."

First, we find that Exhibit 22 constitutes a "medical report" under ORS 656.310(2). See Harold T. Bird, supra; Melvin O. Roberts, supra. In Bird, however, the disputed document was drafted by an out-of-state expert. Thus, it fell under the latter portion of the statute. In contrast, there is no proof that Dr. Coit is not a resident of Oregon. Therefore, the first part of the statute is applicable. That portion provides that a medical report from a self-insured employer constitutes prima facie evidence of the matter contained therein if the doctor consents to submit to cross-examination. The relevant provision does not require examination or treatment by the doctor.

Consequently, we find no merit to claimant's assertion that Exhibit 22 is not admissible because Dr. Coit neither treated nor examined claimant. Rather, we find that ORS 656.310(2) was satisfied because claimant was provided an opportunity to cross-examine Dr. Coit but declined to do so. See Melvin O. Roberts, supra.

Claimant also objects to Exhibit 22 on the basis that it does not conform with OAR 438-07-005(2). That rule provides that, "[t]o avoid unnecessary delay and expense," medical evidence "should include" certain information, including history, symptoms, impairment, and treatment. We first note that, because the rule uses the term "should," there is no requirement that medical reports contain the outlined information in order to be admissible. Therefore, although the inclusion of such information in the report is preferable, its absence is not fatal to its admissibility as evidence. See OAR 438-07-005(2).

Claimant further asserts that the report was not admissible because there was no proof of its authenticity, and it contained double hearsay and was "leading" in that it was drafted by the employer's counsel.

Under ORS 656.310(2), medical reports establish prima facie evidence of medical matters. Zurita v. Canby Nursery, 115 Or App 330, 334 (1992). Having found above that Exhibit 22 constitutes a "medical report" under the statute, it was not necessary for the employer to lay a foundation before it was admissible. Furthermore, even if the report did not fall under ORS 656.310(2), the report was admissible pursuant to ORS 656.283(7). See Zurita v. Canby Nursery, supra.

In short, we find that the Referee did not abuse her discretion in admitting Exhibit 22. See ORS 656.283(7); Brown v. SAIF, 51 Or App 389 (1981).

Compensability

In December 1990, the employer accepted a claim for a lumbar strain and the claim closed in April 1991. In August 1992, claimant's low back pain exacerbated. A MRI revealed a disc herniation at L4-5 on the right and L5-S1 on the left. Claimant seeks compensation for treatment of his herniated disc.

The Referee stated that claimant was required to show that the industrial injury was a material contributing cause of his herniated disc as well as a worsened condition since claim closure. Claimant disagrees with the Referee's characterization of the claim as one for aggravation. We need not resolve that question because even if claimant did not initiate an aggravation claim, we agree with and adopt the Referee's conclusion that claimant did not prove that his herniated disc was causally related to his December 1990 compensable lumbar strain.

Penalties

We affirm and adopt that portion of the Referee's order regarding this issue.

ORDER

The Referee's order dated January 29, 1993 is affirmed.

In the Matter of the Compensation of
HOWARD L. BURTIS, Claimant
WCB Case No. 92-09576
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer requests review of Referee Galton's order that found that it could not stay payment of temporary and permanent disability awarded by a Determination Order pending its appeal of a prior Referee's compensability decision. On review, the issue is claim processing. We reverse.

FINDINGS OF FACT

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

On May 19, 1993, the Court of Appeals affirmed the Board's order, which affirmed Referee Hoguet's order that set aside the insurer's denial of claimant's cervical arthritic condition and need for current treatment. U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

CONCLUSIONS OF LAW AND OPINION

In a prior proceeding, Referee Hoguet set aside the insurer's denial of claimant's current condition and need for treatment and disability. Pending its appeal of the Referee's order, the insurer processed the claim to closure. A June 17, 1992 Determination Order awarded temporary disability and unscheduled permanent disability. The insurer requested reconsideration to "preserve" its stay pending appeal of the underlying compensability decision. It did not pay the temporary or permanent disability compensation awarded by the Determination Order. Claimant also requested reconsideration of the June 1992 Determination Order. An Order on Reconsideration issued on September 25, 1992 awarding additional scheduled permanent disability.

The insurer requested a hearing, continuing to stay the payment of the temporary and permanent disability awards. The insurer alleged that it was not obligated to pay the temporary and permanent disability awarded by the Determination Order. Claimant objected to the insurer's conduct. In addition to seeking payment of the aforementioned benefits, claimant requested an attorney fee award.

The Referee held that the insurer was obligated to pay the temporary and permanent disability awards granted by the Determination Order. We disagree.

Subsequent to the Referee's order, we held, in Felipe A. Rocha, 45 Van Natta 47 (1993), that pending a carrier's appeal of a compensability determination, ORS 656.313(1)(a) authorizes the carrier to stay the payment of temporary disability benefits which accrued prior to the Referee's order. In reaching our conclusion, we reasoned that ORS 656.313 still envisioned the processing of claims pending appeal of an order finding a claim compensable. We determined that ORS 656.313(1) specifically continued to authorize the stay of compensation awarded by a subsequent closure order, although the statute did not authorize a stay of compensation pending the request for reconsideration of the closure order. We, however, concluded that the stay of compensation occasioned by a carrier's appeal of the "compensability" decision would extend to subsequently ordered compensation and that a carrier would not be required to appeal the subsequent closure to "preserve" the previously acquired stay of compensation. Id. at 49-50. The court in Diamond Fruit Growers v. Goss, 120 Or App 390 (1993), agreed, holding that an employer need not seek review of a determination order issued during the pendency of the appeal in order to preserve the stay under ORS 656.313. Id. at 393-394.

In Dale E. Holden, 45 Van Natta 354 (1993) (also issued subsequent to the Referee's order), the employer stayed payment of the compensation awarded by a Notice of Closure and an Order on Reconsideration pending its appeal of a prior referee's compensability decision. We applied our holding in Rocha and held that a carrier was entitled to stay payment of the permanent disability award, because

"[t]o do otherwise would nullify the employer's entitlement to stay compensation pursuant to [ORS 656.313(1)(a)]." Id. Thus, under ORS 656.313, the insurer's appeal of Referee Hoguet's order on the underlying compensability issue stayed the payment of benefits awarded by the Determination Order. SAIF Corporation v. Vanlanen, 120 Or App 613 (1993) (citing Diamond Fruit Growers v. Goss, supra).

Although the court's decision in Sisters of Providence v. East, 122 Or App 366 (1993), lends support to the Referee's analysis regarding the payment of permanent disability benefits, we find East distinguishable. The court in East held that the employer could not stay payment of permanent disability benefits pending an order on reconsideration. The court reasoned that OAR 436-60-150(6)¹ applied to the period before an order on reconsideration issued, whereas ORS 656.313(1) applied after the order on reconsideration issued. Consequently, the court concluded that the employer was required to pay the permanent disability benefits within 30 days of the date of the determination order.

Here, as in East, the issue pertains to a carrier's refusal to pay compensation awarded by a determination order pending appeal of that award. Nevertheless, in contrast to East, the present case involves a previously acquired stay of compensation from a pending appeal of the underlying compensability decision. In light of such circumstances, ORS 656.313(1), as interpreted by the Goss and Vanlanen holdings, controls.

In summary, ORS 656.313(1)(a) allows the insurer to stay payment of compensation, except for the procedural temporary disability benefits that accrued from the date of the prior Referee's January 18, 1991 order until claim closure by the June 17, 1992 Determination Order. Once the claim was closed, it was unnecessary for the insurer to appeal the Determination Order in order to preserve its previously acquired stay of compensation. The stay of compensation applied to the subsequent award of temporary and permanent disability compensation, notwithstanding OAR 436-60-150(4)(e) and (6)(c).

Accordingly, we conclude that the insurer was allowed to stay the payment of temporary and permanent disability benefits awarded by the June 17, 1992 Determination Order pending its appeal of the prior Referee's compensability decision. Therefore, we reverse the Referee's order directing the insurer to pay such benefits.

ORDER

The Referee's order dated October 23, 1992 is reversed.

¹ OAR 436-60-150(4)(e) and (6)(c) provide that a request for reconsideration of a determination order does not stay payment of temporary disability and permanent partial disability compensation ordered.

In the Matter of the Compensation of
MICHAEL S. FISHER, Claimant
WCB Case Nos. 92-04192 & 92-01550
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John B. Motley (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Myzak's order which awarded claimant a \$5,000 assessed attorney fee for prevailing over its denials of claimant's "new injury" claim for a low back condition. On review, the issue is attorney fees.

FINDINGS OF FACT

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

The issues involved in the case were compensability of and responsibility for claimant's current low back condition as either an aggravation of claimant's accepted condition or a new injury against SAIF's insured. The hearing convened in Newport and lasted approximately one and one-half hours, excluding travel time. Approximately 77 exhibits were admitted into the record. Three doctor depositions were conducted. Two witnesses, including claimant, testified on his behalf.

Claimant's attorney submitted documentation to the Referee discussing the factors set forth in OAR 438-15-010 and requesting an assessed fee of \$5,000. Opposing counsel objected to the amount of the requested attorney fee as excessive.

CONCLUSIONS OF LAW AND OPINION

After considering the factors set forth in OAR 438-15-010(4), we conclude that the Referee's award was reasonable. Therefore, we affirm and adopt the Referee's conclusion in regard to the attorney fee issue.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee for defending against the attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 8, 1993 is affirmed.

In the Matter of the Compensation of
EARL J. LOWERY, Claimant
WCB Case No. 91-17548
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of those portions of Referee Podnar's order that: (1) set aside its denials of claimant's occupational disease claim for bilateral shoulder rotator cuff tendinitis and impingement syndrome condition; and (2) assessed a penalty (shared equally by claimant and his counsel) for allegedly unreasonable claims processing. On review, the issues are compensability and penalties.

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

Claimant sought treatment for bilateral shoulder complaints beginning in 1979. (Ex. 1.) Claimant's condition was eventually diagnosed in 1991 as bilateral rotator cuff tendinitis and impingement syndrome. (Ex. 57). Dr. Farris explained that claimant has an underlying predisposition for developing tendinitis and impingement syndrome, which his work caused to become symptomatic. (Ex. 77). He further explained that claimant's preexisting problem is the tendency to develop impingement syndrome, which causes tendinitis. (Ex. 78-17). A predisposition or susceptibility to a disease is not the same as a preexisting condition, and, for the purpose of determining whether a worker has met the major contributing cause standard, we do not consider a susceptibility or predisposition to the disease. Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991); Rodney T. Buckallew, 44 Van Natta 358, 360 (1992).

In addition, we are not persuaded by Dr. Martens' conclusory opinion that claimant's condition was not work-related. (Exs. 37 and 73). Nor are we persuaded by Dr. Lisac's opinion that claimant's work activity caused his unidentified underlying condition to become symptomatic (exs. 57, 59 and 76).

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 issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as a penalty is not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review regarding that issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 2, 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
TROY L. NOEL, Claimant
WCB Case No. 92-10768
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Crumme's order which upheld the self-insured employer's denial of claimant's 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 determined that claimant's claim should be analyzed as an occupational disease because claimant's low back condition did not arise from a discrete, traumatic work incident or episode.¹ He found that causation involved a complex medical question and, because the sole medical opinion was unpersuasive, that the preponderance of the evidence failed to establish that claimant's work activities were the major contributing cause of his condition.

Claimant contends that the Referee erred in failing to rely on the uncontradicted medical opinion of his treating physician that his work exposure was the major contributing cause of his low back condition.

Subsequent to the Referee's order, the court held, in Barnett v. SAIF, 122 Or App 279 (1993), that in a noncomplex case expert medical evidence is not required to prove causation. However, we agree with the Referee that because there were at least two potential causes of claimant's low back condition, with one not work-related, that the causation issue is a complex medical question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Wells, claimant's treating physician, opined that the major contributing cause of claimant's back injury was his employment. We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are a number of reasons not to defer to Wells' opinion. Dr. Wells was unaware of claimant's off-the-job incident, (where a man put his hands on claimant, claimant ended on his back, with the man standing over him ready to hit claimant, and claimant's back hurting so bad the next morning that he could barely get out of bed (Tr. 7-9; 71-73)). Dr. Wells' opinion is, thus, unpersuasive because it was based on an incomplete history. Somers v. SAIF, 77 Or App 259 (1986). Because he had an incomplete history, the doctor was precluded from considering other potential causes which could have contributed to claimant's low back condition. Pamela Wold, 43 Van Natta 362 (1991). We also do not find his opinion persuasive because it is conclusory regarding causation. Moe v. Ceiling Systems, 44 Or App 429 (1980). We, thus, do not rely on Dr. Wells' opinion. There is no other medical evidence in the record to establish causation. Claimant has, therefore, failed to establish the compensability of his claim.

ORDER

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

¹ We do not reach the question of whether claimant's claim should be analyzed as an injury or occupational disease, because given our holding, claimant has failed to establish compensability under either theory.

In the Matter of the Compensation of
MARLENE A. STEBBEDS, Claimant
WCB Case Nos. 91-06335 & 90-21393
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Howell's order that: (1) set aside its denial of the compensability of and responsibility for claimant's claim for a right shoulder condition; and (2) upheld the SAIF Corporation's partial denial of responsibility for claimant's claim for the same condition. Claimant cross-requests review of that portion of the Referee's order that found that Liberty, rather than SAIF, is responsible for her right shoulder condition. On review, the issues are compensability and responsibility.

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

Liberty contends that SAIF is responsible for claimant's right shoulder condition because it resulted from activities of an authorized training program that was a direct and natural consequence of the accepted 1984 injury with SAIF. Liberty relies on Wood v. SAIF, 30 Or App 1103, 1106 (1977), in which the court held that an injury that occurred as a result of vocational retraining activities is compensable because the retraining was a direct and natural consequence of the original, compensable injury.

However, in 1990, the legislature adopted ORS 656.005(7)(a)(A), which provides: "No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." The court recently held that ORS 656.005(7)(a)(A) applies to an injury sustained during vocational rehabilitation because the injury is a consequence of the industrial injury, not a direct result of the industrial accident. Kephart v. Green River Lumber, 118 Or App 76, 79 (1993). See also Albany General Hospital v. Gasperino, 113 Or App 411, 414 (1992).

In this case, therefore, in order to establish the compensability of the right shoulder condition as against SAIF, claimant must prove by a preponderance of the evidence that the accepted 1984 injury was the major contributing cause of the consequential condition. We agree with the Referee that claimant has not sustained this burden of proof.

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

ORDER

The Referee's order dated October 21, 1992, as reconsidered November 12, 1992 is affirmed. Claimant's attorney is awarded \$500 for services on Board review, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
REBECCA J. CLARK, Claimant
WCB Case Nos. 92-11615 & 92-10747
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Hazelett's order that set aside its denial of claimant's aggravation claim for her current right shoulder and arm condition. On review, the issue is aggravation.

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

On review, the employer argues that claimant's condition should be analyzed as a consequential condition pursuant to ORS 656.005(7)(a)(A). We disagree.

Claimant was injured on September 3, 1986, while lifting a box of parts at work. She described her complaints as "right side of back and right arm." A thoracic strain condition was accepted by the insurer. In 1992, Dr. Misko, M.D., reported that claimant's current arm pain and symptoms first developed in 1986 while she was lifting a box at work. Dr. Radecki took claimant's history and found that her cervical and arm problems began in 1986 when she was injured at work. The independent medical examiners' report and the remaining medical evidence also establish that claimant's right arm and shoulder problems began with the 1986 injury. Ex. 34-1; 36-1; 45.

Therefore, because claimant's right shoulder/arm condition was caused by the work injury, it is compensable if claimant establishes that the work injury was at least a material contributing cause of her condition. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We agree with the Referee's conclusion that claimant has established that her work injury is a material contributing cause of her right shoulder/arm condition.

On review, the employer contends that, because the Referee found that there was uncertainty about claimant's diagnosis, the Referee erred in finding the claim compensable. We conclude that a lack of a diagnosis does not necessarily defeat a claim for compensation. See Tripp v. Ridgerunner Timber Services, 89 Or App 355 (1988); Lori A. Sosa, 43 Van Natta 1745 (1991). Accordingly, we do not find the employer's contention to be persuasive.

The employer also argues that the Referee erred in relying upon the opinion of Drs. Misko, Erickson and Duncan. The employer contends that the Referee should have relied upon the opinion of Dr. Porter, an independent medical examiner. However, Dr. Porter merely provided an opinion that claimant had shoulder pain, which was "unexplained." Although Dr. Porter was in disagreement with a diagnosis of thoracic outlet syndrome, he apparently believed that claimant was experiencing shoulder pain, although he provided no explanation for her pain. Under the circumstances, we do not find that Dr. Porter's opinion is in direct opposition to the opinions of the physicians relied upon by the Referee. Moreover, we agree with the Referee's conclusion that claimant has established that the work injury of 1986 was at least a material contributing cause of her right shoulder/arm condition.

Finally, the employer argues that, because claimant was involved in two motor vehicle accidents which occurred after her compensable injury, claimant has failed to establish that her worsened condition is due to the compensable 1986 injury.

In Roger D. Hart, 44 Van Natta 2189 (1992), we concluded that, to establish an aggravation claim, the claimant is first required to prove that the compensable injury is a material contributing cause of the worsened condition. Then, if pursuant to ORS 656.273(1), the employer denies an aggravation on the grounds that an off-the-job injury is the major cause of the worsened condition, the employer, as proponent of the fact, has the subsequent burden of proof on that issue. Roger D. Hart, supra.

Here, we agree with the Referee that claimant has established that the 1986 injury is a material contributing cause of her current worsened condition. However, after reviewing the record and claimant's credible testimony, we do not find that the employer has proven that claimant's motor vehicle accidents are the major cause of the worsened upper extremity condition. Accordingly, we affirm the Referee.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of aggravation. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$1,200 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated February 25, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,200, to be paid by the self-insured employer.

October 21, 1993

Cite as 45 Van Natta 2051 (1993)

In the Matter of the Compensation of
EILEEN A. EDGE, Claimant
WCB Case No. 91-10647
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Referee Spangler's order that set aside its partial denial of claimant's bilateral carpal tunnel syndrome (CTS). Claimant cross-requests review of that portion of Referee Spangler's order that upheld SAIF's partial denial of claimant's current right knee condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On January 23, 1989, SAIF denied claimant's aggravation claim on the basis that her current condition was not related to the compensable injury. In its denial letter, SAIF stated that "[m]edical information in [claimant's] file indicates that your current condition (diagnosed as degenerative arthritis, right knee, with a medial meniscus tear) is unrelated to your industrial injury of October 22, 1987." (Ex. 11-1).

Claimant filed a Request for Hearing to appeal SAIF's January 23, 1989 denial. On July 6, 1989, the Referee approved a stipulation entered into by the parties in which SAIF rescinded its January 23, 1989 denial and reopened the claim as of November 30, 1988. (Ex. 16). In return, claimant's request for hearing was dismissed with prejudice.

Dr. Wilson, orthopedist, began treating claimant on May 2, 1989. (Ex. 13). Dr. Wilson opined that claimant's current right knee condition is the same condition that she had when he began treating her. ((Tr. 55, Ex. 26).

On April 3, 1992, SAIF issued a partial denial of claimant's current right knee condition, stating that "[m]edical information indicates that the major contributing cause of your current condition is your preexisting degenerative knee condition." (Ex. 33).

CONCLUSIONS OF LAW AND OPINION

Compensability of the Current Right Knee Condition

Relying on ORS 656.005(7)(a)(B), the Referee concluded that claimant had not established that the compensable injury was the major contributing cause of her disability or need for treatment. Instead, he found that claimant's preexisting degenerative arthritis was the major contributing cause of claimant's current right knee condition. We disagree that ORS 656.005(7)(a)(B) is determinative. Instead, relying on the doctrine of issue preclusion, we conclude that claimant's current right knee condition is compensable.

In reaching our conclusion, we acknowledge that claimant does not expressly present an issue preclusion theory. Nevertheless, she does rely on the significance of the July 6, 1989 stipulation. Inasmuch as the stipulation forms the basis of the "issue preclusion" theory, we have considered the doctrine in conducting our review.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Issues resolved by a stipulation and settlement are considered to be actually litigated and determined by a valid and final judgment within the meaning of the above rule. See International Paper Company v. Pearson, 106 Or App 121 (1991).

At the time of her fall at work on October 22, 1987, claimant had significant preexisting degenerative arthritis in her right knee. (Exs. 2, 3, 6, 9-4, 12-1, 13, 20-2). On November 2, 1987, SAIF accepted claimant's injury as a disabling "strained right knee" and the claim was first closed in March 1988. (Ex. 5). On January 23, 1989, SAIF denied an aggravation claim on the basis that claimant's "current condition (diagnosed as degenerative arthritis, right knee, with a medial meniscus tear) is unrelated to [claimant's] industrial injury of October 22, 1987." (Ex. 11-1). At the time of this denial, Dr. Puziss, examining orthopedic surgeon, related claimant's right knee problem to her preexisting degenerative arthritis. (Ex. 9-4, -5).

Following the denial, claimant's right knee condition continued to be related to her preexisting degenerative arthritis. Dr. Marble, claimant's initial treating orthopedist, agreed that claimant had significant preexisting degenerative arthritis in her right knee and essentially opined that that condition combined with the work injury. (Ex. 12). On May 2, 1989, claimant began treating with Dr. Wilson, orthopedist. (Ex. 13). In his initial examination, Dr. Wilson opined that claimant's preexisting degenerative arthritis was the primary contributor to her knee problems, although he also noted the possibility that the fall at work began a process of knee pain that lead to significant patellofemoral arthritis. (Ex. 13-2).

Claimant filed a Request for Hearing to appeal SAIF's January 23, 1989 denial. On July 6, 1989, the Referee approved a stipulation entered into by the parties in which SAIF rescinded its January 23, 1989 denial and reopened the claim as of November 30, 1988. (Ex. 16). In return, claimant's request for hearing was dismissed with prejudice.

Following the stipulation, Dr. Wilson continued to relate claimant's ongoing problems to her degenerative arthritis. (Exs. 13-4, 13-5, 13-8, 21). Furthermore, Dr. Wilson testified that claimant's current condition is degenerative arthritis of the right knee, which he opined was the same condition claimant had when she started using crutches and a cane. (Tr. 55). In addition, he stated that claimant had used crutches and a cane since he began treating her. (Ex. 26). Therefore, based on Dr. Wilson's testimony and reports as a whole, we find that claimant's current condition (degenerative arthritis of the right knee) was the same condition claimant had when Dr. Wilson began treating her in May 1989, prior to the stipulation. (Tr. 55, Ex. 26).

Based on this record, we conclude that claimant's current degenerative arthritis condition is the same condition she had at the time of the July 6, 1989 stipulation, when the January 23, 1989 denial was rescinded. Although Dr. Wilson initially noted a possibility that the work injury caused patellofemoral arthritis, he consistently opined that claimant's primary problem was the preexisting degenerative arthritis. Dr. Wilson's reports and testimony as a whole establish that claimant's condition remained the same from the time of the stipulation.

Thus, under the doctrine of issue preclusion, the July 6, 1989 stipulation establishes as a matter of law that claimant's degenerative arthritis condition in her right knee is compensably related to her 1987 work injury. In other words, the connection between claimant's preexisting degenerative condition and the work injury was litigated and determined by a valid and final judgment when the parties entered into the stipulation which rescinded the January 23, 1989 denial. Therefore, SAIF is precluded from subsequently denying claimant's right knee degenerative arthritis on the basis that it is unrelated to the industrial injury. Inasmuch as SAIF's April 3, 1992 denial denies claimant's degenerative knee condition on that basis, it must be set aside under the res judicata doctrine of issue preclusion. See International Paper Company v. Pearson, *supra*; Dewey H. Gilkey, Sr., 43 Van Natta 1154, 1157 (1991).

We find the current case analogous to Cox v. SAIF, 121 Or App 568 (1993). In Cox, in an unappealed 1989 order, the claimant's hypertension, diabetes and hyperlipidemia conditions were found compensable because they were materially related to a compensable injury. Following the adoption of a new statutory standard for determining the compensability of "consequential conditions," the carrier denied those enumerated conditions. Citing North Clackamas School Dist. v. White, supra, the court held that the compensability of those conditions could not be relitigated. Cox, 121 Or App at 571. Relying on the legislative intent expressed in Oregon Laws 1990, chapter 2, section 54(2) to apply pre-amendment law to cases in litigation at the time of the enactment of the amendments, the court reasoned that it would be contrary to that intent to allow relitigation of claims that had been finally litigated at the time of the 1990 amendments. Cox, 121 Or App at 573.

Here, as noted above, issues resolved by stipulation are considered to be actually litigated and determined by a valid and final judgment. See International Paper Company v. Pearson, supra. Thus, the July 6, 1989 stipulation rescinding the January 23, 1989 denial (which had denied claimant's current right knee condition on the basis of lack of causation) finally litigated the compensability of claimant's current right knee condition at that time. Furthermore, as we have found above, claimant's current right knee condition remains the same as it was at the time of the July 6, 1989 stipulation. Therefore, SAIF may not now relitigate that condition under the subsequently created new legal standards for compensability. Cox v. SAIF, supra; North Clackamas School Dist. v. White, supra.

Compensability of the Bilateral Carpal Tunnel Syndrome

Although the Referee found that claimant's current right knee condition was not compensable, he concluded that her bilateral carpal tunnel syndrome (CTS) was compensable as a consequence of her use of crutches and a cane during the time in which her claim was in open status as a result of the July 6, 1989 stipulation. We agree that the bilateral CTS is compensable. However, we rely on the following reasoning.

Claimant contends that she developed bilateral CTS as a result of her need to use crutches and a cane because of her right knee condition. We have found that claimant's current right knee condition is compensable. However, because claimant's CTS condition was not directly caused by the compensable condition, claimant must prove that her compensable condition was the major contributing cause of her consequential CTS condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

Claimant testified that she first had problems with her hands in January 1991. (Tr. 13). On April 15, 1991, she first reported these hand problems to Dr. Wilson. (Ex. 13-9).

On May 22, 1991, Dr. Anderson, consulting neurologist, examined claimant and diagnosed bilateral CTS. (Ex. 24). Although he opined that the electrodiagnostic studies indicated a bilateral CTS of several years duration, he did not discuss the cause of the CTS.

On July 12, 1991, Dr. Radecki, examining M.D., examined claimant. Claimant reported a history of being awakened at night with discomfort in her hands. (Ex. 28-1). Claimant did not know when this began, she stated only that it was "a long time ago" but not until after her fall at work. Dr. Radecki diagnosed bilateral CTS which was chronic or old in nature, with the right CTS being present for at least six months. (Ex. 28-2). He opined that the cause of the CTS was a diffuse peripheral neuropathy of unknown etiology. (Ex. 28-3). Although he agreed that the use of canes or crutches could cause CTS, he did not believe that had occurred with claimant because the EMG tests documented old neuropathic changes that predated her complaints of April 15, 1991 and suggested the CTS problem had likely been present for years. (Ex. 28-3).

Dr. Wilson reviewed Dr. Radecki's report and noted that he had a different history of recent onset of symptoms from claimant, although noting that claimant may have had problems before she reported them to him. (Ex. 29). Dr. Wilson also opined that it could not be unequivocally determined that the symptoms had been present for more than six months due to the nature of "objective motor finding problems." Id. Dr. Wilson opined that the use of crutches and a cane over the years at the recommendation of claimant's treating physicians was the major contributing cause of the bilateral CTS. (Exs. 25, 26, 31, Tr. 53-55). Furthermore, he opined that the need for the use of these walking aides was the degenerative arthritis condition, the same diagnosis and etiology as when claimant first started using the crutches and the cane. (Tr. 54-55).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons not to rely on the opinion of Dr. Wilson. Although Dr. Radecki focuses on April 15, 1991 as the date claimant first reported CTS symptoms and indicates that claimant's CTS predates that date, Dr. Wilson acknowledges that claimant could have had CTS symptoms before she reported them to him. Furthermore, the record shows that claimant has used crutches and a cane over a period of several years as a direct result of her right knee condition. We have found that condition compensable. Therefore, claimant has proved the compensability of her bilateral CTS.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for review of the compensability of the bilateral CTS condition and for prevailing over SAIF's denial of the current right knee condition. ORS 656.382(2); 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 on review concerning the compensability of the bilateral CTS and for claimant's attorney's services at hearing and on review concerning the compensability of the current right knee condition is \$3,000, to be paid by the SAIF Corporation. This fee is in addition to the \$2,000 Attorney fee award granted by the Referee for claimant's counsel's services at the Hearings level in overturning the bilateral carpal tunnel syndrome denial. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's and cross-appellant's briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 29, 1992 is affirmed in part and reversed in part. That portion of the order which upheld the SAIF Corporation's April 3, 1992 denial of claimant's current right knee condition is reversed. SAIF's April 3, 1992 denial is set aside. The remainder of the Referee's order is affirmed. For services on Board review concerning the issue of the compensability of the bilateral carpal tunnel syndrome and for services at hearing and on Board review concerning the issue of the compensability of the current right knee condition, claimant's attorney is awarded \$3,000, to be paid directly to claimant's attorney by the SAIF Corporation.

October 21, 1993

Cite as 45 Van Natta 2054 (1993)

In the Matter of the Compensation of

JESUS FERRER, Claimant

WCB Case No. 92-10400

ORDER ON REVIEW

Scott M. McNutt, Claimant Attorney

Cummins, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Referee Black's order that upheld the self-insured employer's denial of claimant's aggravation claim for a cervical and upper back condition. The employer cross-requests review of that portion of the Referee's order which assessed a penalty for untimely processed medical bills. On review, the issues are aggravation and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's compensable condition had not worsened since February 1, 1991 (the last award or arrangement of compensation), the Referee upheld the employer's denial of claimant's aggravation claim. Relying on Dr. Meyers' post-February 1991 findings (reduced range of motion, muscle spasms, bilateral neuropathy, reflex changes, and reduced grip strength), as well as Meyers' "restrictions" from work, claimant contends that his compensable condition has worsened. We disagree.

The findings and observations recorded by Dr. Meyers are suggestive of changes in claimant's compensable condition since the February 1991 closure of his claim. Nevertheless, despite these findings, Dr. Meyers acknowledged that he could not say whether claimant's condition had worsened. Moreover, Dr. Meyers conceded that it was fair to characterize claimant's claim as one for additional medical treatment rather than an aggravation.

In light of such circumstances, we are persuaded that Dr. Meyers' opinion is supportive of the need for further diagnostic procedures to investigate claimant's symptoms. However, that opinion does not establish a worsening of claimant's compensable condition since the February 1991 closure of his claim. Consequently, we affirm the Referee's decision to uphold the employer's denial of claimant's aggravation claim.

We proceed to the employer's cross-request. Determining that the employer had failed to timely respond to certain medical bills (totalling \$1,375), the Referee directed the employer to pay those bills in their entirety, as well as a 25 percent penalty (to be shared equally by claimant and his attorney).

The employer does not contest the Referee's determination that a penalty for its conduct is warranted. Instead, noting that it paid the disputed bills in a reduced amount as permitted under ORS 656.248, the employer seeks modification of the Referee's penalty assessment to acknowledge this statutorily authorized reduction.¹ Claimant does not oppose the employer's request.

After reviewing this matter, we concur with the Referee's reasoning that a penalty is justified. However, we modify the Referee's penalty assessment in the following manner. The employer shall pay a penalty equal to 25 percent of Dr. Meyers' disputed medical bills (subject to the reduction permitted under ORS 656.248). This penalty shall be paid to claimant and his attorney in equal shares.

ORDER

The Referee's order dated December 18, 1992 is affirmed in part and modified in part. In lieu of the Referee's penalty assessment, the employer is assessed a penalty equal to 25 percent of Dr. Meyers' disputed billings subject to the reductions permitted under ORS 656.248, to be shared in equal amounts by claimant and his attorney. The remainder of the Referee's order is affirmed.

¹ In response to the employer's motion for reconsideration, the Referee subsequently amended his order to modify the penalty assessment. Nevertheless, since claimant's request for Board review was filed prior to the issuance of the Referee's amended order, the Referee's later order was invalid.

October 21, 1993

Cite as 45 Van Natta 2055 (1993)

In the Matter of the Compensation of
ANTHONY FOSTER, Claimant
WCB Case No. 92-06071
ORDER DENYING RECONSIDERATION
Coons, Cole & Cary, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Claimant requests reconsideration of our October 5, 1993 Order on Reconsideration that: (1) set aside the SAIF Corporation's denial of claimant's occupational disease claim for bilateral upper extremity conditions; and (2) awarded a \$5,500 carrier-paid attorney fee under ORS 656.386(1). Specifically, claimant asserts that we erred as a matter of law in the following manner: (1) issuing our October 5, 1993 order without addressing his October 6, 1993 motion to strike SAIF's October 4, 1993 "Supplemental Argument;" and (2) reducing the amount of claimant's attorney fee award granted in our August 23, 1993 Order on Review.

Concerning claimant's first contention, there is a simple reason why claimant's motion to strike was not addressed in our reconsideration order. That is, our October 5, 1993 order had already issued by the time claimant's October 6, 1993 motion was filed. Moreover, although SAIF's October 4, 1993

"Supplemental Argument" was received prior to our October 5, 1993 order, there is no mention in our order that such an argument was considered. In fact, our order expressly stated that "[h]aving received claimant's reply and after completing our further consideration of this matter, we issue the following order." In any event, since our September 23, 1993 abatement order did not provide for a supplemental reply from SAIF, the "Supplemental Argument" could not be, and was not, considered.

Finally, claimant asserts that it was an error of law for us to reconsider and reduce the attorney fee award granted by our August 23, 1993 order. For the reasons set forth in our October 5, 1993 reconsideration order, we continue to conclude that we are authorized to conduct such a reconsideration and to determine a reasonable attorney fee award under OAR 438-15-010(4).

In reaching this conclusion, we acknowledge that, in determining a reasonable award, we did not discuss "the assertion of frivolous issues or defenses" as set forth in section (4)(h). Such a factor was not addressed because our review of the record did not support a conclusion that the factor was relevant to a determination of a reasonable attorney fee in this case. Moreover, this factor was not listed in claimant's counsel's statement of services as a fact that counsel "believes important in settling the fee." In any event, as claimant concedes, we are not obligated to make specific findings concerning all relevant factors in determining a reasonable attorney fee award. See Leo Polehn Orchards v. Hernandez, 122 Or App 241, 248 (1993); Diamond Fruit Growers v. Davies, 103 Or App 280, 282 (1990).

Accordingly, claimant's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our October 5, 1993 order.

IT IS SO ORDERED.

October 21, 1993

Cite as 45 Van Natta 2056 (1993)

In the Matter of the Compensation of
DARRELL HANKEL, Deceased, Claimant
 WCB Case No. 92-07452
 ORDER ON REVIEW
 John E. Uffleman, Claimant Attorney
 Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerland.

The SAIF Corporation requests review of Referee Hoguet's order that: (1) found claimant's widow was entitled to permanent total disability survivor benefits; and (2) awarded claimant's counsel an assessed attorney fee. On review, the issues are survivor's benefits and attorney fees. We reverse.

FINDINGS OF FACT

Claimant was compensably injured on March 1, 1966. At the time of his injury, claimant was married.

Claimant was found permanently and totally disabled by a November 16, 1973 Opinion and Order.

Claimant's first wife passed away, and claimant was subsequently remarried on July 10, 1977.

Claimant died on February 4, 1990. At the time of his death, claimant was still receiving permanent total disability benefits. Claimant's second wife, who was married to him at the time of his death, filed a request for hearing on June 8, 1992, contesting SAIF's "de facto" denial of survivor's benefits.

CONCLUSIONS OF LAW AND OPINION

Persuaded by claimant's widow's arguments, the Referee concluded that she had established entitlement to survivor's benefits. We disagree.

At the time of claimant's injury in 1966, ORS 656.202(2) provided that:

"Except as otherwise provided by law, payment of benefits for injuries or deaths under this chapter shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

Additionally, at the time claimant was injured, former ORS 656.208(1) provided that:

"If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving:

"(a) A widow who was his wife either at the time of the injury causing the disability or within two years thereafter....the surviving widow....shall receive [monthly benefits] until death or remarriage."

ORS 656.208 was amended by Or Laws 1985, ch 108, §2, to eliminate the requirement that a surviving spouse be married to the worker at the time when an industrial injury occurred, or within two years thereafter. Thus, at the time of claimant's death in February 1990, ORS 656.208 provided that:

"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."

On review, SAIF contends that the law in effect at the time of claimant's injury applies in this case. SAIF argues that, because claimant's widow was not married to him at the time of his injury (nor within two years following the time of his injury), she is not entitled to survivor's benefits.

Claimant's widow, however, argues that the law in effect at the time of claimant's death controls. Claimant's widow contends that, because the "two-year marriage requirement" was eliminated from the statute in 1985, she is entitled to survivor's benefits because she was married to claimant at the time of his death and while he was receiving permanent total disability benefits.

At the time of claimant's death in 1990, the statute provided that, except as otherwise provided by law, payment of benefits "shall be continued as authorized, and in the amounts provided for, by the law in force at the time of the injury giving rise to the right to compensation occurred." ORS 656.202(2)(emphasis added). Consequently, because the law in effect at the time of claimant's injury contained the two-year marriage requirement, claimant's widow can only prevail if she can show that the amended statute, ORS 656.208(1) (which deleted the two-year marriage requirement), was intended to be applied retroactively.

In Independent Paper Stock v. Wincer, 100 Or App 625 (1990), the court held that ORS 656.202 embodies the general rule that the law in effect at the time of the claim applies, unless there is a clear legislative directive to do otherwise. Furthermore, the court has previously held that it will not apply statutes or amendments retroactively, unless there is legislative support for doing so. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Whipple v. Howser, 291 Or 475 (1981).

Here, claimant's beneficiary has provided no legislative history or legislative intent to support a retroactive application of the statute. Moreover, we have found no legislative intent to support such a proposition.¹

Claimant's beneficiary's primary argument for an application of the amended statute is, instead, based upon her contention that her rights are independent and not derivative of the decedent's rights. Claimant's widow, therefore, argues that her rights originated at the time of claimant's death in 1990, and consequently, the law in effect at the time of his death applies. We disagree.

¹ Although there is no evidence that the 1985 amendments to ORS 656.208(1) were intended to be applied retroactively, the legislature did provide for a retroactive application of another part of the bill. ORS 656.202 was amended and subsection (5) provided that, notwithstanding subsection (2) of the section, the increase in benefits to the surviving spouse of an injured worker made by the amendment to ORS 656.204(2)(c) by section 1 of the Act applied to a surviving spouse who remarried after the effective date of the 1985 Act "regardless of the date of injury or death of the worker." Or Laws 1985, ch 108, §3.

A similar argument was rejected by the court in Bradley v. SAIF, 38 Or App 559 (1979). In Bradley, the widow seeking survivor's benefits argued that whether or not the statute was applied retroactively was not dispositive as her rights were independent of the claimant's rights and accrued not at the time of injury, but rather at the time of the worker's death. The court found that claimant's argument was answered by its construction of ORS 656.202(2). The court concluded that because the statute governed the rights of survivors and workers, the application of the law in effect at the time of the worker's injury was mandated, unless the amendments applied retroactively. Bradley, supra at 564.

Accordingly, because we have found no clear legislative support or directive to retroactively apply the law in effect at the time of claimant's death, we conclude that ORS 656.202(2) requires the application of the law in effect at the time of claimant's injury.

Finally, claimant's widow contends that the statutory requirement that she had to be married to claimant within two years of his injury pursuant to former ORS 656.208(1) is unconstitutional. Although claimant's widow concedes that this issue was decided in Tevepaugh v. SAIF, 80 Or App 685 (1986), she argues that the court wrongly decided the issue.

We conclude that, regardless of whether a party believes that the court incorrectly decided a case, it is nonetheless our duty to follow the holding unless and until it is overturned. In Tevepaugh, supra, the worker was married at the time of his injury in 1964. However, his first marriage was terminated and the claimant was subsequently remarried in 1968. He was receiving permanent total disability benefits and was still married to his second wife at the time of his death in 1984. The court in Tevepaugh found that application of former ORS 656.208(1) precluded the claimant's widow from asserting entitlement to his permanent total disability benefits, as she was not married to the worker at the time of his injury or within two years thereafter.

With respect to the widow's constitutional argument, the court also found that the statute was not unconstitutional, as the legislature could have had a rational basis for distinguishing between surviving spouses who were married to the worker at the time when the injury occurred, or within two years thereafter, and surviving spouses who married an injured worker more than two years after the injury. Tevepaugh, supra at 688.

Under the circumstances, we apply the reasoning expressed by the court in Tevepaugh, supra, and conclude that the former statute is not unconstitutional.

Consequently, as we have found that the law in effect at the time of claimant's injury controls, and claimant's surviving spouse was not married to claimant at the time of his injury or within two years thereafter, her claim for survivor's benefits is precluded pursuant to former ORS 656.208(1). The Referee's order is, therefore, reversed.

ORDER

The Referee's order dated September 17, 1992, as supplemented October 6, 1992, is reversed. The SAIF Corporation's denial of survivor's benefits is reinstated and upheld. The Referee's attorney fee award is also reversed.

In the Matter of the Compensation of
JAY A. NERO, Claimant
WCB Case No. 92-09566
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of Referee Crumme's order that: (1) set aside its denial of claimant's aggravation claim; (2) directed it to pay the permanent disability awarded by a prior referee's order; and (3) awarded a \$2,000 attorney fee for claimant's counsel's services in connection with overturning the aggravation denial. Claimant cross-requests review of that portion of the order that declined to assess a penalty for the employer's allegedly unreasonable claim processing. On review, the issues are aggravation, claim processing, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

The employer did not cross-request Board review of the prior referee's July 10, 1992 Opinion and Order. (See O&O p. 3, paragraph 12).

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee set aside the employer's denial of claimant's aggravation claim. We agree, based on the following reasoning.

To establish an aggravation claim for his unscheduled low back condition, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991).

In this case, the employer does not contest that claimant's low back symptoms worsened, causing claimant to miss two weeks of work. Instead, the employer contends that claimant's worsening did not exceed the waxing and waning of symptoms anticipated at claim closure. See ORS 656.273(8). We disagree.

At the outset, we agree with and adopt the Referee's opinion that claimant suffered diminished earning capacity as a result of worsened symptoms, which are established by medical evidence supported by objective findings. In addition, we agree with the parties that pre-closure medical evidence establishes the possibility of future flare-ups and claimant's last arrangement of compensation thus contemplated such flare-ups. See Lucas v. Clark, supra. In this regard, we note that Dr. Flemming released claimant to "regular" work, with cautionary limitations. For example, Flemming repeatedly warned claimant to avoid forced or vigorous twisting such as the twisting of hydrants that caused the initial injury. (Exs. 25, 26, 28, 32). Considering these warnings, we find that the last arrangement of compensation thus anticipated waxing and waning of symptoms with certain activities.

We further find that claimant's worsening was greater than anticipated. As we have stated, Flemming released claimant to "regular" work, with cautions. He instructed claimant to use proper body mechanics and avoid prolonged sitting. Flemming recommended only conservative treatment until May 1992. However, when claimant's symptoms worsened after claim closure, sitting for only 10 minutes caused claimant to limp due to leg pain, a new complaint. In light of these complaints, Flemming authorized a release from work and recommended surgery for the first time. (See Ex. 39A-2).

Considering Flemming's "post-closure" opinion and in the absence of countervailing evidence, we conclude that claimant's current worsening is greater than the flare-ups anticipated at the last arrangement of compensation. Consequently, claimant has proven his aggravation claim.

Enforcement of permanent disability payment

We agree with the Referee that ORS 656.313(1)(a) did not authorize the employer to stay payment of claimant's permanent disability award pending claimant's appeal of that award. See Terry G. Palumbo, 45 Van Natta 1145 (1993).

Penalty for failure to pay permanent disability pending appeal

We adopt the Referee's opinion on this issue. See Timothy H. Krushwitz, 45 Van Natta 158, 160 (1993).

Attorney fees

The employer contests the Referee's \$2,000 attorney fee award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the aggravation issue is \$2,000. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved to claimant, and the risk that claimant's attorney might go uncompensated.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation and payment of the prior referee's permanent disability award issues is \$750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to a fee for his unsuccessful efforts regarding the penalty issue or for his defense of the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated December 29, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of \$750, payable by the self-insured employer.

October 21, 1993

Cite as 45 Van Natta 2060 (1993)

In the Matter of the Compensation of
RODNEY S. NORTON, Claimant
 Own Motion No. 93-0268M
SECOND OWN MOTION ORDER ON RECONSIDERATION
 Malagon, et al., Claimant Attorneys

The insurer requested reconsideration of our August 25, 1993 Own Motion Order On Reconsideration in which we awarded an approved fee for claimant's attorney's services culminating in our August 10, 1993 Own Motion Order. The insurer states that it had paid claimant all amounts due pursuant to our August 10, 1993 order before claimant's counsel submitted a copy of his retainer agreement and requested reconsideration for an attorney fee payable out of the increased compensation awarded by that order. The insurer requests that the Board instruct claimant's attorney to seek the attorney fees directly from claimant.

On September 22, 1993, we abated our prior order to allow sufficient time to consider the motion for reconsideration. We allowed claimant 14 days within which to respond to the insurer's motion. Inasmuch as that 14-day period has expired and no such response has been forthcoming, we proceed with our reconsideration.

When exercising our own motion authority pursuant to ORS 656.278, we may award claimant's attorney a fee payable out of claimant's compensation, if the attorney is instrumental in obtaining increased disability compensation. See 656.386(2); OAR 438-15-080. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1).

Here, claimant's attorney was instrumental in obtaining increased disability compensation for claimant and is entitled to a reasonable attorney fee payable out of claimant's compensation. However, claimant's attorney had not submitted a retainer agreement at the time of our August 10, 1993 order reopening claimant's claim, and the Board did not award an attorney fee. By letter dated August 17, 1993, claimant's attorney requested reconsideration of our order and submitted a copy of his retainer agreement. On August 25, 1993, we issued an Own Motion Order on Reconsideration in which we awarded claimant's attorney a fee payable out of claimant's compensation. It appears, however, that the insurer had already paid all temporary disability benefits due regarding our August 10, 1993 order directly to claimant.

We agree with the insurer that the reasoning in Gabriel M. Gonzales, 44 Van Natta 2399 (1992), is controlling in this case. In Gonzales, an Order on Reconsideration granted increased compensation but did not award an "out-of-compensation" attorney fee because the claimant's attorney had not submitted a retainer agreement. By the time the claimant's attorney submitted an agreement and an amended order issued granting 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" fee was attributable to the claimant's attorney's failure to submit a retainer agreement, the Board held that the attorney must seek payment from the claimant rather than the carrier.

Here, claimant's attorney's failure to submit a retainer agreement pursuant to OAR 438-15-010(1) prevented the Board from awarding an out of compensation fee. Therefore, we conclude that claimant's attorney must seek payment of his attorney fee from claimant rather than from the insurer. Gabriel M. Gonzales, supra; Kenneth V. Hambrick, 43 Van Natta (1991); Gerald L. Billings, 43 Van Natta 399 (1991); compare Nancy E. O'Neal, 45 Van Natta 1591 (1993) (where there was no preventive action that the claimant's attorney could have taken to secure the "out-of-compensation" fee and the carrier had received documentation that the claimant's attorney had taken the sole action available to secure the fee, it is not inequitable to require the carrier to pay the "out-of-compensation" fee to claimant's attorney with an authorization to recover the resulting overpayment from future permanent disability awards on the claim).

Accordingly, our August 10, 1993 order, as reconsidered on August 25, 1993, is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 10, 1993 order, as reconsidered on August 25, 1993, effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

October 21, 1993

Cite as 45 Van Natta 2061 (1993)

In the Matter of the Compensation of
DORIS A. PACE, Claimant
WCB Case No. 90-08372
ORDER ON REMAND
Starr & Vinson, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Stanley Smith Security v. Pace, 118 Or App 602 (1993). The court affirmed that portion of our order, Doris A. Pace, 43 Van Natta 2526 (1991), which held that claimant was entitled to interim compensation even though her aggravation claim had subsequently been found not compensable. However, noting that our order neglected to make findings concerning whether claimant had been released by her attending physician to her regular work, the court has remanded to determine when the self-insured employer's duty to pay interim compensation ended. We proceed with our reconsideration.

FINDINGS OF FACT

We republish the findings of fact contained in our November 18, 1991 order with the following supplementation.

Following a January 10, 1990 examination, Dr. Clibborn, chiropractor, reported that claimant's condition was not medically stationary and that claimant was unable to return to her previous security guard job. In February 1990, the Independent Chiropractic Consultants (ICC) performed an examination. In light of the acuteness of claimant's symptoms, the Consultants recommended further studies and testing.

Pursuant to a March 12, 1990 "829 Form," claimant announced that Dr. Blake, family physician, had become her attending physician. Diagnosing a chronic pain syndrome, Dr. Blake suggested a pain center evaluation.

On April 17, 1990, Dr. Blake issued the following report. After reviewing the ICC report and a September 1989 independent medical examination report from the Western Medical Consultants (which concluded that claimant's condition was medically stationary and that she could return to her security guard job), Dr. Blake agreed with their conclusions. Reiterating that claimant was suffering from a chronic pain syndrome, Dr. Blake was unaware of whether claimant had been seen by a pain center. Recommending conservative treatment, Dr. Blake determined that claimant's condition was medically stationary without documentable impairment and that she should be released back to work.

On April 23, 1990, Dr. Berman reported that ICC did not consider claimant's condition to be medically stationary. Instead, ICC suggested additional diagnostic studies to fully differentiate her condition.

On May 10, 1990, Dr. Blake responded to a vocational rehabilitation counselor's letter inquiring into whether claimant should perform the described duties of a security officer. Dr. Blake signed the letter and checked a box indicating that claimant could perform the job as described.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we determined that claimant was entitled to interim compensation from January 18, 1990 (the date of the employer's notice of claimant's medically verified inability to work) to July 11, 1990 (the date of hearing). Doris A. Pace, supra. Citing ORS 656.268(3), the court has concluded that the termination of temporary total disability is governed by that statute. Stanley Smith Security v. Pace, supra, at page 610. The court has further reasoned that one basis for termination of such benefits is an attending physician's release to regular work. See ORS 656.268(3)(b). Inasmuch as our order neglected to make findings concerning whether and when claimant was actually released by her attending physician for regular work, the court has remanded.

After conducting our reconsideration, we find that claimant was released to her regular work by her attending physician on April 17, 1990. We base this conclusion on the following reasoning.

Dr. Blake became claimant's attending physician on March 12, 1990. At that time, Blake recommended a pain center evaluation for claimant's chronic pain syndrome. Dr. Blake continued to mention the pain center evaluation when reporting to the employer on April 17, 1990. Notwithstanding claimant's apparent failure to receive such an evaluation, Dr. Blake expressly concluded that claimant's condition was medically stationary and that she should be released to work.

In releasing claimant to work Dr. Blake did not specifically identify the security guard position. Nevertheless, Blake's report was issued after a review of prior independent medical examiner's reports. One of those reports was issued by the Western Medical Consultants, who had opined that claimant was able to return to her security guard job. In light of such circumstances, we are persuaded that Dr. Blake's unqualified release to work constitutes a release for claimant to return to her regular employment as a security guard/officer. Consequently, we conclude that claimant was entitled to interim compensation until April 17, 1990.

The Referee awarded interim compensation from January 18, 1990 to April 16, 1990. The employer was also assessed a penalty equal to 25 percent of this compensation. (Shared equally between claimant and her counsel). As a result of our decision, the aforementioned portions of the Referee's order are modified as follows.

Claimant is awarded interim compensation from January 18, 1990 to April 17, 1990. In addition, the employer is assessed a penalty equal to 25 percent of this compensation to be distributed in equal shares to claimant and her attorney.

IT IS SO ORDERED.

October 21, 1993

Cite as 45 Van Natta 2063 (1993)

In the Matter of the Compensation of
DAVID J. ROWLEY, Claimant
WCB Case No. 90-20805
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Claimant has requested reconsideration of those portions of our August 26, 1993 Order on Review that: (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. In order to further consider this matter, we abated our order on September 23, 1993.

Aggravation

In our prior order, we found that claimant did not timely challenge the classification of his injury claim as nondisabling, despite having sufficient time to do so. We concluded, therefore, that claimant had to make his claim (that his nondisabling injury had become disabling) as a claim for aggravation pursuant to ORS 656.273. See ORS 656.277(2). Analyzing the claim under ORS 656.273, we concluded that claimant has not sustained his burden of proving that his trigger finger condition had worsened since the condition was accepted and classified as nondisabling. Hence, we concluded that a claim for aggravation was not proven.

On reconsideration, claimant argues that our decision 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 misunderstands our holding.

We held that claimant has not proved a worsened condition. A "worsened condition" means a change in condition which renders the claimant more disabled. Smith v. SAIF, 302 Or 396, 399 (1986). Here, we did not find that claimant had proved a change in his condition since acceptance of his claim. Although we found some evidence to suggest that claimant's condition was disabling from the outset, we concluded that an aggravation claim is not established by proof that the original classification of his claim as nondisabling was erroneous.

Contrary to claimant's contention, our holding that proof of a "worsened condition" is required is entirely consistent with prior case law. Indeed, in both cases cited by claimant--Jeffrey D. Morgan, 43 Van Natta 2348 (1991) and Louis A. Duchene, 41 Van Natta 2399 (1989)--the claimant had proved a worsened condition. Hence, we view those cases as supporting our holding in this case.

Attorney Fees

Claimant also contends that his attorney is entitled to an assessed attorney fee for prevailing against SAIF's denial of the compensability of his trigger finger condition. We agree.

SAIF accepted claimant's 1988 injury claim for a trigger finger condition. Claimant subsequently filed an aggravation claim in 1990. In response, SAIF issued a denial letter on September 21, 1990, which denied that claimant's compensable finger condition had worsened. The denial letter also stated

that medical bills for the accepted finger condition would be paid up to the date of the denial letter. (Ex. 11). At the commencement of the hearing, SAIF's counsel contended that claimant's current condition is not related to the accepted 1988 claim and that, if it is related, the condition has not worsened. (Tr. 11-12). After the hearing but before the issuance of the Referee's order, SAIF's counsel withdrew its contention that the current condition is unrelated to the 1988 claim. (Tr. 19).

SAIF's withdrawal of its compensability denial after the hearing but before the issuance of the Referee's order entitles claimant to an assessed attorney fee under ORS 656.386(1) for prevailing against the compensability denial. See Safeway Stores, Inc. v. Hayes, 119 Or 319, 322 (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 at hearing concerning the compensability issue is \$900, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review for securing his attorney fee award at hearing. See Amador Mendez, 44 Van Natta 736 (1992).

Accordingly, on reconsideration, as modified and supplemented herein, we adhere to and republish our August 26, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 21, 1993

Cite as 45 Van Natta 2064 (1993)

In the Matter of the Compensation of
CLEON K. SINSEL, Claimant
 WCB Case No. 92-10297
 ORDER ON REVIEW
 Schneider, et al., Claimant Attorneys
 David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Myzak's order that upheld the SAIF Corporation's denial of claimant's chest pain claim. On review, the issue is compensability.

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

The Referee, finding that claimant's episode of chest pain was due to job stress, applied ORS 656.802 pursuant to SAIF v. Hukari, 113 Or 475 (1992). We agree with the Referee that claimant's stress claim is not compensable under ORS 656.802(3), as claimant does not have a diagnosed mental disorder. Accordingly, under the rationale expressed in Hukari, supra, his stress claim is not compensable. Also see Mathel v. Josephine County, 122 Or App 424 (1993).

On review, claimant asserts that the claim is more appropriately analyzed as an accidental injury under ORS 656.005(7)(a) since, according to claimant, the medical evidence shows that claimant's chest pain was caused by exhaustion from long working hours rather than job stress. More specifically, claimant argues that he has established the compensability of a discrete incident of "fatigue," caused by overwork.

Inasmuch as claimant related his growing weariness to long hours of firefighting dating back for at least one week, we have serious reservations as to whether or not his "fatigue" was sudden in onset. The appropriate standard to evaluate his claim may well be the "major contributing cause" standard for an occupational disease. ORS 656.802(1); Morrow v. Pacific University, 100 Or App 198 (1990); Valtinson v. SAIF, 56 Or App 184, 187-188 (1982). In any event, even if analyzed under an "injury" theory, we conclude that claimant has not established the compensability of an accidental injury.

Pursuant to the statute, an accidental injury will be compensable, if, among other things, it requires medical services or results in disability or death. ORS 656.005(7)(a). Here, however, claimant has not proven that an incident of fatigue led to his need for medical services or resulted in disability.

Rather, claimant testified that he sought medical attention due to his chest pain. Furthermore, Dr. Mutch, claimant's treating physician, diagnosed chest pain with a strong family history of coronary disease, history of dyspepsia and probable esophageal reflux, and elevated blood sugar. Dr. Mutch later attributed the chest pain to "stress, and lack of adequate rest." Specifically, Dr. Mutch stated that claimant's work activities "could be the cause of his chest pain." In a "check-the-box" letter prepared by claimant's attorney, Dr. Mutch later agreed that claimant's work activities on and before June 5, 1992 were the cause of his "chest pains and the need for hospitalization and treatment on June 5, 1992."

Consequently, although claimant contends that his discrete incident of fatigue should be compensable as an accidental injury, we conclude that the medical evidence supports a finding that claimant's need for treatment was due to chest pain. Furthermore, considering the notations in the medical reports regarding claimant's past history as a smoker, his strong family history of coronary disease and his problems with dyspepsia, esophageal reflux and hyperglycemia, Dr. Mutch's later, conclusory opinion is insufficient for us to conclude that claimant's need for medical treatment/disability for chest pains was materially related to "work-related" fatigue.

Finally, we find that Dr. Mutch's initial opinion established only that work-related stress and fatigue were "possible" explanations for claimant's chest pain. However, an opinion that suggests only a possible relationship between claimant's condition and his work does not support compensability. See Gormley v. SAIF, 52 Or App 1055 (1981). Additionally, although Dr. Mutch later supported the work relationship between claimant's work and his chest pains, he did not explain his reason for his subsequent opinion.

In light of claimant's prior medical history, we decline to rely upon Dr. Mutch's opinion which fails to discuss those factors. Additionally, Dr. Mutch did not differentiate between claimant's stress and fatigue conditions. Therefore, because claimant's stress is not compensable, we cannot use speculation to determine which portion of claimant's chest pain condition may be attributable to fatigue. Accordingly, for the aforementioned reasons, we do not find Dr. Mutch's opinion to be persuasive medical evidence on the issue of causation.

Under the circumstances, we agree with the Referee's conclusion that claimant has failed to establish the compensability of his claim. We, therefore, affirm.

ORDER

The Referee's order dated November 27, 1992 is affirmed.

October 21, 1993

Cite as 45 Van Natta 2065 (1993)

In the Matter of the Compensation of
JAIME G. TELLEZ, Claimant
WCB Case No. 91-15609
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Barber's order which upheld the insurer's denial of his aggravation claim for a herniated disc. The insurer moves to strike claimant's brief as untimely. On review, the issues are motion to strike and aggravation. We deny the motion and reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The insurer has moved to strike claimant's appellant's brief on the basis that it was not filed within 21 days after the mailing of the transcript. It relies, in part, on the date given on the certified notice of mailing attached to the brief. We deny the motion.

Here, claimant's appellant brief was due on December 22, 1992. OAR 438-05-046(1)(c) provides that briefs filed with the Board are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." The insurer contends that the certificate of service accompanying the brief sent to it indicated that the appellant's brief was mailed to the Board on December 23, 1992. Thus, the insurer argues, the appellant's brief was untimely. However, the certificate of service attached to the appellant's brief sent to the Board indicates that it was deposited in the mail to the Board on December 22, 1992. Further, the brief was mailed certified and the Receipt for Certified Mail indicates a post mark date of December 22, 1992. Accordingly, under the applicable administrative rule, claimant's appellant's brief was timely filed. Duane R. Paxton, 44 Van Natta 375 (1992).

Aggravation

The Referee found that claimant's September 15, 1984 compensable injury was not a material contributing cause of his current herniated disc at L5-S1. Therefore, the Referee concluded that claimant had not established a compensable aggravation of his industrial injury. We disagree.

The issue for resolution is whether claimant's current herniated disc is causally related to his 1984 compensable injury. A compensable worsening is generally proved by showing that the compensable injury was a material contributing cause of the worsening. Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if an off-the-job injury is the major contributing cause of the worsened condition, the worsening is not compensable. See ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992). Furthermore, it is the carrier's burden to prove that an off-the-job injury was the major contributing cause of the worsened condition. Roger D. Hart, 44 Van Natta 2189 (1992). Finally, when a compensable injury has combined with a preexisting condition, before addressing whether there has been a compensable worsening, the compensability of the resultant condition must first be established by proving that the compensable injury is the major contributing cause of the resultant condition. See Gray v. SAIF, 121 Or App 217 (1993).

Here, Dr. Mitchell, treating physician, opined that claimant's herniated disc was caused by his 1984 compensable injury rather than a February 1991 off-work incident. (Exs. 27; 28; 36). Dr. Malos, orthopedic surgeon, conducted a one-time examination upon referral from Dr. Mitchell. Based on a sparse history, Dr. Malos concluded that there was "no relationship" between claimant's herniated disc and the work-related injury of 1984. (Ex. 30). Subsequently, Dr. Malos reported that he had "no opinion" as to the causative factors of claimant's herniated disc and he would "have to defer to the opinions of others." (Ex. 35). Dr. Malos also opined that claimant's disc herniation predated the February 1991 off-work incident. (Ex. 38). Later, however, he reported that he had "no evidence that suggests to me that his disk herniation was a result of anything prior to that [February 1991 incident]." (Ex. 39-8). Further, he reported that it was the off-work February 1991 incident that was the more likely cause of claimant's disc herniation. (Exs. 39-12, 13, 14). He also opined that the 1984 compensable injury could have caused the disc herniation or the herniation could have happened in August 1991. (Exs. 39-17, 20, 23, 29-30). He also stated that he had no opinion as to the causation of claimant's disc herniation. (Ex. 39-23).

The Western Medical Consultants initially opined that the 1984 injury was the cause of claimant's disc herniation. (Ex. 32). However, without explanation, the Consultants later reported that the February 1991 incident was the major contributing cause of the herniation. (Exs. 33; 37).

We do not find the Consultants' opinions persuasive because they do not provide an explanation for their contradictory conclusions. Further, we are not persuaded by the opinions of Dr. Malos because he failed to provide any explanation for his several changes of opinion.

The Board generally gives the most weight to the conclusions of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no such reasons. Based on Dr. Mitchell's medical opinion, we conclude that claimant has established that the 1984 compensable injury was a material contributing cause of his herniated disc. Moreover, we conclude that the insurer has failed to carry its burden of proving that the February 1991 off-work incident was the major contributing cause of claimant's herniated disc.

Alternatively, the insurer contends claimant's disc herniation should be analyzed as a secondary consequence of the 1984 injury since the herniation was not discovered until 1991. On this basis, the insurer contends that claimant must prove that the 1984 compensable injury is the major contributing cause of the disc herniation. See Gray v. SAIF, supra; Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Dr. Mitchell opined that claimant substantially injured the L4-5 disc during the 1984 injury, and that the disc finally collapsed completely in 1991. He concluded that the 1984 compensable injury was the major contributing cause of claimant's herniated lumbar disc. First, we note that Dr. Mitchell's opinion would support the conclusion that the disc herniation arose directly, although belatedly, from the 1984 injury and therefore would not be considered a secondary consequence of the compensable injury. See Suzanne Day-Henry, 44 Van Natta 1792 (1992). However, even assuming that the herniation is viewed as a secondary consequence of the 1984 injury, we would conclude, based upon Dr. Mitchell's persuasive opinion, that claimant has established that the 1984 compensable injury is the major contributing cause of the herniation.

The insurer next contends that since claimant did not appeal its March 1991 denial, the law of the case "requires" Dr. Mitchell to assume that the February 1991 incident was the major contributing cause of claimant's back condition and February 1991 treatment. We do not agree that the March 1991 denial precludes claimant from contending that his disc herniation and need for surgery is related to the 1984 compensable injury.

The March 1991 denial merely denied that the employer was responsible for the February 1991 tire changing incident and advised that medical treatment for that incident was not authorized. (Ex. 21). The denial does not deny that the disc herniation is related to the 1984 compensable injury. Accordingly, we reject the insurer's argument. See International Paper Company v. Pearson, 106 Or App 121 (1991) (DCS resolving medical treatments resulting from a motor vehicle accident which occurred while claimant was traveling to a physician's office for treatment for a compensable injury did not preclude claimant from seeking payment of medical bills for subsequent treatments allegedly related to compensable injury).

We have concluded that claimant has established that his herniated disc is causally related to his 1984 compensable injury. We now address whether claimant has established a compensable aggravation.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

We find that claimant's herniated disc constitutes objective findings of a worsened condition of his compensable injury. Nevertheless, although claimant has established a worsening of his compensable injury, he must also establish that this worsening has resulted in diminished earning capacity. Smith v. SAIF, supra.

Prior to his last claim closure, claimant was released to return to regular work. In August 1991, claimant experienced significant back pain and returned to Dr. Mitchell. Dr. Mitchell subsequently released claimant from all work in August 1991 due to his back condition and claimant has not worked since being so advised by Dr. Mitchell. (Tr. 20-21). Therefore, we conclude that claimant has established diminished earning capacity as a result of his worsened condition.

Finally, as claimant had previously been awarded unscheduled permanent disability, he must also show that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8). If there was medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra.

Claimant's last arrangement of compensation was the October 1987 stipulation which awarded him 15 percent unscheduled permanent disability. On July 8, 1987, prior to the date of the stipulation, Dr. Webb, D.C., indicated that claimant remained very limited in lifting above shoulder height. Dr. Webb advised that when lifting above shoulder height, claimant "should never lift over 15 pounds and should limit lighter weights to an occasional basis only. To exceed these limitations will, in all medical probability, result in re-aggravation and flare-up of his condition." (Ex. 17-2). Based on Dr. Webb's July 1987 report predicting the possibility of future flare-ups, (at least of claimant's compensable left shoulder condition), we conclude that future waxing and waning was contemplated by the last award of compensation. Accordingly, we must determine whether claimant's worsened condition was more than a waxing and waning contemplated by the stipulation.

As a result of the 1984 compensable injury, claimant suffered injuries to his left shoulder and cervical spine as well as the low back. Dr. Webb predicted that claimant would re-aggravate his compensable left shoulder condition if he exceeded his lifting restrictions. Claimant's worsened condition (for which he now seeks compensation) is a herniated disc in his low back. We find that Dr. Webb's predictions of a future flare-up relate specifically to a waxing and waning of the left shoulder condition, rather than the low back. However, even assuming that Dr. Webb's predictions extend to a waxing and waning of the low back condition, his report does not persuade us that he contemplated a severe worsening of the low back condition such as the disc herniation which has occurred was contemplated.

Based on this record, we conclude that claimant has established that his worsened condition is more than a waxing and waning of symptoms contemplated by the last award of compensation (the 1987 stipulation). Accordingly, we conclude that claimant has established a compensable aggravation claim.

Claimant's counsel is entitled to an attorney fee for finally prevailing against the employer's denial. 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 assessed fee for claimant's counsel's services at hearing and on Board review is \$4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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 October 1, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of \$4,000, to be paid by the insurer.

October 21, 1993

Cite as 45 Van Natta 2068 (1993)

In the Matter of the Compensation of
WEBSTER N. WHITE, Claimant
 WCB Case No. TP-93010
THIRD PARTY DISTRIBUTION ORDER
 Gatti, et al., Claimant Attorneys
 William Brickey (Saif), Defense Attorney

The SAIF Corporation has petitioned the Board for resolution of a dispute concerning SAIF's entitlement to recover its entire lien from a third party judgment. See ORS 656.593(1)(c). Specifically, claimant contends that: (1) SAIF's share should be reduced by 15 percent (commensurate with the degree of claimant's comparative negligence); (2) SAIF is not entitled to full reimbursement because it interfered in claimant's prosecution of his third party action; and (3) claimant's attorney is entitled to an extraordinary attorney fee. We hold that SAIF is entitled to the remaining balance of proceeds which is in dispute. (\$1,552.84).

FINDINGS OF FACT

In February 1990, while performing his work activities, claimant was injured in a motor vehicle accident. The accident occurred when a third party attempted to turn left in front of the vehicle claimant was operating. As a result of the ensuing collision, claimant suffered a dislocated shoulder, a bruised kidney, and assorted bruises/lacerations.

SAIF, the workers' compensation insurer for claimant's employer, accepted the claim and has provided benefits. To date, SAIF has incurred claim costs totalling \$10,352.27. These costs are composed of medical bills (\$3,030.45), temporary disability (\$4,121.82), and permanent disability (\$3,200).

Claimant retained legal counsel to explore the possibility of bringing suit against the third party. Eventually, claimant filed a cause of action, contending that the third party had been negligent in causing the accident. Claimant sought damages totalling \$101,154.45. These damages were comprised of the following items: (1) medical bills (\$3,030.45); (2) future medical expenses (\$1,500); (3) lost wages (\$6,624); (4) economic damages (future impairment to earning capacity) (\$25,000); and (5) non-economic damages (permanent pain, anguish, and suffering) (\$65,000).

Claimant's cause of action was subsequently referred to binding arbitration. In February 1993, a hearing was convened. The arbitrator reached the following decision. Claimant had suffered damages totalling \$30,337.60. (\$12,337.60 in economic damages and \$18,000 in non-economic damages). The arbitrator further determined that claimant had been comparatively negligent. Evaluating claimant's comparative negligence at 15 percent, the arbitrator reduced claimant's award to \$25,786.96.

In March 1993, claimant's counsel notified SAIF of the arbitrator's decision. In light of the arbitrator's comparative negligence finding, claimant reasoned that SAIF's recovery should likewise be reduced by 15 percent.

SAIF did not agree with claimant's proposal. Relying on ORS 656.593, SAIF contended that it was entitled to full reimbursement of its lien from claimant's award. Thereafter, the parties agreed that claimant would forward to SAIF 85 percent of its claimed lien (\$8,799.43). They further stipulated that an amount equal to the remaining 15 percent of SAIF's claimed lien (\$1,552.84) would be held by claimant's counsel in trust pending Board resolution of their dispute.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker shall elect whether to recover damages from the third person. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, 84 Or App 616 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Since claimant elected to seek recovery from a third party for damages resulting from his compensable injury, his 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.

Here, claimant does not challenge SAIF's assertion that it has incurred the claim costs for which it seeks reimbursement. Instead, claimant objects to SAIF's request to recover its entire lien from the third party judgment. Claimant bases his objection on three grounds. One, because his judgment was reduced by 15 percent (based on his comparative negligence), claimant argues that SAIF's lien should likewise be reduced by 15 percent. Two, since SAIF's conduct either contributed to the reduction of his judgment or interfered in the prosecution of his cause of action, claimant asserts that SAIF's reimbursement claim should be reduced. Three, claimant's counsel is entitled to an extraordinary attorney fee.

We are not persuaded by any of claimant's arguments. To begin, his first two contentions are essentially based on the proposition that it would be "just and proper" for SAIF to receive less than its full share of the third party recovery. Yet, the "just and proper" distribution scheme is applicable only to third party settlements. See ORS 656.593(3); Estate of Troy Vance v. Williams, supra.

Inasmuch as this dispute concerns SAIF's share of a third party judgment, the "just and proper" language of ORS 656.593(3) does not apply. Instead, SAIF is entitled to be paid and retain the balance of the third party recovery to the extent that it is compensated for the claim expenditures described in ORS 656.593(1)(c). Since it is undisputed that SAIF incurred the claim costs it has presented in its lien and because the remaining balance of claimant's third party judgment is sufficient to satisfy that lien, SAIF is entitled to recovery of its entire lien.

Even assuming that a "just and proper" analysis was applicable, we would continue to conclude that SAIF is entitled to its full share. As previously noted, SAIF's lien attaches to the proceeds of any damages that claimant recovers from the third party. See ORS 656.593(1). Since claimant's judgment arose from his third party cause of action and because that action was also a compensable injury for which SAIF has expended compensation, the entire judgment is subject to SAIF's lien. See Galé E. Charlton, 43 Van Natta 1356 (1991). The entire judgment includes general, as well as special, damages. Kenneth Owens, supra.

Obviously, the arbitrator's finding of comparative negligence effected claimant's ultimate recovery in that his award was reduced by 15 percent. Nevertheless, the comparative negligence finding does not alter the fact that SAIF incurred the claim costs listed in its lien while lawfully processing claimant's compensable claim. Moreover, claimant was never granted an award prior to the attachment of the comparative negligence reduction. In other words, the comparative negligence finding was merely another component of claimant's cause of action (albeit a significant one) leading to his eventual third party judgment.

Because SAIF's lien attaches to claimant's third party judgment, it is entitled to receive its lawful share of the remaining balance of the judgment proceeds to the extent possible. Since the remaining balance can fully satisfy SAIF's lien, SAIF is entitled to receive reimbursement for its entire lien.

Claimant's "conduct/interference" argument is likewise premised on the "just and proper" distribution standard set forth in ORS 656.593(3). As discussed above, that standard is inapplicable. However, even if such a standard applied, we would not consider it "just and proper" to reduce SAIF's recovery based on claimant's argument.

Claimant has submitted an affidavit from his counsel contending that the "comparative negligence award arose as a result of an independent witness' testimony that SAIF's investigator improperly paraphrased her statement." Counsel further states that the witness would not provide a statement in advance of trial because the witness "had already provided a statement to [claimant's] representative." Finally, counsel asserts that "SAIF was unable to provide any taped statement to counsel and had in effect prevented counsel from obtaining additional investigation."

Notwithstanding such contentions, claimant fails to explain how the independent witness' statement was misparaphrased. More importantly, other than counsel's conclusory statement, there is nothing in the record to establish that such paraphrasing resulted in the comparative negligence finding. Specifically, the arbitrator's judgment provides no explanation for such a conclusion.

In any event, even if this so-called "improper paraphrasing" did prompt the comparative negligence finding, such a determination does not lead to a conclusion that SAIF hindered or interfered with claimant's prosecution of his cause of action against the third party. As the prosecutor of his third party claim, it was incumbent on claimant to prepare his case for trial. Such preparations would necessarily include an examination of already existing statements, as well as possible further interviews with potential witnesses. If a particular witness became recalcitrant in providing additional information, there would certainly be readily available pre-trial discovery tools; i.e., deposition, interrogatories. Finally, as claimant's counsel essentially acknowledges in her affidavit, it was the witness who refused to provide another "pre-trial" statement; there is no proof that SAIF either explicitly or implicitly directed the witness not to cooperate in the prosecution of claimant's case nor is there evidence that SAIF refused to comply with any request from claimant for claim information.

Finally, as his third objection to SAIF's full recovery, claimant seeks an extraordinary attorney fee; i.e., 40 percent of the judgment. Claimant asserts that 200 hours of work (150 by his counsel) were expended over the course of 36 months. Furthermore, claimant notes that, without SAIF's financial assistance, he was able to obtain a \$25,789.96 judgment when the pre-trial third party settlement offer had been \$8,000.

Since claimant has neglected to present an executed retainer agreement, we are unable to grant his request for an extraordinary attorney fee. See OAR 438-15-010(1). In any event, even if such an agreement was filed, we would decline to grant claimant's request because we do not consider the circumstances to be extraordinary.

It is undisputed that claimant's counsel has expended a significant amount of time in pursuing claimant's third party judgment. In addition, with the exception of the comparative negligence finding, those efforts have produced a favorable result. Nevertheless, there is no contention that this motor vehicle accident / negligence case was either legally or factually complex.

Moreover, despite the extensive number of hours devoted to this case, such efforts do not favorably compare with the efforts expended in cases where we have previously found extraordinary circumstances. John Galanopoulos, 35 Van Natta 548 (1983) (40 percent attorney fee granted where claimant's counsel expended nearly three full months in preparation for a 5-day malpractice trial and obtained an extremely favorable result); John P. Christensen, 38 Van Natta 613 (1986) (50 percent attorney fee granted where claimant's counsel had litigated case for 10 years, including two presentations on procedural issues before the Oregon Supreme Court and one mistrial, and the paying agency had no objection to the request). Finally, SAIF, the paying agency, is objecting to claimant's request for an extraordinary attorney fee.

Accordingly, based on the foregoing reasoning, we conclude that this case does not present extraordinary circumstances warranting an attorney fee in excess of 1/3 of claimant's third party judgment. See ORS 656.593(1)(a); OAR 438-15-095; Lela Nyseth, 42 Van Natta 2057 (1990). Consequently, claimant's request for an extraordinary attorney fee is denied.

In conclusion, we hold that SAIF is entitled to recover its entire lien from the remaining balance of claimant's third party judgment. ORS 656.593(1)(c). Therefore, claimant's counsel is directed to immediately forward to SAIF the disputed amount which has been held in trust pending resolution of this matter (\$1,552.84).

IT IS SO ORDERED.

October 21, 1993

Cite as 45 Van Natta 2071 (1993)

In the Matter of the Compensation of
HARLEY D. WRIGHT, Claimant
WCB Case Nos. 92-08220 & 92-03652
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Davis, et al., Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of that portion of Referee Hazelett's order that upheld the self-insured employer's denial of his aggravation claim for his current low back condition. In his brief, claimant contends that the Referee abused his discretion by admitting into evidence Exhibits 81A, 82, 82A, 82B, 82C, 82D, 93A and 93B. Claimant also moves to have the case remanded for another hearing. On review, the issues are evidence, remand and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAWEvidence

The Referee admitted Exhibits 81A, 82, 82A and 82B solely for impeachment purposes. On review, claimant contends that the exhibits should not have been admitted because they were not relevant and because the exhibits were used for impeachment on collateral matters. Claimant also contends that the remaining disputed exhibits were prejudicial and were intended to offer evidence of prior bad acts.

After reviewing the record, we conclude that the case for finding an abuse of discretion is a close one, with respect to certain exhibits. However, due to our conclusion on the merits of this case, we do not reach the issues of abuse of discretion or remand.

Compensability

The Referee concluded that credibility was a central issue to the determination of this matter. He further concluded that, if claimant's version of an event was not corroborated, he would not rely solely upon claimant's testimony.

Although we agree with the Referee's ultimate conclusion that claimant's claim is not compensable, we do not find that credibility is a central issue in this case. Therefore, we substitute the following conclusions on the issue of compensability.

On review, claimant contends that he is entitled to medical services for his accepted low back condition. Claimant must prove that his need for medical services is materially related to his compensable 1981 low back injury. ORS 656.245; Van Blokland v. OHSU, 87 Or App 694 (1987).

Claimant primarily relies upon the opinion of Dr. Ordonez, who treated him in 1991 for low back pain. On an 829 form, Dr. Ordonez stated that claimant had had no recent injury or accident, but since June 1990, his symptoms had intensified. Dr. Ordonez further stated that claimant "relates this pain to a work injury of 1980 or 1981." On June 9, 1992, Dr. Ordonez signed a letter from claimant's counsel, agreeing that the work-related injury which occurred on November 23, 1981 remains the major cause of claimant's current need for treatment.

Considering the extensive time lapse between 1981 and 1991 and without further medical explanation of how claimant's current low back condition is related to his 1981 injury, we are not persuaded by the conclusory opinion provided by claimant's counsel and signed by Dr. Ordonez. Furthermore, the only other opinion in the record which discusses causation is that of Dr. Watson, an independent medical examiner. Dr. Watson reviewed claimant's records and noted that claimant had experienced hip pain associated with climbing out of a truck in February 1991. Dr. Watson opined that, as a result, claimant had new symptoms "on the opposite side as those identified ten years before." For that reason, Dr. Watson concluded that claimant's strain of 1981 was "no longer responsible" for his current condition and need for treatment.

Consequently, we conclude that there is no persuasive medical evidence in the record to establish a causal relationship between claimant's current low back condition and the 1981 injury. We, therefore, conclude that claimant has failed to establish that his need for medical services is materially related to the 1981 injury.

ORDER

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

In the Matter of the Compensation of
JACK L. PETIT, Claimant
Own Motion No. 93-0548M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable multiple pelvic fractures injury. Claimant's aggravation rights expired on November 22, 1977. SAIF recommends that we do not authorize the payment of temporary disability compensation since claimant did not miss any time from work as the result of his surgery.

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

Claimant underwent surgery related to his compensable condition on July 2, 1993, and was released from the hospital on that same day. Thus, we are persuaded that claimant's compensable injury has worsened requiring surgery. However, we are unable to authorize the reopening of claimant's claim to provide temporary total disability compensation since claimant did not suffer time loss from work due to the surgery.

Temporary disability benefits are to compensate workers for wages lost because of their inability to work due to the compensable injury. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985); William C. Ford, 42 Van Natta 810 (1990). In a letter dated August 24, 1993, SAIF's claims examiner stated that "[a]ccording to [claimant], he did not miss any time from work as a result of his surgery." Claimant's submits no proof that the surgery caused him to lose any wages. Therefore, on this record as presently developed, claimant is not entitled to temporary disability compensation.

Accordingly, claimant's current request for temporary disability compensation resulting from his July 2, 1993 surgery 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.

October 21, 1993

Cite as 45 Van Natta 2073 (1993)

In the Matter of the Compensation of
WALTER MOORE, Claimant
WCB Case No. 92-08444
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of his current right eye condition. On review, the issues are res judicata and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

We note that the Referee's order indicates that only Exhibits 1 through 24 were received into evidence. However, the Referee made reference to and relied on Exhibit 25, a report from Dr.

Stoumbos, in her order. In addition, the insurer refers to Exhibit 25 in its brief. Neither party raised any evidentiary objections in the record and claimant does not object to Exhibit 25 in his brief. Accordingly, we conclude that the Referee intended to admit, and implicitly did admit, Dr. Stoumbos' report (Exhibit 25) into evidence. See Aletha R. Samperi, 44 Van Natta 1173, 1174 (1992); Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991).

Res Judicata

The Referee found that res judicata did not bar the insurer from denying compensability of claimant's current right eye condition. We agree.

On December 16, 1987, claimant struck his eye on the corner of a battery while at work. A corneal abrasion was diagnosed and the claim was accepted as an injury. Claimant came under the treatment of Dr. Huber, an eye surgeon, in early 1988. Dr. Huber diagnosed a traumatic pre-retinal hemorrhage of the right eye and background diabetic retinopathy. At that time, claimant had had diabetes for eight years.

On review, claimant contends that the insurer is barred by the doctrine of res judicata from denying his current right eye condition, diagnosed as neovascular glaucoma. Specifically, claimant argues that the permanent disability awarded by the October 20, 1988 Determination Order was for the preexisting diabetic retinopathy rather than the corneal abrasion and pre-retinal hemorrhage due to the compensable injury. Based on this reasoning, claimant contends that the Determination Order constituted an adjudication of, or an opportunity to adjudicate, compensability of claimant's preexisting diabetic retinopathy. Therefore, claimant asserts that the insurer is now bound by claim preclusion from denying compensability of that condition. We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). Here, the October 20, 1988 Determination Order became final without "actual litigation," therefore issue preclusion does not apply.

Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980).

Here, the October 20, 1988 Determination Order did not decide or litigate compensability of diabetic retinopathy. Rather, the unappealed Determination Order settled only issues relating to temporary and permanent disability resulting from the compensable injury and the date claimant became medically stationary from that injury.

Moreover, the medical evidence indicates that claimant's condition has changed since the date of the 1988 Determination Order, creating a new set of operative facts that previously could not have been litigated. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989). Specifically, prior to the 1988 permanent disability award, Dr. Huber had diagnosed background diabetic retinopathy. According to Dr. Stoumbos, claimant's condition has worsened since 1988 and claimant's current condition is neovascular glaucoma which is a complication of diabetic retinopathy.

Based on this record, we conclude that the extent and medically stationary issues related to claimant's 1987 corneal abrasion injury (which were decided by the 1988 Determination Order) and the compensability of claimant's preexisting diabetic retinopathy do not arise out the same factual transaction and are, therefore, not the same "claim" for purposes of claim preclusion. Accordingly, we conclude that the Determination Order did not present a prior opportunity to litigate the compensability of the preexisting diabetic retinopathy condition.

Claimant's contentions on review can be interpreted as asserting that the insurer admitted liability for the diabetes condition by failing to challenge the permanent disability award. We disagree. The mere fact that the insurer did not challenge the permanent disability award does not equate with acceptance of the underlying diabetic retinopathy condition or an admission of liability for that condition. See ORS 656.262(9) (Merely paying or providing compensation shall not be considered

acceptance of a claim or an admission of liability); see also Dotty C. Fowler, 45 Van Natta 951 (1993) (payment of a permanent disability award does not constitute an acceptance of the condition for which the compensation was paid). Accordingly, we conclude that the insurer is not barred by res judicata from denying claimant's current right eye condition. Having determined that res judicata does not bar the insurer from denying claimant's current right eye condition, we turn to the merits of the denial.

Compensability

Dr. Huber opined in September 1988 that claimant's diabetic retinopathy may well have been exacerbated by the compensable injury. The record contains no opinions from Dr. Huber subsequent to September 1988 which addresses causation of claimant's right eye condition.

After conducting a file review, Dr. Stoumbos, an eye surgeon, provided a September 8, 1992 report. In that report, Dr. Stoumbos opined that the original injury may have contributed to an exacerbation of claimant's diabetic macular edema. However, Dr. Stoumbos indicated that claimant's current condition, neovascular glaucoma, is most likely a complication of diabetic retinopathy which is unrelated to the corneal abrasion or traumatic pre-retinal hemorrhage resulting from the 1987 injury.

Based on the medical evidence, we conclude that claimant has not established that the 1987 injury is a material or the major contributing cause of his current right eye condition (diagnosed as neovascular glaucoma). Consequently, we uphold the insurer's denial.

ORDER

The Referee's order dated November 2, 1992 is affirmed.

October 25, 1993

Cite as 45 Van Natta 2075 (1993)

In the Matter of the Compensation of
SHIRLEY J. DAVIS, Claimant
WCB Case Nos. 91-18467 & 91-13994
ORDER ON REVIEW
Miller, et al., Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Davis' order which upheld the denial by Fred Meyer, Inc., a self-insured employer, of claimant's aggravation claim for a cervical and low back condition. Fred Meyer cross-requests review of those portions of Referee Davis' order that: (1) set aside its disclaimer and denial of responsibility for claimant's cervical and low back condition; and (2) dismissed Portland Community College from this proceeding. On review, the issues are compensability (aggravation), responsibility, and joinder.

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

In cases involving issues of compensability and responsibility, the threshold issue is compensability. If the claim is compensable, then the trier of fact must address the issue of responsibility. Cindy L. Sanders-Ahern, 44 Van Natta 801 (1992). Consequently, before addressing the issue of responsibility, we examine whether claimant has established a valid aggravation claim.

To establish an aggravation, claimant must prove a worsening of her compensable condition since the last award or arrangement of compensation. ORS 656.273(1). Because claimant seeks disability compensation for a worsening of an unscheduled body part, claimant must prove that her symptoms have increased or that her underlying condition has worsened, resulting in diminished earning capacity. ORS 656.273; Smith v. SAIF, 302 Or 396 (1986); Leroy Frank, 43 Van Natta 1950 (1991). The worsening must be more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. ORS 656.273(8).

The Referee found that claimant had shown, by medical evidence supported by objective findings, a symptomatic worsening of her condition as a result of the February 20, 1991 incident. He also found that the worsening resulted in diminished earning capacity. We disagree.

Claimant's treating physician, Dr. Berkeley, examined claimant on March 3, 1991 and found no neurological changes in her condition. He opined that, based on claimant's history, claimant had "re-exacerbat[ed]" her condition. He recommended palliative treatment. (Ex. 64A). Dr. Berkeley's opinion is otherwise conclusory regarding the worsening of claimant's condition. (See Ex. 74A).

Dr. Gardner performed a medical arbiter examination on May 10, 1991. His neurological examination was also normal. Dr. Gardner opined that claimant remained medically stationary since her September 20, 1990 claim closure. Dr. Gardner felt that claimant was capable of performing at least light work, if not more. He placed no restriction with regard to bending, lifting, and stooping. (Ex. 63A).

Dr. Fuller, who had examined claimant in December 1989 and again in December 1991, found, based upon a review of medical records and upon examination, no change in claimant's condition based on objective evidence, other than claimant's subjective limitations in ranges of motion. He felt that claimant had severe psychogenic magnification and embellishment of her subjective symptoms. Dr. Fuller further stated that a comparison of the ranges of motion in various reports varied widely without any change in pathology. He, therefore, concluded that claimant's condition had not worsened. (Exs. 73B, 75).

On the question of whether claimant has established, by medical evidence supported by objective finding, a worsened condition, we find Dr. Fuller's opinion well-reasoned and, thus, persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Consequently, we conclude that claimant has not established, by medical evidence supported by objective findings, a worsening of her compensable condition.

Even assuming claimant has established a worsening of her condition, claimant has failed to establish that the worsening resulted in diminished earning capacity or was more than a waxing and waning of symptoms contemplated at the time of the last award of compensation.

Claimant has not worked for Fred Meyer since April 1989. At the time of the claim for aggravation, claimant was attending school and working part-time at the school's resource center checking materials in and out. Prior to claim closure, claimant had been released for light work. This restriction has not changed. Claimant continued to work following the February 20, 1991 incident, but apparently left school prior to June 1991. (Tr. 18, Ex. 7A). Dr. Berkeley, however, has not taken claimant off work nor authorized time loss or otherwise indicated that she was less able to work in February 1991. Thus, even if we were to find a worsening of claimant's condition, we find the evidence insufficient to establish that the worsening resulted in diminished earning capacity.

On the waxing and waning issue, we agree with and adopt the conclusions and reasonings as set forth in the Referee's order.

Fred Meyer argues on appeal that if claimant's aggravation claim is found compensable, Portland Community College (PCC), as the subsequent employer, should have been joined in these proceedings for purposes of deciding the responsibility issue. Given our finding that claimant has failed to establish a compensable aggravation, we need not reach the issue of responsibility. Therefore, the joinder issue is moot.

ORDER

The Referee's order dated December 14, 1992, as modified on December 23, 1992, is affirmed.

In the Matter of the Compensation of
NANCY M. BUCKLES, Claimant
WCB Case No. 91-12482
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Miller, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Menashe's order which held that an Order on Reconsideration, which had issued without the appointment of a medical arbiter, was invalid and remanded the matter to the Appellate Unit. On review, the issues are the validity of the Order on Reconsideration and extent of permanent disability. We remand.

FINDINGS OF FACT

On June 4, 1990, claimant sustained a compensable injury to her right shoulder. The claim was accepted by the self-insured employer as a disabling contusion of the upper arm. Claimant's treating physician for her injury was Dr. Ellison.

Claimant's claim was closed by a February 22, 1991 Determination Order. Claimant was found medically stationary as of January 4, 1991 and was awarded no permanent disability.

On May 9, 1991, claimant requested reconsideration of the Determination Order. (Ex. 36A). Her request for reconsideration was made on the form provided by the Department of Insurance and Finance. On the form, claimant checked the box indicating that she disagreed with the impairment findings made by her attending physician at the time of claim closure and added the statement that the findings were incomplete. With her request for reconsideration, claimant submitted a supplemental report form from Dr. Ellison which consisted of answers to questions from claimant's counsel with regard to the extent of claimant's permanent disability under the relevant Director's rules. Dr. Ellison indicated that claimant was medically stationary on January 4, 1991 and that the examination on which her findings were based took place on April 18, 1991. (Exs. 34A, 35 and 36).

On August 30, 1991, an Order on Reconsideration issued which affirmed the Determination Order. The order stated that the Appellate Unit was unable to complete a substantive review of the reconsideration request within the time limits of the court injunction in Benzinger, et al v. Department of Insurance and Finance, Multnomah County Circuit court, No. A9102-01201 and affirmed the prior determination order without appointing a medical arbiter. Claimant was nevertheless instructed to attend an examination by a medical arbiter to be scheduled by the Appellate Unit or to notify the Appellate Unit if she wanted to cancel the medical arbiter process.

At hearing, the Referee concluded that he was bound by our decision in Olga I. Soto, 44 Van Natta 697 (1992), recon den 44 Van Natta 1609 (1992), which required that the Order on Reconsideration be set aside as invalid because the Department had failed to appoint a medical arbiter. (Tr. 4). Claimant's counsel acknowledged that claimant had checked the box indicating that she disagreed with the impairment findings, but that her disagreement included her statement that the attending physician's findings were incomplete and that she was providing the supplemental information. (Tr. 6). In her appellate briefs, claimant indicated that she did not want a medical arbiter appointed. (Appellant Brief at p. 2; Reply Brief at p. 1). Rather, claimant relied on Dr. Ellison's impairment findings as supplemented by Exhibit 36, Dr. Ellison's April 29, 1991 report.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the Order on Reconsideration was not valid because an arbiter had not been appointed and therefore concluded he lacked jurisdiction to consider the merits of the reconsideration order. We disagree.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). In Pacheco-Gonzalez, the court held the validity of an Order on

Reconsideration is not a prerequisite for determining jurisdiction. The court noted that ORS 656.268(6)(b) allowed any party to request a hearing under ORS 656.283 if there was an objection to a reconsideration order. The court further noted that ORS 656.283(1) allowed any party or the Director to request a hearing on any question concerning a claim at any time. The court reasoned that "neither statute requires a 'valid' order on reconsideration for the referee to have jurisdiction. No statute divests the Board of its obligation where an 'invalid' order on reconsideration occurs." Id.

Accordingly, inasmuch as the validity of an Order on Reconsideration has no bearing on the Referee's jurisdiction, claimant's challenge to the Order on Reconsideration was properly before the Referee and should be considered on its merits.

In addition, we note parenthetically, that also subsequent to the Referee's order, 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.

In light of his conclusion that the Order on Reconsideration was invalid, the Referee concluded the hearing without permitting the parties an opportunity to present testimony. Under these circumstances, we find that the record is improperly, incompletely or otherwise insufficiently developed and find it appropriate to remand this matter to the Referee for further proceedings consistent with this order. See ORS 656.295(5). Such proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated June 2, 1992 is vacated. The matter is remanded to Referee Menashe for further proceedings consistent with this order.

October 26, 1993

Cite as 45 Van Natta 2078 (1993)

In the Matter of the Compensation of
GENAVÉE I. INGRAM, Claimant
 WCB Case No. 91-11009
ORDER ON REVIEW
 Floyd H. Shebley, Claimant Attorney
 Davis, et al., Defense Attorneys

Reviewed by the Board Members Westerband, Neidig, and Gunn.

The insurer requests review of Referee Mills' order which set aside its denial of claimant's claim for an ulcerated finger 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

It is undisputed that claimant has preexisting, noncompensable scleroderma. Scleroderma is a collagen vascular disease that causes capillaries to vanish and small blood vessels to become occluded. Most people with scleroderma will eventually develop digital ulcerations.

On February 28, 1991, claimant sustained a compensable laceration of her third right finger. Claimant self-treated the laceration. On April 9, 1991, she sought treatment for an ulcer on her finger. On July 16, 1991, the insurer issued a denial of claimant's current condition.

Relying on the opinions of Drs. Porter and Cofield, the Referee found that the ulcer resulted from the laceration, but that the ulcer also would not have occurred absent the scleroderma, and, therefore, both the laceration and the preexisting scleroderma caused claimant's current condition. He determined that "but for" the laceration, there would have been no ulcer or need for treatment. The Referee, therefore, concluded that the laceration remained the major contributing cause of the need for treatment because the laceration had not resolved to the point where its relative contribution was no longer major.

We agree with the Referee that the medical evidence establishes that the compensable laceration combined with the preexisting scleroderma resulting in a chronic, nonhealing ulcer. However, because we disagree with the Referee's application of ORS 656.005(7)(a)(B), we reverse.

Under ORS 656.005(7)(a)(B), in cases where the initial injury has been found compensable, "[a] condition resulting from a combination of the injury and a preexisting condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment of the 'resultant condition.'" Tektronix, Inc. v. Nazari, 117 Or App 409, mod 120 Or App 590 (1993); U-Haul of Oregon v. Burtis, 120 Or App 353 (1993).

Here, the "resultant condition" is the chronic, nonhealing finger ulceration. Accordingly, 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. Burtis, 120 Or App at 357-358. The "major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983).

Numerous physicians have rendered opinions on the causation of claimant's ulceration condition. Drs. Geary, Nathan, Cofield, and Porter expected, within reasonable medical probability, that claimant's laceration would have healed promptly and without difficulty in the absence of scleroderma. These doctors also opined that the laceration did not worsen the preexisting scleroderma.

Dr. Parson, claimant's initial treating physician, opined that the laceration was the inciting event that led to the ulcer, explaining that in the absence of the injury, the ulcer would probably not exist. He recognized that the scleroderma predisposed the condition to become a nonhealing ulcer. He concurred with Dr. Cofield that the scleroderma was not the major cause of the chronic nonhealing ulcer, but was the major cause in the maintenance of the chronic nonhealing ulcer.

Dr. Geary, vascular surgeon (referred by Cofield), opined that the preexisting scleroderma was the major contributing cause of claimant's current condition and need for treatment. He felt that in the absence of the scleroderma, claimant's laceration would have already healed.

Dr. Nathan, hand surgeon, opined that the case was a classic example of "which came first, the chicken or the egg." He stated that, based on Drs. Parsons and Cofield's premise that the ulcer would not be present absent the laceration, the laceration was the precipitating event in the development of the ulcer, but the major contributing cause of claimant's present nonhealing ulcer was the underlying disease process.

Dr. Cofield, claimant's present treating physician, opined that the laceration was the major contributing cause of the ulcer, because the ulcer would not have been present in the absence of the laceration. But, he also concluded that the scleroderma was the cause of the ulcer's maintenance and inability to heal.

Dr. Porter, specialist in vascular surgery, opined that the laceration occurring in the setting of the scleroderma resulted in the development of the chronic nonhealing ulcer. However, the underlying scleroderma was the major contributing cause of the ulcer's failure to heal. He opined that the scleroderma caused the ulcer, explaining that there would have been no ulceration in the absence of the scleroderma. Porter further explained that the perpetuation, worsening, and continuation of the ulcer was related to the scleroderma. Even if the laceration caused some ulceration, absent the scleroderma, Porter stated that the laceration would not have resulted in the type of condition, disability, and need for treating that claimant experienced.

The medical evidence consistently points to the compensable laceration as the initial cause of the ulcer, in that the ulcer would not have existed absent the laceration. We interpret this evidence as establishing that the injury is a material contributing cause of the finger ulceration. However, the well-reasoned and thorough opinion of Dr. Porter persuades us that the laceration no longer remains the major contributing cause of the chronic nonhealing ulcer. Rather, the major contributing cause of the ulcer's failure to heal and, therefore, of the ulcer's chronic state, is the preexisting scleroderma. The resultant condition is the chronic nonhealing ulcer. Prior to the compensable injury, other lacerations had healed without difficulty. The failure of the ulcer to heal is caused by the scleroderma and not the compensable laceration.

Dr. Porter's opinion is supported by Drs. Nathan, Geary, and Cofield. Although Dr. Cofield opined that the major cause of the ulceration was the laceration, he felt that the ulcer's atypical progression and inability to heal was due to the scleroderma.

Accordingly, we conclude that claimant did not prove that her compensable finger laceration injury remains the major contributing cause of the resultant finger ulceration. Consequently, the insurer's denial is reinstated and upheld.

ORDER

The Referee's November 23, 1992 order is reversed. The insurer's denial of claimant's current condition and need for treatment is reinstated and upheld. The Referee's attorney fee award is reversed.

Board member Gunn dissenting.

The majority holds that claimant's current finger condition is not compensable. Implicit in their holding is the finding that claimant has a preexisting scleroderma condition which has "combined" with claimant's accepted finger "laceration" to produce a resultant condition, namely, the current finger ulceration. Applying the legal standard of major contributing cause pursuant to ORS 656.005(7)(a)(B), the majority concludes that claimant has failed to meet this burden. Because I find the majority has erred, both as a factual and legal matter, I respectfully dissent.

To begin, application of ORS 656.005(7)(a)(B) requires evidence of a preexisting condition which has combined with the compensable injury. Here, there is no evidence of a medical condition necessitating treatment which preexisted the compensable claim. It has only been since the compensable injury that her physicians have entertained the possibility of an underlying condition. Because of the finger's failure to heal, the physicians have speculated that the underlying disease process might be early scleroderma (or a variant thereto), a fungal infection, factitial dermatitis, or possibly Buerger's disease.¹ Regardless of the actual diagnosis, there is no persuasive evidence this problem preexisted the compensable claim. There is simply no medical history of claimant being diagnosed or treated with such a disorder. Nor is there evidence of manifestations of an underlying condition, i.e., finger ulcerations. Indeed, claimant, prior to this injury, has never had any problems with cuts. It was not until the compensable injury that the presence of an underlying disease process suggested itself to the medical experts.

Given these facts, the only sensible approach is to conclude that claimant's underlying disease process, whatever its eventual diagnosis turns out to be, was a predisposition or susceptibility. It is established legal principle in workers' compensation law that a predisposition or susceptibility to a disease process is no bar to compensability. See Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991); John W. Walters, 45 Van Natta 55 (1993); Rodney T. Buckallew, 44 Van Natta 358 (1992), Aff'd Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993). Accordingly, I would

¹ Dr. Nathan originally diagnosed "Buerger's disease." (See Ex. 10-2). Based on this diagnosis, the insurer issued a partial denial. (See Ex. 11-1). The diagnosis of scleroderma first began as a probability by the treating doctor. By the time of the deposition of the insurer's independent medical examiner, it was described as follows: "I do believe Dr. Cofield is correct. I happen to share his suspicion. I believe this patient has scleroderma, but I'm not positive." (See Ex. 33-14 (emphasis added)).

submit that a physical condition which has not resulted in medical attention, diagnosis, treatment or disability prior to a compensable injury is, at most, a predisposition, and not a preexisting medical condition within the meaning of ORS 656.005(7)(a)(B). That being the case, the underlying process cannot be a "cause" in determining whether or not claimant has carried her burden of proof. Thus, there can be no causal preexisting condition to combine with and produce a "resultant condition." Therefore, the application of ORS 656.005(7)(a)(B) is incorrect.

Rather, I find this case should be analyzed as a consequential condition in accordance with ORS 656.005(7)(a)(A). In Gasperino the court made a clear distinction between a condition or need for treatment that is caused by an industrial accident, and a condition or need for treatment that is caused in turn by the compensable injury. In the former case, the legal standard is material contributing cause. In the latter case, the legal standard is major contributing cause. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

The facts of this case are straightforward. Claimant cut herself at work. This laceration quickly developed into a festering wound that would not heal. The physicians have characterized this condition as a "chronic ulceration." It was for this condition, not the laceration, that claimant sought medical care, was disabled, and filed a workers' compensation claim. It was on this basis the claim was accepted by the insurer.² From these facts only one conclusion can be reached that makes any sense. Claimant's condition directly arose from the industrial injury. That being the case, the legal standard is material contributing cause. Clearly, and overwhelmingly, claimant has met this burden of proof. As did the Referee, I would find claimant's condition compensable and set aside the insurer's denial.

² As an additional aside, I would also argue the "current condition" denial is in contravention of the spirit of ORS 656.262(6). This statute provides that if the insurer issues a "back-up" denial and claimant requests a hearing, the insurer must prove by clear and convincing evidence that the condition is not compensable. Although couched in terms of a "current condition" denial, and therefore technically correct, the reality is the insurer is attempting to "back-up" and deny the entire claim. As noted above, claimant never sought treatment for a cut. She only sought treatment for the ulceration. Therefore, to deny the ulceration is to deny the entire claim. That being the case, the insurer should be bound by the statute governing "back-up" denials and be required to prove by "clear and convincing" evidence that the claim was not compensable. It is clear that on this record the insurer cannot sustain such a burden.

October 26, 1993

Cite as 45 Van Natta 2081 (1993)

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

On September 16, 1993, we withdrew our July 19, 1993 Order on Remand, as reconsidered August 18, 1993, which directed the SAIF Corporation 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. We took this action to consider SAIF's contention that our reasoning was inconsistent with ORS 656.388(1), (2), and the holding in Mohammad Zarifi, 42 Van Natta 670 (1990). Having received claimant's reply, we proceed with our reconsideration.

We briefly summarize the relevant facts. Claimant, through her counsel, filed a "supplemental" hearing request, seeking additional temporary disability. Specifically, claimant was contending that SAIF had miscalculated the rate for her temporary disability. SAIF, which had previously received claimant's executed retainer agreement, also received a copy of claimant's supplemental hearing request. Shortly thereafter, SAIF recalculated the rate of claimant's temporary disability and paid her increased benefits. SAIF did not notify claimant's counsel of its intended action nor did it withhold / pay a portion of the increased compensation to claimant's counsel.

Pursuant to our July 19, 1993 order, we concluded that claimant's counsel was entitled to an "out-of-compensation" attorney fee for efforts expended in obtaining increased compensation for claimant. We further held that SAIF was required to pay the fee directly to claimant's attorney and recover the overpayment from claimant's future permanent disability awards.

In reaching this conclusion, we reasoned that there was no preventive action that claimant's counsel could have taken to secure the "out-of-compensation" fee other than to have filed a hearing request / executed retainer agreement and provided copies of the same to SAIF. Since claimant's counsel had taken the sole action available and SAIF had been aware of claimant's representation at the time it paid the compensation directly to claimant, we did not consider our attorney fee distribution to be inequitable.

We distinguished our decision from several cases where we had required the claimant's attorney to seek an "out-of-compensation" fee for previously paid compensation directly from the claimant. 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). Noting that in each of those cases there was an action that the claimant's attorney could have taken to secure receipt of the "out-of-compensation" fee, we repeated that it would be inequitable to require the carriers in those cases to reimburse the attorney and create an overpayment.

SAIF seeks further consideration of our conclusion that it must pay the "out-of-compensation" fee directly to claimant's attorney. In support of its argument, SAIF relies on ORS 656.388(1), (2), and Mohammad Zarifi, *supra*, for the proposition that there was not an enforceable attorney fee lien in existence at the time it paid the recalculated temporary disability to claimant. In the absence of a referee, Board, or court order approving the attorney fee, SAIF reasons that it was under no duty to pay claimant's attorney a portion of the increased compensation. Moreover, once it discovered its miscalculation of claimant's temporary disability, SAIF asserts that it was at risk of subjecting itself to a penalty assessment if it did not promptly remedy its error. Contending that it was justified in paying the entire additional temporary disability to claimant, SAIF again asks that we modify our order to direct claimant's counsel to seek the "out-of-compensation" fee from claimant.

The statutory and case authorities do support the conclusion that an enforceable attorney fee lien is not created until either a referee, Board, or court has approved the fee. Nevertheless, our decision to require SAIF to pay claimant's attorney the "out-of-compensation" fee is not premised on whether an enforceable attorney fee lien existed at the time it paid claimant all of the additional temporary disability. Rather, our determination is based on whether claimant could have taken any other action to secure receipt of the fee and whether SAIF was aware that claimant was represented. Since the answer to the first inquiry is "no" and the answer to the second inquiry is "yes," we continue to conclude that it would not be inequitable under these particular circumstances to require SAIF to pay the fee awarded by our July 19, 1993 order directly to claimant's attorney and seek recovery of any overpayment created by our order against claimant's future permanent disability awards.

Our holding does not conflict with Zarifi. In Zarifi, a Board order awarded additional permanent disability. Although the Board order allowed an "out-of-compensation" fee, the order did not expressly require the carrier to pay the fee directly to the claimant's attorney. When the carrier paid the entire award to the claimant, the claimant's attorney requested a hearing. The Zarifi Board held that the carrier was under no obligation to reimburse the attorney for the fee because the Board order did not require the fee to be paid directly to the attorney and the claimant had not consented to such a direct payment. In reaching its conclusion, the Zarifi Board reasoned that the claimant's attorney's lien had never been perfected and was not enforceable.

Since Zarifi pertains to a carrier's "post-order" actions involving the non-payment of attorney fees and this case involves a carrier's "pre-order" actions, the Zarifi holding is readily distinguishable. Moreover, as in the cases discussed in our prior order, the claimant's attorney in Zarifi could have taken

an action to avoid the non-payment of the attorney fee; *i.e.*, the attorney could have requested reconsideration of the Board's order that failed to direct the carrier to pay the fee directly to the attorney.¹

In any event, the determinative question before us is not whether claimant's attorney had an enforceable lien. Instead, the question is whether SAIF should have known that claimant was represented by an attorney and that the attorney should have been consulted before SAIF unilaterally chose to pay the disputed compensation (which was an issue scheduled for resolution at a pending hearing) directly to claimant without prior notification to claimant's attorney.

SAIF does not contest the fact that it was aware of claimant's representation. Rather, noting its potential liability for penalties if it delayed the payment of recalculated benefits, SAIF asserts that it had no other alternative but to immediately pay the entire compensation to claimant. SAIF's reasoning overlooks a readily-available mechanism with which every party or practitioner before this forum is well-acquainted.

That resolution method is a stipulation. In other words, if SAIF was concerned about potential "penalty" ramifications and its authority to pay an "out-of-compensation" attorney fee, it should have contacted claimant's attorney and arranged for the preparation of a stipulated agreement for Referee approval. In this way, the issues raised by claimant's hearing request could have been fully resolved and the hearing request formally dismissed.

In the event that negotiations for a stipulation did not bear fruit, SAIF could then have paid the disputed compensation directly to claimant. Such a procedure would have provided justification for SAIF's conduct in defense of any subsequent charge of unreasonable claim processing. Moreover, had SAIF been unsuccessful in pursuing resolution of the dispute through negotiations, it is entirely conceivable that we would have concluded that it would be inequitable to now require SAIF to pay the attorney fee award directly to claimant's attorney. Because SAIF did not avail itself of this opportunity to resolve this dispute in a manner which would involve the full participation of all litigants and their respective legal representatives, but instead essentially preempted an orderly resolution process, we do not consider it inequitable to direct SAIF to pay our "out-of-compensation" attorney fee award directly to claimant's attorney.

¹ SAIF cites two other Board decisions, which it contends support its argument that claimant's attorney must look to claimant for the "out-of-compensation" fee. After reviewing the decisions, we find neither one to be inconsistent with our reasoning.

In Douglas D. Dutton, 39 Van Natta 1123 (1987), the Board declined to award penalties and attorney fees for a carrier's failure to pay temporary disability benefits within 14 days of a Board Own Motion order. The claimant's attorney also objected to the carrier's payment of the entire benefits to claimant. Reasoning that the carrier was under no obligation to pay the fee directly to the attorney, the Dutton Board concluded that the attorney must look to claimant for payment of the fee.

The Dutton order is silent concerning what the "attorney fee" portion of the first order stated. Thus, we do not agree with SAIF's contention that there was nothing that the claimant's attorney in Dutton could have done to secure payment of the "out-of-compensation" attorney fee directly to the attorney. It is equally as likely, just as in Zarifi, that the order neglected to direct the carrier to pay the fee directly to the attorney. Thus, as in Zarifi, the attorney could have sought reconsideration of the order to modify the attorney fee directive.

The other decision cited by SAIF suffers from the same deficiency. In Joe Holmes, Jr., 36 Van Natta 601 (1984), an amended Own Motion order had increased an "out-of-compensation" attorney fee award from \$750 to \$1,200. However, by the time the carrier received notice of the amended order, the carrier had fully paid the claimant's compensation. The Board held that an attorney must look to the claimant for payment of the additional "out-of-compensation" fee. As with Dutton, the Holmes order is silent regarding whether the carrier was expressly directed to pay the fee directly to the claimant's attorney. Lacking such information, it cannot be said that there was nothing that the claimant's attorney in Holmes could have done to secure the payment of the fee directly to him.

When extended to its logical conclusion, SAIF's position would lead to an unworkable system. Specifically, according to SAIF, at any time prior to a litigation order, a carrier could pay disputed compensation to a claimant without also notifying the claimant's counsel concerning arrangements regarding the payment of an "out-of-compensation" attorney fee. Such a result would not only be inconsistent with the litigation process which encourages full disclosure between litigants and their legal representatives, but would also inevitably lead to instances of "gamesmanship" concerning the recovery of an attorney fee to which an attorney was rightfully entitled. Neither result would be consistent with the express purpose of the workers' compensation system to reduce litigation and eliminate the adversarial nature of the compensation proceedings to the greatest extent practicable. See ORS 656.012(2)(b). In conclusion, we decline to support such reasoning, particularly where, as here, claimant's attorney had taken whatever action was available to secure his receipt of an attorney fee and SAIF was aware of that legal representation.²

As SAIF notes, without a litigation order so directing, it was under no obligation to pay the "out-of-compensation" fee to the attorney. Nevertheless, that fact does not alter our conclusion that SAIF must directly pay our attorney fee award to claimant's attorney.

Inasmuch as SAIF was a party to a pending hearing which involved a dispute regarding the rate of claimant's temporary disability, it was certainly incumbent on SAIF to notify claimant's duly-retained legal representative of its intentions to resolve that dispute in advance of the hearing. Had such actions been taken, it is reasonable to assume that claimant and her attorney would have received their respective shares of the increased compensation. Since SAIF chose not to take such unilateral action and claimant's attorney could have taken no other action to prevent this occurrence, we continue to hold that it is not inequitable to require SAIF to pay the "out-of-compensation" fee directly to claimant's attorney and recover the overpayment against claimant's future permanent disability awards.

Accordingly, as supplemented herein, we republish our July 18, 1993 and August 18, 1993 orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

² SAIF also argues that it should not serve as the "watch dog" for the workers' compensation system concerning the payment of an attorney fee to claimant's counsel. Our decision is not designed to invest SAIF or any other carrier with such responsibility. To the contrary, the statutory authority to determine and police such awards squarely rests with this forum. Nevertheless, our decision is premised on the fact that, as a party to a pending hearing, SAIF was responsible for notifying claimant's duly retained legal representative of its intentions to essentially resolve one or more of the issues scheduled for litigation at the upcoming hearing before SAIF took actions which could have a direct effect on the interests of both claimant and her attorney.

In the Matter of the Compensation of
LARRY L. SCHUTTE, Claimant
WCB Case Nos. 91-11252 & 90-06482
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Mongrain's order that: (1) upheld the self-insured employer's denial of claimant's new injury claim for a herniated L3-4 disc; and (2) upheld its "de facto" denial of his occupational disease claim for the same condition. On review, the issues are scope of review and claim processing (whether the claim should be processed as an aggravation or new injury). We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for "Ultimate Finding of Fact" number 4.

CONCLUSIONS OF LAW AND OPINION

Scope of review

The Referee upheld the employer's "de facto" denial of claimant's occupational disease claim for a herniated disc at L3-4. On review, the employer argues that claimant did not plead and prove such a claim. We agree that the occupational disease issue was not properly raised before the Referee.

A Referee's scope of review is limited to issues raised by the parties. Michael R. Petkovich, 34 Van Natta 98 (1982). Here, the occupational disease issue was not raised in claimant's request for hearing or during the pre-hearing discussion of issues. (See Tr. 17). Rather, claimant first asserted that his current condition qualifies as an occupational disease in closing argument. We have consistently held that we will not consider an issue raised for the first time during closing argument. Leslie Thomas, 44 Van Natta 200 (1992); John C. Schilthuis, 43 Van Natta 1396, 1399 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989).

We acknowledge that claimant's position could be characterized as merely a different theory of compensability, rather than a separate issue. See Alan B. Cooper, 40 Van Natta 1915 (1988). However, because the occupational disease "theory" was not pleaded before or during the hearing, we conclude that the employer would be prejudiced if we resolved this case based on the late-raised theory. Gunther H. Jacobi, 41 Van Natta 1031 (1989). In other words, we believe it would be fundamentally unfair to decide the case on a different basis than that argued while the record was open. Gunther H. Jacobi, supra; see Donald A. Hacker, 37 Van Natta 706 (1985) (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Accordingly, even assuming (without deciding) that claimant filed an occupational disease claim and that the claim was denied by the time the hearing convened, we conclude that the occupational disease issue was not properly before the Referee.

Claim processing

We adopt that portion of the Referee's order holding that the claim is properly processed as an aggravation rather than as a new injury. See Lillian D. Thompson, 45 Van Natta 832 (1993) (citing Peggy Holmes, 45 Van Natta 278 (1993)).

ORDER

The Referee's order dated December 23, 1992 is affirmed in part and vacated in part. That portion of the order that upheld the self-insured employer's "de facto" denial of claimant's occupational disease claim is vacated. The remainder of the order is affirmed.

In the Matter of the Compensation of
HARIBU R. STEWARD, Claimant
WCB Case No. 91-12621
ORDER ON REVIEW
John M. Pitcher, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of Referee Nichols' order that: (1) affirmed an Order on Reconsideration which affirmed a Notice of Closure that awarded no scheduled or unscheduled permanent disability; (2) found that claimant was not entitled to additional temporary disability benefits; (3) found that the claim was not prematurely closed; and (4) granted the self-insured employer's request for an offset of temporary disability benefits. The employer has moved to strike claimant's "brief" received by the Board on May 11, 1993 and claimant's appellant's brief which was received by the Board on July 6, 1993. On review, the issues are the extent of scheduled and unscheduled permanent disability, temporary disability, premature closure, offset and motion to strike.

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

The employer has moved to strike claimant's "brief" which was received by the Board on May 11, 1993, prior to the implementation of the briefing schedule in this case. OAR 438-11-020(2) sets out the procedure for filing briefs for consideration on Board review. Unless otherwise authorized by the Board, no briefs other than those authorized by OAR 438-11-020(2) will be considered.

Inasmuch as claimant submitted his May 11, 1993 "brief" prior to the implementation of the briefing schedule under OAR 438-11-020(2), that brief is not authorized. Accordingly, we grant the employer's motion to strike the May 11, 1993 brief. In granting the employer's motion to strike, we note that it is the Board's policy not to hold an unrepresented worker strictly accountable for failing to comply with the Board's rules. OAR 438-05-035. However, here, claimant did submit a timely brief which has been considered by the Board. In any event, even if considered, the May 11, 1993 brief would not affect our decision in this matter.

The employer also moves to strike claimant's appellant's brief (received by the Board on July 6, 1993) on the grounds that it refers to matters outside of the hearing record. We deny the motion to strike the July 6, 1993 brief. However, we will not consider any evidence that was not previously made a part of the record.

We agree with the Referee that claimant has not established entitlement to further temporary disability. Dr. Peden opined that claimant was medically stationary on December 11, 1990. (Ex. 8). The March 28, 1991 Notice of Closure (affirmed by the August 27, 1991 Order on Reconsideration) awarded claimant temporary disability through his medically stationary date. (Ex 11). Thus, the record does not establish an entitlement to further temporary disability.

ORDER

The Referee's order dated April 21, 1993 is affirmed.

In the Matter of the Compensation of
ROBERT M. BARSTAD, Claimant
WCB Case Nos. 91-02285, 91-00689 & 90-15059
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Garaventa's order which: (1) set aside its denial insofar as it pertained to claimant's low back condition; and (2) upheld the SAIF Corporation's (B & C Logging) denial of the same condition. Claimant cross-requests review of those portions of the order which: (1) upheld Liberty's denial insofar as it pertained to claimant's depression and its denial of claimant's bicipital tendinitis; and (2) upheld the SAIF Corporation's (Crescent Hill) denial of claimant's depression. Additionally, Liberty moves to strike claimant's respondent/cross-appellant's brief for failure to timely serve a copy of its brief on Liberty. On review, the issues are Liberty's procedural motion, compensability and responsibility. We deny the motion, reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant filed an 827 form with Liberty stating that the date of his right shoulder and arm injury was February 6, 1989. (Ex. 40). He also filed an 801 form with Liberty stating that the date of the same injury was December 24, 1988. (Ex. 41). Liberty accepted an injury claim for "right shoulder and upper back strain" on April 24, 1989. (Ex. 43). The injury is referred to throughout the record as a 1988 injury.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Liberty moved to strike claimant's brief because it was not timely served on Liberty. We deny the motion.

OAR 438-05-046(2)(b) provides that anything delivered for filing shall include proof of service in the form of a certificate showing deposit in the mails together with the names and addresses of the persons served. Here, claimant's attorney included such a certificate with his respondent's/cross-appellant's brief certifying that a copy of the brief had been mailed to the Board and to the insurers' attorneys on June 25, 1992, the day the brief was due. In light of such circumstances, we conclude that the brief was timely filed and served. Furthermore, even if the brief was hand-delivered on June 29, 1992, as Liberty argues, Liberty was still able to timely file its reply/cross-respondent's brief. Since Liberty has not been prejudiced, we deny the motion to strike. See David F. Weich, 39 Van Natta 468 (1987).

Compensability of Depression and Right Shoulder Tendinitis

We affirm and adopt the Referee's order with respect to these issues.

Compensability of Low Back Condition

The Referee concluded that Liberty was responsible for claimant's low back condition, including surgery, because the accepted 1988 injury was a material contributing cause of a worsening of claimant's condition. In reaching this conclusion, the Referee reasoned that Liberty had previously accepted claimant's low back condition. We disagree.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Whether an acceptance has occurred is a question of fact, to be decided on a case by case basis. SAIF v. Tull, 113 Or App 449 (1992).

Here, claimant first sought medical treatment from Dr. Matthews 5 days after his December 24, 1988 neck and shoulder injury with Liberty's insured. In his first chart note, the doctor indicated low back pain that had been increasing over the past few months, and diagnosed an exacerbation of a previous old injury. (Ex. 39-1). Dr. Matthews did not relate the low back symptoms to the 1988 injury. (Ex. 39-4, 5).

In February 1989, Dr. Matthews stated that claimant had pain in the mid-thoracic region that radiated along the scapula into the right trapezius. (Ex. 39-2). On February 15, Dr. Matthews reported that claimant's right upper back myofascial pain and cervical myofascial pain had been increasing since December 1988 and that claimant was going to file a workers' compensation claim. (Ex. 39-4). On an 827 form signed February 15, 1989, Dr. Matthews diagnosed right shoulder and neck myofascial pain. (Ex. 40). Claimant stated that the cause of the injury was carrying tools and a saw on his shoulder. *Id.*

Dr. Lewis examined claimant on April 16, 1990. Claimant told Dr. Lewis that he was carrying some heavy jacks on his shoulder and developed neck and shoulder pain. (Ex. 84). Dr. Lewis diagnosed a probable herniated disc at C6-7. Claimant did not mention a low back injury during that visit. By letter of April 24, 1989, Liberty accepted a "right shoulder and upper back strain." (Ex. 43). In light of Liberty's specific acceptance, we find that the accepted conditions were right shoulder/upper back strain, rather than a low back condition.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the low back condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). On the other hand, when a condition or need for treatment is caused by the compensable injury, a worker must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A). Albany General Hospital v. Gasperino, *supra*. We conclude that claimant has failed to prove either with respect to his low back condition.

As previously discussed, beginning in December 1988, claimant was treating for upper back, neck and shoulder pain. (See e.g. Exs. 39, 40, 46, 48, 49). It was not until December 1989, during a visit to Dr. Matthews, that claimant mentioned low back pain with radiating leg symptoms that had occurred while working 12 days previously. (Ex. 57). In January 1990, claimant again reported low back pain to Dr. Matthews. Dr. Matthews related the low back condition to claimant's 1976 injury with SAIF's insured, B & C Logging. (Ex. 64-1).

Other than the brief mention (during a December 1988 examination) of low back pain that had been present for several months prior to December 1988 (Ex. 39-1), the evidence shows that nearly a full year passed before claimant again reported low back symptoms to Dr. Matthews. Even then, the doctor did not relate the symptoms to claimant's 1988 injury. Accordingly, we conclude that claimant's low back condition was not directly related to the 1988 industrial accident. Albany General Hospital v. Gasperino, *supra*. Claimant must, therefore, prove that his low back condition requiring surgery is a consequence of his December 1988 compensable right shoulder and upper back injury, and that the 1988 injury is the major contributing cause of the required surgery. ORS 656.005(7)(a)(A). Albany General Hospital v. Gasperino, *supra*.

Dr. Lewis, orthopedic surgeon, first examined claimant on April 16, 1990. (Ex. 82). Claimant gave a history of carrying heavy jacks out of the woods and developing neck and shoulder pain. On examination, Dr. Lewis diagnosed a herniated C6-7 disc. Dr. Lewis again examined claimant on May 22, 1990, this time concerning claimant's low back. Dr. Lewis noted that x-rays showed significant degenerative changes in the lumbosacral spine with spondylitic changes and spondylosis at L4-5. (Ex. 91). A subsequent MRI indicated a developmentally small spinal canal and multilevel disc degenerations. (Ex. 92). In a letter dated July 6, 1990, Dr. Lewis would not relate leg and low back problems to claimant's December 1988 injury because the problems did not coincide with claimant's initial presentation to his office, or with other evaluations. (Ex. 102).

Dr. Woolpert, orthopedic surgeon, conducted an independent medical examination. He also opined that, because there was no contemporaneous documentation of low back problems following the 1988 injury, that injury was not the major contributing cause of claimant's need for low back surgery. (Ex. 149-24). Rather, Woolpert attributed the major contributing cause to claimant's preexisting degenerative disc disease. *Id.* at 25.

The Western Medical Consultants examined claimant in an independent medical examination in June 1990. (Ex. 100). For the first time, claimant related a history of falling down a hill at the time of the 1988 injury. (Ex. 100-1). The Consultants reported that the 1988 injury made claimant's low back pain worse. (Ex. 100-3).

There is no evidence corroborating contemporaneously a "hill fall" in 1988, prompting low back complaints. The existence of such evidence (e.g. a chart note reference or notation in a medical report) from that time would tend to support the accuracy of the history claimant gave two years after the fact.

Under the circumstances, we find the Consultant's opinion to be based on an inaccurate history. Therefore, we do not rely on the opinion concerning causation of claimant's low back symptoms. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Moreover, they do not offer an opinion concerning the extent to which the 1988 injury contributed to claimant's low back condition.

Rather, we are persuaded by the well-reasoned opinions of Drs. Lewis and Woolpert who attributed claimant's condition to preexisting degenerative disc disease. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant has failed to establish that his 1988 compensable right shoulder and upper back condition is the major contributing cause of his low back condition. Alternatively, even if claimant was required to prove the compensability of his low back condition by a "material contributing cause" standard, we would find that these opinions do not support such a conclusion. Therefore, claimant has not established the compensability of his low back condition and need for surgery as a consequence of his 1988 right shoulder and upper back injury. Albany General Hospital v. Gasperino, *supra*.

We next address the relationship of claimant's 1976 back injury, while working for SAIF's insured (B & C Logging), to his current low back condition. As in the case of Liberty's 1988 injury, claimant must prove that his current low back condition is a consequence of the 1976 back injury, and that the 1976 injury is the major contributing cause of his current need for surgery. Albany General Hospital v. Gasperino, *supra*.

No doctor has related, to any degree, claimant's current low back condition and need for surgery to his 1976 injury. Dr. Lewis, who requested permission for surgery, related the need for surgery to significant degenerative spinal stenosis. Moreover, Dr. Woolpert specifically stated that the surgery was not related to the 1976 injury, for several reasons. (Ex. 147-6). The main reason was that claimant had preexisting degenerative changes in his lumbar spine at the time of the 1976 strain injury. Subsequently, claimant has had an expected increase in the degenerative process. (Ex. 147-7). Thus, Dr. Woolpert opined that the 1976 injury was not the major contributing cause of the current low back condition or need for surgery.

In light of the above, we agree that the medical evidence shows that claimant has failed to prove that his current low back condition and need for surgery is compensably related to either Liberty's or SAIF's accepted injuries.

ORDER

The Referee's order dated March 30, 1992 is reversed in part and affirmed in part. That portion which found Liberty responsible for claimant's current low back condition and surgery is reversed. Liberty's July 17, 1990 denial is reinstated and upheld in its entirety. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

October 27, 1993

Cite as 45 Van Natta 2089 (1993)

In the Matter of the Compensation of
CHARLES A. BOSTON, Claimant
WCB Case No. TP-93009
ORDER OF ABATEMENT
Jolles, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On September 27, 1993, we issued a Third Party Distribution Order, concluding that Safeco Insurance Company was not entitled to a share of claimant's settlement proceeds. Representing that the parties have reached a settlement of their dispute, Safeco seeks withdrawal of our order so that we can retain jurisdiction to consider their proposed agreement.

In light of such circumstances, we withdraw our September 27, 1993 order. On receipt of an executed agreement, we will proceed with our consideration of the settlement. Meanwhile, the parties are requested to keep us fully apprised of any further developments. In the event that a settlement cannot be successfully achieved, the parties are requested to immediately provide written notification. Thereafter, we would reinstate our September 27, 1993 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT HUNTLEY, Claimant
WCB Case No. 92-12551
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee Tenenbaum's order that awarded a penalty and related attorney fee. Claimant cross-requests review of those portions of the order that upheld the employer's denial of claimant's pneumonia and resulting hospitalization. On review, the issues are compensability, medical services, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, entitled "Findings," except the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt that portion of the Referee's order finding that claimant's pneumonia is not compensable.

Medical Services

Claimant is a paraplegic as a result of a compensable injury. After contracting pneumonia, claimant was hospitalized. Claimant challenges the Referee's conclusion that such medical services are not compensable.

Claimant's treating physician, Dr. Bogardus, internal medicine specialist, reported that claimant was hospitalized because the pneumonia weakened him to such an extent that he was unable to care for himself. (Exs. 64, 66, 67-10). She compared claimant to nonparaplegic men of the same age, stating that such persons with the same illness could likely stay home to recover. (*Id.*) Dr. Bogardus explained that claimant was placed in the hospital in order to be moved and assisted with coughing, since, as a paraplegic, he was unable to move himself. (Exs. 66, 67-10). She stated that, therefore, the major contributing cause of claimant's need for hospitalization was his paraplegia. (Ex. 67-12). In other words, claimant was hospitalized to replace the normal bodily functions (e.g. hands, legs) that he lost as a result of the compensable injury. Dr. Ward, physical medicine and rehabilitation specialist who conducted an outpatient evaluation, provided a similar opinion. (Ex. 65).

Dr. Ironside, pulmonary specialist, conducted a record review for the employer. Dr. Ironside found that claimant's hospitalization was caused by the pneumonia and "could have been handled on an outpatient basis, based on the appearance of his status. Possibly an increased amount of attention could have been given to him by his home care aid and averted the hospitalization." (*Id.*)

Unlike Dr. Ironside, Dr. Bogardus personally examined and treated claimant. Furthermore, she provided a well-reasoned opinion. Consequently, we defer to Dr. Bogardus' opinion as the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). According to Dr. Bogardus, claimant's need for hospitalization was in major part due to his paraplegia. Therefore, regardless of whether the appropriate standard of proof is major or material contributing cause, we conclude that claimant proved the compensability of such medical services. See ORS 656.245, 656.005(7)(a)(A).

Penalties and Attorney Fees

We affirm and adopt that portion of the Referee's order regarding the imposition of a penalty, noting that we have found the medical services for claimant's hospitalization to be compensable. See George Goddard, 45 Van Natta 145, on recon 45 Van Natta 557 (1993).

Furthermore, claimant's attorney is entitled to an assessed fee for prevailing against the employer's denial of medical services. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services at hearing and on review regarding the medical service issue is \$3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's cross-appellant's and reply briefs), the complexity of the issue, and the value of interest involved.

Claimant is not entitled to an attorney fee award for services on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 19, 1993 is affirmed in part and reversed in part. That portion of the order upholding the self-insured employer's denial of medical services is reversed. The employer's denial of medical services is reversed and the claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the medical services issue, claimant's attorney is awarded an assessed fee of \$3,000, to be paid by the employer.

October 27, 1993

Cite as 45 Van Natta 2091 (1993)

In the Matter of the Compensation of
NAN Q. PATTON, Claimant
WCB Case No. 92-00416
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Nichols' order that: (1) declined to consider a medical report; and (2) affirmed an Order on Reconsideration awarding her 6 percent (8.1 degrees) scheduled permanent disability for loss of use or function of the left ankle. On review, the issues are evidence and extent of scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant's claim was closed by Determination Order on February 12, 1991, based on a November 12, 1990 closing examination by Dr. Ure, claimant's attending physician.

On March 4, 1991, claimant requested reconsideration of the Determination Order.

Thereafter, on June 6, 1991, claimant underwent an independent physical capacities evaluation (PCE) by Medical Consultants Northwest. The Consultants found that claimant has 12 degrees of dorsiflexion and 20 degrees of plantar flexion of the left ankle, good muscle strength in the lower extremities, and limitations on walking and standing. Dr. Ure reviewed the Consultants' report and concurred with it in its entirety.

On August 30, 1991, the Appellate Unit issued an Order on Reconsideration which affirmed the Determination Order in all respects.

CONCLUSIONS OF LAW AND OPINION

Evidence

Reasoning that neither ORS 656.268(5) nor ORS 656.268(7) allows for the consideration of findings made in an examination performed after claim closure (with the exception of that performed by a medical arbiter), the Referee declined to consider the Consultants' report. Instead, the Referee relied on Dr. Ure's November 12, 1990 closing report to rate claimant's permanent disability, and affirmed the August 1991 Order on Reconsideration. On review, claimant argues that because the Consultants' medical report was based on an examination conducted prior to the date the Order on Reconsideration issued, the Referee should have considered it. We agree that the Referee should have considered the Consultants' report. However, we do so for the following reasons.

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, the Referee did not consider the Consultants' report 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. Moreover, no medical arbiter was either appointed or a report issued. (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical Arbiter's report. See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993)). Consequently, the report should not have been excluded from consideration in determining the extent of claimant's permanent disability. ORS 656.283(7). Smith, supra; Linda L. Demanche, 45 Van Natta 2014 (1993); Darlene K. Bentley, 45 Van Natta 1719 (1993).

Finally, we disagree with the Referee's conclusion that the Consultants' report could not be used to rate claimant's permanent disability because the PCE was performed by an occupational therapist. We have previously held that the findings of an independent medical examiner may be used for rating impairment when claimant's attending physician has ratified those findings. Raymond L. Owen, 45 Van Natta 1528 (1993); Raymond D. Lindley, 44 Van Natta 1217 (1992).

Dr. Ure reviewed the independent PCE and concurred with it in its entirety. Since the attending physician ratified the report, pursuant to Smith and Luciani, the Referee had the authority to consider that report. Phillip A. Mullins, 45 Van Natta 1794, 1795 n.1 (1993).

Extent of Scheduled Disability

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 in effect at the time of the Determination Order. WCD Admin. Orders 6-1988, 1-1989, 15-1990, and 20-1990.

Claimant contends that she is entitled to an 11 percent disability award. We find that the preponderance of medical evidence based upon objective findings establishes that claimant has 12 degrees of dorsiflexion and 20 degrees of plantar flexion of the left ankle. Former OAR 436-35-190(6) provides for an award of 3.2 percent for 12 degrees of retained dorsiflexion of the left ankle. Former OAR 436-35-190(8) provides for an award of 7 percent for 20 degrees of retained plantar flexion of the left ankle. Adding those values, the total rating for lost range of motion of the left ankle is 10.2 percent. Rounded to the next higher percent, claimant's unscheduled disability under the standards is 11 percent. Former OAR 436-35-010(6).

ORDER

The Referee's order dated July 23, 1992 is affirmed in part and modified in part. In addition to the 6 percent (8.1 degrees) scheduled permanent disability awarded by the Determination Order, claimant is awarded 5 percent (6.75 degrees) scheduled permanent disability, for a total award to date of 11 percent (14.85 degrees) scheduled permanent disability. Claimant's counsel 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 order is affirmed.

October 27, 1993

Cite as 45 Van Natta 2093 (1993)

In the Matter of the Compensation of
LISA E. THAYER-NICKERSON, Claimant
WCB Case No. 92-12951
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of that portion of Referee Schultz's order that: (1) found that there had been no "de facto" denial of medical bills; and (2) declined to reopen the record for receipt of additional evidence. On review, the issue is remand. We affirm.

FINDINGS OF FACT

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

Claimant has a compensable overuse syndrome condition. Claimant filed a claim asserting that some medical bills had not been paid by the insurer and, therefore, were "de facto" denied. At hearing, the insurer asserted that claimant failed to show a "de facto" denial since there was no evidence of receipt by the insurer of the disputed bills.

Following closure of the record after the hearing, claimant's attorney filed a motion to reopen the record pursuant to OAR 438-07-025 for receipt of all medical billing documents held by the insurer. Claimant's counsel asserted that, based on pre-hearing discussions with the insurer's attorney, she believed that receipt of medical bills by the insurer would not be disputed at hearing and, therefore, she was not aware until the hearing that the insurer's counsel had not complied with her discovery request by failing to provide her with a copy of the medical bills.

The Referee, finding no evidence that the insurer received the bills, concluded that claimant had failed to prove a "de facto" denial. Furthermore, the Referee denied claimant's post-hearing motion to reopen the record for receipt of the medical bills.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee abused his discretion in refusing to allow claimant's motion to reopen the record. Claimant requests that the Board remand the case to the Referee for admission of the evidence.

OAR 438-07-025(1) provides that the Referee may reopen the record and reconsider his or her decision before a request for review is filed upon the showing of "error, omission, misconstruction of an applicable statute or the discovery of new material evidence." If, as here, the motion is based upon newly discovered evidence, the moving party must state the "nature of the new evidence" and explain why the evidence could not reasonably have been discovered and produced at the hearing. OAR 438-07-025(2). We review a Referee's ruling under this provision for abuse of discretion. See e.g. Mark G. Smith, 43 Van Natta 315 (1991).

We agree with claimant that, if the medical bills were received by the insurer, they and their production were under the control of the insurer rather than claimant. However, as claimant also notes, she requested discovery of all relevant evidence by the insurer when she filed her request for hearing. See OAR 438-07-015(1). As provided by the rules, the remedy for a party's failure to comply with discovery is to request a continuance, see OAR 438-07-015(5), or postponement, see OAR 438-07-081(4), before closure of the record. Claimant did not request a continuance or postponement, nor did she object on the basis of surprise.

Because claimant could have remedied, before closure of the record, any failure by the insurer to comply with discovery, we agree with the Referee that the medical bills, if any, could have been discovered and produced by claimant at hearing. Even if claimant's counsel had reasonably understood that receipt of the billings would not be disputed, when they were disputed during closing argument, claimant had the duty to object on the basis of surprise, and request a continuance or postponement so that the billings could be produced. Under the terms of OAR 438-07-025, reopening of the record for reconsideration was not a proper remedy. Consequently, we find no abuse of discretion by the Referee in denying claimant's motion to reopen the record. See OAR 438-07-025(2). Having found no abuse of discretion, we also find no grounds to remand the case. See ORS 656.295(5).

ORDER

The Referee's order dated January 20, 1993 is affirmed.

October 28, 1993

Cite as 45 Van Natta 2094 (1993)

In the Matter of the Compensation of
PATRICIA A. AVILA, Claimant
 WCB Case No. 92-13385
 ORDER ON REVIEW
 Bischoff, et al., Claimant Attorneys
 Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Referee Livesley's order that: (1) increased claimant's scheduled permanent disability award for her right arm from 10 percent (19.2 degrees), as awarded by an Order on Reconsideration, to 11 percent (21.12 degrees); (2) increased claimant's scheduled permanent disability award for her left arm from 10 percent (19.2 degrees), as awarded by an Order on Reconsideration, to 14 percent (26.88 degrees); and (3) awarded claimant additional temporary disability from April 4, 1992 through April 17, 1992. On review, the issues are extent of scheduled permanent disability and temporary disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation. We do not adopt his ultimate findings of fact.

Claimant worked as a chicken de-boner for approximately three years for the employer.

Claimant's closing examination by the Eugene Hand Rehabilitation Center took place on April 1, 1992 (not April 3, 1992).

The claim was closed by a July 14, 1992 Determination Order (not Notice of Closure).

The Determination Order awarded claimant temporary disability from September 23, 1990 through April 3, 1992.

As of April 3, 1992, no further material improvement in claimant's compensable condition was reasonably to be expected from medical treatment or the passage of time.

Dr. Fry, orthopedic surgeon, performed a medical arbiter examination on September 14, 1992.

The October 8, 1992 Order on Reconsideration reduced claimant's scheduled permanent disability from 16 percent for the right arm and 17 percent for the left arm, as awarded by the Determination Order, to 10 percent for each arm. It affirmed temporary disability as awarded by the Determination Order.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Partial Disability

The Referee increased claimant's scheduled permanent disability awards based on findings of a bilateral loss of grip strength and chronic condition impairment. The insurer contends that these bilateral awards should be modified to exclude the bilateral grip strength and right arm chronic condition components because claimant has no loss of strength due to nerve damage or to disruption of the musculotendonous unit and no right arm chronic condition.

The burden of proving the nature and extent of any disability resulting from a compensable injury or occupational disease is upon the worker. 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).

Claimant's claim was closed on July 14, 1992. Accordingly, we apply the standards effective March 13, 1992, as amended June 17, 1993. OAR 436-35-003 (WCD Admin. Order 93-052) (Temp.). 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) and 656.268(7). Evaluation of the worker's disability by the referee shall be as of the date of the reconsideration order pursuant to ORS 656.268. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

Loss of Strength

Loss of strength is rated when the cause is a peripheral nerve injury. The value of impairment is determined based upon the specific nerve affected as described in the table in OAR 436-35-110(8) and as modified pursuant to 436-35-007(14). OAR 436-35-110(8). Loss of strength due to loss of muscle or disruption of the musculotendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired. OAR 436-35-110(8)(a).

Here, Dr. Tearse, claimant's attending neurosurgeon, found that claimant has 4/5 strength in her left arm. He did not identify any loss of strength in her right arm. However, he was unable to specify a nerve or root causing her weakness, as her nerve conduction tests showed consistent right median nerve damage but only intermittent and mild left median nerve abnormalities. He concluded that claimant may have other conditions that are affecting her arm pain and weakness. (Ex. 11A). Dr. Fry, the medical arbiter, concluded that claimant's muscle strengths are 5/5 bilaterally. (Ex. 15-3). Accordingly, we conclude that claimant has failed to prove that she has a rateable loss of grip strength in either arm. ORS 656.266; OAR 436-35-110(8). Furthermore, although claimant testified to being unable to grip well enough to use a can opener or remove the lids from bottles, lay testimony is insufficient to establish "impairment" under the standards. ORS 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

Chronic Condition Impairment

OAR 436-35-010(6) provides:

"A worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow, and arm."

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) (Order on Reconsideration).

Claimant was diagnosed with bilateral carpal tunnel syndrome. She had a left carpal tunnel release. After claimant returned to work, she developed bilateral arm and shoulder pain, for which Dr. Tearse increased claimant's work restrictions to include no repetitive gripping or other use of her hands.

On March 1, 1992, Dr. Tearse, who had not examined claimant since January 14, 1991, identified claimant's condition as "persistent left arm and neck pain and carpal tunnel syndrome" and his restrictions as "no heavy, frequent or repetitive lifting or gripping with her hands." (Ex. 4B).

However, on March 9, 1992, Dr. Tearse saw claimant and reevaluated her condition. He stated that claimant had persistent tenderness and pain in the left arm that had resulted in light duty restrictions for the left arm. (Ex. 5A). He made no mention of the right arm or any restrictions regarding it. Consequently, we conclude that claimant has failed to prove that she has a permanent chronic condition affecting the right arm. ORS 656.266; Donald E. Lowry, supra.

We recalculate claimant's scheduled permanent impairment as follows.

Left Arm. A chronic condition of 5 is combined with elbow dorsiflexion of 3, which is combined with wrist dorsiflexion of 2 for a total of 10 percent scheduled permanent loss of use and function of the left arm.

Right arm. Elbow dorsiflexion of 3 is combined with wrist dorsiflexion of 2 for a total of 5 percent scheduled permanent loss of use and function of the right arm.

Temporary Disability

The Referee concluded that the correct medically stationary date is April 17, 1992, based on the date that Dr. Tearse signed a statement concurring with a finding that claimant was medically stationary. The insurer argues that the Determination Order, which selected April 3, 1992 as the date claimant became medically stationary, should be reinstated. (App. brief at 7 and 8).

"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 question 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, 4 Or App 7, 12 (1980).

Claimant was last examined on April 1, 1992, when the Eugene Hand Rehabilitation Center performed a closing examination. Although the Center's April 3, 1992 report did not specifically declare claimant to be medically stationary, Dr. Tearse, claimant's attending neurosurgeon, concurred with that report without conducting a further examination and indicated that claimant was medically stationary. There is no medical evidence that claimant was not medically stationary as of April 1, 1992. The preponderance of the medical evidence establishes that claimant was medically stationary at the time of her last examination on April 1, 1992. Nevertheless, since the insurer seeks reinstatement of the April 3, 1992 date found by the Department, we affirm the Order on Reconsideration's medically stationary date.

Alternatively, we note that OAR 436-30-035(4) and (6) provide another basis for our decision. These rules provide that the date of the last medical examination prior to the date of the medically stationary opinion controls the medically stationary date unless a different date is specified by a physician. Here, no doctor specified a different date than that of the April 1, 1992 medical examination. Although Dr. Tearse's report in which he stated that claimant was medically stationary was dated April 17, 1992, he does not state that claimant was medically stationary as of April 17, 1992. Rather, he concurs in the April 3, 1992 report that is based on the April 1, 1992 examination.

ORDER

The Referee's order dated February 10, 1993 is reversed in part and modified in part. Those portions of the order that awarded claimant an additional 4 percent (7.68 degrees) scheduled disability for the left arm and awarded temporary disability benefits from April 4, 1992 through April 17, 1992 are reversed. Those portions of the Order on Reconsideration that awarded claimant 10 percent (19.2 degrees) scheduled permanent disability for the left arm and awarded temporary disability benefits through the medically stationary date of April 3, 1992 are reinstated and affirmed. In lieu of the Order on Reconsideration and Referee's awards totalling 11 percent (21.12 degrees) scheduled permanent disability for the right arm, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for a right arm injury.

In the Matter of the Compensation of
KELLY R. BAKER, Claimant
WCB Case Nos. 92-12676 & 92-12557
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of those portions of Referee Tenenbaum's order that: (1) found that an Order on Reconsideration was valid; and (2) affirmed an Order on Reconsideration which awarded claimant 14 percent (18.9 degrees) scheduled permanent disability for loss of use or function of the left foot. In addition, the employer challenges several evidentiary rulings made by the Referee. On review, the issues are validity of an Order on Reconsideration, admission of evidence, and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

In October 1991, claimant sustained a compensable injury to his left ankle. He sought treatment at Portland Orthopedic Clinic. The medical treatment was provided by a physical therapist. The physical therapist treatment was authorized and reviewed by Drs. Irvine and Grewe.

On January 14, 1992, claimant's claim was closed by a Notice of Closure. The Notice of Closure awarded temporary disability benefits, but did not award any permanent disability benefits. On June 10, 1992, claimant requested reconsideration of the Notice of Closure. With his request for reconsideration, claimant submitted a June 2, 1992 medical report from Dr. Grewe. (Ex. 8A). In his request for reconsideration, claimant indicated that the report from Dr. Grewe was intended to supplement the record. (Ex. 9). Claimant further indicated that he was not requesting the appointment of a medical arbiter. (Ex. 9A).

On June 15, 1992, the employer cross-requested reconsideration of its Notice of Closure. (Ex. 10A). In its request, the employer indicated that it disagreed with the impairment findings it used to close claimant's claim and asked that a medical arbiter be appointed. (Exs. 10A, 10B).

By letter dated June 29, 1992, the Appellate Unit of the Workers Compensation Department informed the parties that the reconsideration process would be postponed for the appointment of a medical arbiter. (Ex. 11). On advice of counsel, claimant did not attend the medical arbiter examination. On July 17, 1992, the Appellate Unit wrote Dr. Grewe asking for clarification of his June 2, 1992 report. (Ex. 14A). The letter also indicated that Dr. Grewe was claimant's attending physician of record. Dr. Grewe responded to the Appellate Unit in an August 24, 1992 letter.

On August 28, 1992, an Order on Reconsideration issued awarding claimant 14 percent scheduled permanent disability. (Ex. 16). Thereafter, the employer requested a hearing concerning the Order on Reconsideration. (Ex. 17).

On October 26, 1992, Dr. Irvine indicated that he concurred with Dr. Grewe's August 24, 1992 report. (Ex. 19).

As a result of his compensable left foot injury claimant has lost 6 degrees dorsiflexion. In addition, claimant's left foot inversion is limited to 24 degrees and his left foot eversion is limited to 10 degrees. Finally, claimant has sustained mild lateral ligamentous laxity in the left foot.

CONCLUSIONS OF LAW AND OPINION

Validity of Order on Reconsideration

We adopt the Referee's conclusions and reasoning as set forth in the "Validity of Reconsideration Order" portion of her order with the following supplementation.

The employer contends that the Order on Reconsideration is not valid because the employer improperly requested appointment of a medical arbiter following the issuance of its Notice of Closure and because the Appellate Unit did not issue a reconsideration order within the statutory time limit set forth in ORS 656.268(6)(a). The employer further contends that since the Order on Reconsideration is invalid, the Referee did not have jurisdiction to consider the Order on Reconsideration.¹ We disagree with the employer's contention that the Referee was without authority to review the reconsideration order.

Subsequent to the Referee's order, the Court of Appeals issued its decision in Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). In Pacheco-Gonzalez, the court held the validity of an Order on Reconsideration is not a prerequisite for determining jurisdiction. The court noted that ORS 656.268(6)(b) allowed any party to request a hearing under ORS 656.283 if there was an objection to a reconsideration order. The court further noted that ORS 656.283(1) allowed any party or the Director to request a hearing on any question concerning a claim at any time. The court reasoned that "[n]either statute requires a 'valid' order on reconsideration for the referee to have jurisdiction. No statute divests the Board of its obligation where an 'invalid' order on reconsideration occurs." Id.

Accordingly, as explained by Pacheco-Gonzalez, the validity of an Order on Reconsideration has no bearing on the Referee's jurisdiction to consider the order. Consequently, we agree with the Referee that the Order on Reconsideration was properly before the Hearings Division.²

Evidence

We adopt the Referee's conclusions and reasoning as set forth in the "Evidentiary Matters" portion of her order with the following supplementation.

The insurer contends that Exhibits 8A and 15 (both reports from Dr. Grewe) are not admissible because they are based on post-closure examinations. We disagree.

¹ The employer also contends that claimant's request for hearing, concerning the reconsideration order was untimely. We disagree. A hearing request from a Notice of Closure/Determination Order must be filed within 180 days of the closure notice/order (not counting the date a party requests reconsideration to the date of the reconsideration order. ORS 656.268(6)(b); Nowak v. SAIF, 121 Or App 563 (1993). Claimant's request for hearing was received by the Board on September 29, 1992, the 181st day (including the time tolled by claimant's request for reconsideration of the Notice of Closure) after the date of the January 14, 1992 Notice of Closure. In addition, claimant's request for hearing was not mailed by registered or certified mail. Accordingly, the filing of the hearing request is presumed to be untimely. See OAR 438-05-046(1)(b).

However, this presumption of untimeliness may be rebutted if the filing party establishes that the mailing was timely. See Id.; Richard S. Olson, 43 Van Natta 657 (1991). With the hearing request, claimant's counsel included a certificate of mailing attesting to the fact that the hearing request was mailed on September 28, 1992, the 180th day. Other than asserting that claimant's request was filed on October 1, 1992, the employer does not contest claimant's certificate of mailing. In light of such circumstances, we are persuaded that claimant's counsel mailed claimant's hearing request on September 28, 1992, the 180th day. Accordingly, claimant has overcome the presumption of untimeliness and therefore the hearing request was timely filed.

In any event, there is no dispute that the employer's request for hearing concerning the reconsideration order was timely. Therefore, even if claimant's request for hearing was untimely, the reconsideration order was properly before the Referee by virtue of the employer's request for hearing. See Judith L. Duncan, 45 Van Natta 1457 (1993). Thus, claimant could raise the arguments of his choosing based on the employer's timely hearing request.

² Parenthetically, we note that the employer has requested oral argument. We ordinarily do not entertain oral argument. OAR 438-11-015(2). However, we may grant such a request if a case presents an issue that could have a substantial impact on the workers' compensation system. See Ruben G. Rothe, 45 Van Natta 369 (1993). Here, through their extensive appellate briefs, the parties have availed themselves of the opportunity to fully address the issues for determination. Inasmuch as the parties' respective positions regarding these issues have been thoroughly defined, we are unpersuaded that oral argument would appreciably assist us in reaching our decision. Moreover, recent court and Board decisions have answered most of the issues raised on review. Consequently, we decline to grant the employer's request.

Subsequent to the Referee's order, 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, there is no other basis preventing the admission of Exhibits 8A and 15 (reports from Dr. Grewe, claimant's attending physician). Particularly, since a medical arbiter was not appointed, the evidentiary restrictions set forth in ORS 656.268(7) concerning no subsequent medical evidence after a medical arbiter's report are not applicable. See Pacheco-Gonzalez, supra (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report). Therefore, pursuant to Smith and Luciani, the Referee had the authority to consider those exhibits.

In addition, we note that while we agree with the Referee that Dr. Grewe is claimant's attending physician, we would reach the same conclusion even if we agreed with the employer's contention that Dr. Irvine was claimant's attending physician. In this regard, Dr. Irvine concurred with Dr. Grewe's August 24, 1992 letter. In light of this concurrence from the alleged attending physician, Dr. Grewe's findings could be considered. See Timothy J. Smith, 44 Van Natta 2246 (1992).

Extent of Scheduled Permanent Disability

We adopt the Referee's conclusions and reasoning as set forth in the "Extent of Disability" portion of her order with the following supplementation.

The employer contends that claimant is precluded from challenging the impairment findings used to close his claim because he did not specifically challenge those findings at the reconsideration process. Assuming, arguendo, that the employer's contention is correct, claimant would still be allowed to challenge, at hearing, the impairment findings used to close his claim.

Subsequent to the Referee's order, we issued our decision in Darlene K. Bentley, 45 Van Natta 1719 (1993). In Bentley, we disavowed our prior decision in Raymond L. Mackey, 45 Van Natta 776 (1993), which held that a party is barred from raising at hearing an issue stemming from a notice of closure or determination order that was not first raised on reconsideration before the Department. Relying on Safeway Stores, Inc. v. Smith, supra, we concluded that the clear language of ORS 656.283(7) allowed a party to establish at hearing that the standards were incorrectly applied in the reconsideration proceeding without limitation. Id. Thus, a party 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. Id.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 20, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,200, payable by the self-insured employer.

Board Member Haynes specially concurring.

While I agree with the result reached in this case, I wish to express my agreement with Chair Neidig's concurrence in Cynthia L. Luciani, 45 Van Natta 1734 (1993) and her dissent in Darlene K. Bentley, 45 Van Natta 1719 (1993). I also am concerned that recent court and Board cases have given the reconsideration process little effect, despite a clear intention by the Legislature to use the reconsideration process as a nonlitigious method for resolving extent of disability issues.

In addition, I would like to point out that although the disputed exhibits are based on post-closure examinations, they are based on claimant's condition prior to the issuance of the reconsideration order. In this regard, ORS 656.283(7) provides that claimant's disability will be evaluated as of the date of issuance of the reconsideration order. Had the disputed exhibits been based on claimant's condition after the date of the reconsideration order, I do not believe the exhibits could be considered.

October 28, 1993

Cite as 45 Van Natta 2100 (1993)

In the Matter of the Compensation of
JOHN R. HANEY, Claimant
WCB Case No. 92-10963
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order that upheld the insurer's denial of his low back condition. On review, the issue is compensability.

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

The issue at hearing was the compensability of claimant's low back condition for which he has received medical services since March 1992. On review, claimant raises the issue of compensability of certain medical bills as diagnostic services. However, reimbursement for diagnostic services was not raised as an issue at hearing. Accordingly, that issue is not properly before us. See James F. Higgins, 41 Van Natta 895 (1989) (when the only issue raised at hearing was the compensability of the claimant's inner ear condition the issue of compensability of diagnostic services was not properly before the Board).

ORDER

The Referee's order dated December 2, 1992 is affirmed.

In the Matter of the Compensation of
RHONDA M. HENDRICKSON, Claimant
WCB Case No. 91-18008
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for myofascial pain syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the last sentence of the first finding of fact.

When claimant first sought medical treatment on August 5, 1991, she reported January 1991 as the date of onset of her symptoms. (Ex. 2-1). Claimant was laid off due to lack of work in late November 1990 and did not return to work until some time around March or April 1991. (Tr. 30). Claimant had definitely returned to work by the time of her birthday in May 1991. Id.

CONCLUSIONS OF LAW AND OPINION

Dr. Grant, treating physician, provided the only medical opinion which addressed causation. The Referee concluded that claimant failed to establish the compensability of her occupational disease claim because he found the opinion of Dr. Grant unpersuasive. We agree with the Referee.

In order to establish her occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that her work activities were the major contributing cause of her disease or its worsening. ORS 656.802(1)(c), (2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). "Major 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).

Claimant argues that the Referee erred in finding Dr. Grant's opinion unpersuasive based on the doctor's unawareness of claimant's off-the-job activities. Claimant contends that the record does not demonstrate any off-the-job activities. We disagree.

Although claimant was examined and treated by four physicians in the course of her treatment, only Dr. Grant gave an opinion as to the cause of claimant's condition. Dr. Grant first treated claimant on December 13, 1991. (Ex. 12B). He opined that the major contributing cause of claimant's myofascial pain syndrome was her work activities. (Ex. 13, Tr. 16-4, -5). Dr. Grant based this opinion, at least in part, on the fact that claimant reported a history of her problems beginning in June 1991 while she was working as a seamstress. (Ex. 12B-1).

However, claimant first sought medical treatment on August 5, 1991 from Dr. Valentic, treating chiropractor. At that time, claimant reported the date of onset of her symptoms as January 1991. (Ex. 2-1). Furthermore, claimant reported that she had two children under the age of five and that "carrying them, moving them in/out of [the] car, etc. has resulted in increasing irritation lately." (Ex. 2-1). In January 1991, at the time claimant reported the onset of symptoms, claimant was not working. Instead, she was laid off from late November 1990 until at least March 1991 due to lack of work.

Furthermore, in her initial examination, claimant made no report of any problems due to her work activity; instead, the only activity she reported that increased her symptoms was lifting and carrying her children. Thus, the record does demonstrate off work activities that claimant reported affected her condition.

Dr. Grant was apparently unaware of this prior reported history. Both in his initial report and his deposition, Dr. Grant reported that claimant told him that the onset of her problems began about June 1991, at which time claimant was working as a seamstress. (Ex. 12B-1, Tr. 16-5). Therefore, because we find Dr. Grant's opinion to be based on an inaccurate/incomplete history, we do not find it persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983).

On October 10, 1991, claimant filed a workers' compensation claim alleging that three separate incidents occurred at work which caused an injury to her back and legs. (Ex. 5-1). Dr. Grant was unaware of this report of specific work incidents. Instead, he opined that claimant's pain syndrome was caused by microtrauma or repetitive stress from her work activities. (Ex. 16-4).

Claimant argues that the Referee erred in finding Dr. Grant's opinion unpersuasive because Dr. Grant was unaware of claimant's report of three distinct work incidents. Claimant contends that, because these alleged incidents were work related, Dr. Grant's lack of awareness of them is not relevant. Because we find Dr. Grant's opinion unpersuasive based on his incomplete history, we need not address claimant's alternative argument regarding the persuasiveness of Dr. Grant's opinion.

Accordingly, we agree with the Referee that claimant has failed to establish a compensable occupational disease claim.

ORDER

The Referee's order dated October 14, 1992 is affirmed.

October 28, 1993

Cite as 45 Van Natta 2102 (1993)

In the Matter of the Compensation of
GENE G. MARTIN, Claimant
WCB Case Nos. 92-06438 & 92-05056
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Livesley's order that: (1) reversed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability for each forearm (wrist); (2) directed the insurer to pay claimant the permanent disability benefits awarded by the Order on Reconsideration; (3) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable refusal to pay the benefits; and (4) authorized an offset. On review, the issues are claims processing, and penalties and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

A March 6, 1992 Order on Reconsideration awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for each forearm for a chronic condition limiting repetitive use. The order also authorized an offset of overpaid temporary disability benefits from the permanent disability award. (Ex. 26).

On April 8, 1992, claimant requested from the Director a penalty pursuant to ORS 656.262(10)(a) and OAR 436-60-155(1) for the insurer's failure to pay the benefits awarded by the Order on Reconsideration within 30 days.

On April 9, 1992, the insurer requested a hearing on the Order on Reconsideration, raising the issues of temporary disability, permanent disability, and offset. (WCB File No. 92-05056).

On April 22, 1992, the insurer notified the Director that it had filed a request for hearing. The insurer contended that jurisdiction of the penalty issue had shifted to the Hearings Division, pursuant to OAR 436-60-155(5).

On May 4, 1992, claimant requested a hearing, raising the issue of a penalty. (WCB File No. 92-06438). He also asked that his penalty request be consolidated with the insurer's earlier request for hearing.

On May 19, 1992, claimant amended his request for hearing, raising the issue of the insurer's failure to pay permanent disability within 30 days under OAR 436-60-150(6), penalty and attorney fees.

On May 29, 1992, the Director issued an order referring claimant's request for ORS 656.262(10) penalties to the Hearings Division.

The parties stipulated to the following at hearing: (1) the insurer overpaid \$2,219.87 temporary disability for the periods April 11 through April 16, 1991, and August 30 through December 18, 1991; and (2) the insurer had not paid the permanent disability awarded by the Order on Reconsideration.

FINDINGS OF ULTIMATE FACT

The insurer failed to pay the permanent disability awarded by the Order on Reconsideration within 30 days of its issuance.

The insurer failed to request a hearing within the same 30-day period.

CONCLUSIONS OF LAW AND OPINION

The Referee reversed the Order on Reconsideration that awarded claimant permanent disability and reinstated the Determination Order, which had awarded no permanent disability. The Referee nevertheless directed the insurer to pay the permanent disability as awarded by the Order on Reconsideration. The Referee then assessed a penalty of 25 percent of that amount for the insurer's failure to pay the permanent disability timely, based on the authority of OAR 436-60-150(6)(c). The Referee next authorized an offset of \$2,219.87 against the permanent disability award (after the assessment of the penalty) with the remainder of the overpayment to be an offset against any future permanent disability awards.

Payment of Permanent Partial Disability Award

The insurer contends that it should not be required to pay the disputed permanent disability award to which claimant had no substantive entitlement. We agree.

Based on OAR 436-50-150(6)(c), the Referee concluded that the insurer was obligated to pay the permanent disability benefits within 30 days of the Order on Reconsideration unless it had filed its request for hearing within the same period. We conclude, however, that the Referee's reliance on OAR 436-50-150(6)(c) to require the payment of the permanent disability award after it was overturned on the merits is misplaced.

Subsequent to the Referee's order, the court issued its opinion in Sisters of Providence v. East, 122 Or App 366 (1993). In East, the court held that under OAR 436-60-150(6) the employer was required to pay the claimant's permanent disability benefits within 30 days of the date of the determination order. The court reasoned that OAR 436-60-150(6) applied to requests for reconsideration, while ORS 656.313 applied to appeals of a reconsideration order. Id. at 369.

Also after the issuance of the Referee's order, in Pascual Zaragoza, 45 Van Natta 1221 (1993), we relied on ORS 656.313 and the court's decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992) to hold that the insurer was not required to pay "pre-reconsideration order" temporary disability benefits where the order on reconsideration which awarded those benefits was subsequently reversed. We reasoned that to do so would result in an "administrative" overpayment, to which the claimant was not substantively entitled.

In this case, the Order on Reconsideration awarded permanent disability where the Determination Order had awarded none. The insurer appealed the reconsideration order and therefore could stay payment of the permanent disability award, pursuant to ORS 656.313. Furthermore, the insurer was not required to pay permanent disability benefits when the Referee reversed the Order on Reconsideration which awarded those benefits. Pascual Zaragoza, supra.

Offset

The Referee concluded that the insurer was entitled to offset overpaid temporary disability benefits against the permanent disability benefits ordered to be paid. We agree that the insurer is entitled to an offset. However, because we have found that the insurer is not required to pay the permanent disability awarded by the Order on Reconsideration, the insurer is authorized to offset its \$2,219.87 overpayment against claimant's future permanent disability awards, if any, resulting from this claim.

Penalty and Attorney Fees

In Zaragoza, we also addressed the issue of when the insurer must file a request for hearing on an order on reconsideration in order to stay compensation under ORS 656.313(1). We held that for the insurer to take advantage of the stay provisions of ORS 656.313(1) and to avoid a penalty under ORS 656.262(10) for unreasonable delay or refusal to pay the benefits awarded, it was required to request a hearing within the time limitations outlined in OAR 436-60-150.¹ Pascual Zaragoza, supra.

We recognize that ORS 656.319(4) provides a 180 day appeal period (commencing on the mailing date of the determination order) in which to request a hearing challenging an order on reconsideration. However, for the reasons stated in Lydia L. Kent, 44 Van Natta 2438 (1992), and Pascual Zaragoza, supra, we hold that the insurer's failure to pay the permanent disability benefits awarded by the March 6, 1992 Order on Reconsideration constituted an unreasonable resistance to the payment of compensation, unless a request for hearing was filed within 30 days of issuance of the order.

Here, the insurer appealed the Order on Reconsideration on April 9, 1992, 34 days after the order was mailed. Thus, at the time the insurer requested a hearing, the permanent disability benefits were "then due," upon which a penalty was appropriately assessed. ORS 656.262(10)(a); Pascual Zaragoza, supra; Lydia L. Kent, supra. Consequently, we affirm the Referee's penalty assessment based on the full amount of the permanent disability benefits as awarded by the Order on Reconsideration.

We further find that claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Likewise, claimant is not entitled to an attorney fee under ORS 656.382(2) regarding the offset issue. See Strazi v. SAIF, 109 Or App 105 (1991).

ORDER

The Referee's order dated July 17, 1992 is reversed in part, modified in part, and affirmed in part. That portion of the order that required the insurer to pay the permanent disability benefits as awarded by the March 6, 1992 Order on Reconsideration is reversed. In lieu of the Referee's "offset" authorization, the insurer is authorized to recover overpaid temporary disability benefits (\$2,219.87) against any future permanent disability awarded on this claim. The remainder of the order is affirmed.

¹ OAR 436-60-150(6)(c) provides that permanent disability benefits "shall be paid no later than the 30th day after the date of any department order which orders payment of compensation for permanent partial disability *** benefits, unless the order has been appealed by the insurer pursuant to ORS 656.313."

In the Matter of the Compensation of
HEATHER I. SMITH, Claimant
WCB Case No. 91-05062
ORDER ON REMAND
Francesconi & Busch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). The court has reversed our prior order, Heather I. Smith, 44 Van Natta 2207 (1992), which rated claimant's permanent disability (adaptability) as of the time of a Determination Order, rather than as of the date of an Order on Reconsideration. Relying on ORS 656.283(7), the court held that a claimant's disability shall be evaluated as of the date of the reconsideration order. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability, whereas an Order on Reconsideration had awarded no unscheduled permanent disability. The Referee's award was based on a 5 percent "chronic condition" impairment value and an adaptability value of 8.

In our prior order, we affirmed the Referee's unscheduled permanent disability award. Heather I. Smith, supra. In doing so, we acknowledged that claimant (who had been working in a medium work capacity at the time of her compensable injury) had returned to part-time work in a sedentary to light capacity at the time of the Order on Reconsideration. However, we further noted that claimant had not been working at the time of the Determination Order. Reasoning that claimant's permanent disability should be rated as of the Determination Order date, we evaluated claimant's adaptability under former OAR 436-35-310(4). Finding that claimant's residual physical capacity under that rule was "light to sedentary with restrictions," we concluded that claimant was entitled to an adaptability value of 8.

The court has reversed our order. Safeway Stores, Inc. v. Smith, supra. Citing ORS 656.283(7), and 656.726(3)(f)(A), the court has held that claimant's permanent disability (including adaptability to perform a job) shall be evaluated as of the date of the reconsideration order. Therefore, the court has remanded for a determination of claimant's adaptability as of the date of reconsideration order and, if necessary, to adjust her permanent disability award based on that adaptability determination.

Inasmuch as claimant was performing modified work at the time of the reconsideration order, her adaptability value is computed under former OAR 436-35-310(3). (WCD Admin. Order 15-1990, Temporary Rule, effective October 1, 1990). Since claimant was performing medium work at the time of her compensable injury and subsequently returned to sedentary/light duties, her adaptability value equals 2.5. Former OAR 436-35-310(3)(a), (d).

The parties have previously stipulated that claimant's values for age, education, and training total 1. When that value is multiplied by her adaptability value (2.5), the product is 2.5. When claimant's permanent impairment (5) is added to 2.5, the total is 7.5. Rounding this total to the next higher whole number equals 8. Former OAR 436-35-280(7).

Accordingly, the Referee's order dated July 26, 1991 is modified. Claimant's 13 percent (41.6 degrees) unscheduled permanent disability award, as granted by the Referee's order, is reduced to 8 percent (25.6 degrees).

IT IS SO ORDERED.

In the Matter of the Compensation of
VERONICA M. STRACKBEIN, Claimant
WCB Case No. 90-18142
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of those portions of Referee Hoguet's order which: (1) set aside its partial denial of claimant's psychological condition; and (2) awarded claimant an assessed attorney fee of \$11,000 for her counsel's services at hearing. On review, the issues are compensability and attorney fees.

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

SAIF objects that the attorney fee awarded by the Referee for claimant's counsel's services at hearing is unreasonable, because only two out of eight claimed conditions were found compensable. After considering the parties' arguments, as well as the factors set forth in OAR 438-15-010(4) as applied to this case, we find that the Referee's attorney fee award was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel's services might go uncompensated.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$900, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issue, and the value of the interest involved. We have also considered 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 October 5, 1992 is affirmed. Claimant's attorney is awarded \$900 for services on Board review, to be paid by the SAIF Corporation.

October 28, 1993

Cite as 45 Van Natta 2106 (1993)

In the Matter of the Compensation of
LYNDA K. WEBBER, Claimant
WCB Case No. 92-07245
ORDER ON REVIEW
Royce, Swanson, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Hoguet's order that: (1) set aside its partial denial of claimant's current condition and need for medical services; and (2) set aside its de facto denial of claimant's chronic lumbosacral sprain and symptomatic worsening of her degenerative disc disease at L5-S1. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant sought no medical treatment from January (not March) 1991 through February 1992.

Claimant's accepted nondisabling 1986 low back injury claim is in own motion status.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's partial denial of claimant's current condition and need for medical services and its de facto denial of claimant's chronic lumbosacral sprain and symptomatic worsening of her degenerative disc disease at L5-S1. SAIF contends that claimant's current low back problems are not related to her accepted 1986 industrial injury. We disagree.

The threshold question is what injury did claimant sustain as the result of the industrial accident in 1986. SAIF accepted a "low back strain." Claimant contends, however, that the proper diagnosis is a chronic lumbosacral sprain, which caused her degenerative disc disease to become permanently symptomatic. She further contends that her 1986 injury is the major contributing cause of her current need for treatment.

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).

The issue of whether claimant's compensable injury is related to her current need for medical treatment 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).

The medical record indicates that claimant has degenerative disc disease of the lumbar spine that preexisted her July 1986 compensable injury. This condition was asymptomatic prior to the injury. Dr. Gritzka explained the difference between a strain and a sprain and opined that claimant's chronic lumbosacral sprain was superimposed on her degenerative disc disease at L5-S1 to cause it to become permanently symptomatic. He also opined that the bulging discs at L3-4 and L4-5, and the underlying degenerative disease itself, were not caused by the 1986 injury. (Ex. 31-5). We agree with the Referee's reasons for finding Dr. Gritzka's report more persuasive than those of Drs. Kaesche and Brett, Somers v. SAIF, 77 Or App 259 (1986), and adopt that portion of the order in which he explains his reasoning on the compensability issue. Consequently, we conclude that claimant's compensable 1986 injury combined with her degenerative disc disease at L5-S1 to result in the symptomatic worsening of her degenerative disc disease at L5-S1.

Claimant must next prove that her July 1986 compensable injury remains the major contributing cause of her current need for medical treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra. Dr. Gritzka opined that the injury was the major contributing cause of claimant's worsened symptoms. He explained that, when traumatic forces are superimposed upon a degenerated disc, it becomes symptomatic, and will often be permanently symptomatic. He opined that, absent the 1986 injury, claimant's degenerative disc disease would appear the same on x-rays, but her condition would not be symptomatic. He also opined that, absent the 1986 injury, he would not expect to see claimant continuing to suffer low back and leg problems. (Ex. 31-5).

We conclude that Dr. Gritzka's opinions, taken together, establish that claimant's 1986 injury is the major contributing cause of her current need for medical services. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). In reaching this conclusion, we note that no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). We consequently conclude that claimant has satisfied her burden of proving that her July 1986 compensable injury is the major contributing cause of her current need for medical treatment.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is

\$600, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 23, 1993 is affirmed. Claimant's attorney is awarded \$600 for services on Board review, to be paid by the SAIF Corporation.

October 29, 1993

Cite as 45 Van Natta 2108 (1993)

In the Matter of the Compensation of
SHERRY A. YOUNG, Claimant
WCB Case No. 91-12999
ORDER OF ABATEMENT
Callahan & Stevens, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Claimant requests reconsideration of our September 30, 1993 order that affirmed a Director's order which found that claimant's proposed surgery (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1) was not appropriate. Asserting that the Director's order was not supported by substantial evidence, claimant contends that the Director's order must be set aside.

Subsequent to our order, the court issued its opinion in Jefferson v. Sam's Cafe, 123 Or App 464 (1993). Analyzing ORS 656.327, the Jefferson court held that the process of Director review does not apply to requests for future medical treatment and that the Hearings Division and the Board have jurisdiction to resolve disputes concerning proposed medical treatment.

In light of claimant's motion and the Jefferson holding, we withdraw our September 30, 1993 order. In addition, we implement the following supplemental briefing schedule. The SAIF Corporation's supplemental response shall be due 14 days from the date of this order. Claimant's supplemental reply shall be due 14 days from the date of mailing of SAIF's response. Thereafter, we shall take this matter under advisement.

In submitting their respective supplemental briefs, the parties are requested to discuss the effect, if any, the Jefferson holding has on this dispute. In addition, the parties are requested to respond to the following inquiry. In light of claimant's subsequent low back surgery, does the proposed surgery request remain pending? In other words, would a determination that the proposed surgery is appropriate result in further surgery?

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT G. VANDOLAH, Claimant
WCB Case No. C3-02509
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On September 27, 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 October 7, 1993, the Board requested that the parties submit an addendum eliminating a reference to claimant's attorney's "out-of-pocket" costs on page four of the CDA. On October 11, 1993, the Board received an addendum stating that it was necessary, for the purpose of Social Security benefits, to retain the reference to claimant's attorney's costs in the CDA. Claimant contends that, although no part of the CDA should be subject to a Social Security offset, it is best to include as much information as possible in order to protect the proceeds from an inappropriate Social Security offset.

We have previously held that we have no way of verifying the accuracy of such costs. See Janelle I. Neal, 40 Van Natta 359 (1988). Further, although the attorney fee payable to claimant's counsel is to be prescribed by the Board pursuant to ORS 656.236(4) and OAR 438-15-052, costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to an attorney. Debbie K. Ziebert, 44 Van Natta 51 (1992); Janelle I. Neal, supra. Moreover, because the costs in question in this CDA concern a matter outside ORS Chapter 656, they are not a proper matter for disposition under ORS 656.236 and the rules promulgated thereunder. Karen Vearrier, 42 Van Natta 2071 (1990).

Therefore, while we understand claimant's concerns regarding a possible Social Security offset, we have no authority to determine which amounts might constitute an offset for Social Security purposes. Furthermore, our decision in this matter does not preclude claimant from memorializing the expenditure of such costs in a separate agreement, nor does our decision preclude claimant from establishing to the appropriate authorities that he has, in fact, incurred those costs. Rather, we merely reiterate that a CDA containing such a cost reference cannot be approved.

Accordingly, for these reasons, we conclude that the portion of the CDA referencing claimant's attorney's costs is unreasonable as a matter of law. See Debbie K. Ziebert, supra. In reaching our conclusion, however, we emphasize that we are not ruling that claimant's attorney did not incur the stated costs. Rather, consistent with the statute and prior cases, we are reiterating that costs, as distinguished from attorney fees, cannot be assigned prior to their receipt by the beneficiary entitled thereto. See ORS 656.234; Debbie K. Ziebert, supra. As such, consideration of such matters exceeds our statutory authority under ORS 656.236.

Finally, 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
CHRISTOPHER C. GRAYSON, Claimant
WCB Case Nos. 92-12201 & 92-10247
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of that portion of Referee Peterson's order that awarded claimant's counsel an assessed attorney fee of \$8,000 for his services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant's attorney an assessed fee of \$8,000 for his services at hearing. On review, SAIF contends that the award is excessive. Specifically, SAIF questions the amount of time claimant's attorney spent on this case. SAIF argues that the case was not overly complex and should not have required a substantial number of attorney hours, since the case primarily involved medical and legal questions rather than lay testimony and disputes over witness credibility. However, SAIF does concede that a fee in excess of \$2,000-2,500 would be warranted in this case.

Claimant contends that the time reported on the statement of services accurately reflects the actual attorney time spent on the denials, penalties and attorney fee issues, and later on SAIF's partial denials of claimant's condition, unreasonable resistance to payment of compensation, hearing, travel time, and to clarify the very complex medical issues. Claimant also argues that his attorney is highly skilled and there was a significant risk that the claim would be found not compensable and counsel's efforts would go uncompensated.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.386(1), which is applicable in this case, provides that where the claimant prevails finally on a denial of compensation in a hearing before the referee, the referee shall allow a reasonable attorney fee, which is to be paid by the insurer or the self-insured employer.

The statute makes it clear that to be entitled to an assessed attorney fee, claimant must "prevail" on a claim, that is, "obtain" compensation. Claimant prevailed only on the denials of compensation. After reviewing the statement of services, we note that it includes attorney time spent on issues on which claimant did not prevail. Consequently, we do not consider the time devoted to those issues in establishing a reasonable attorney fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue is \$5,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this case as represented by the hearing record and claimant's counsel's statement of services (less time devoted to issues other than compensability), the complexity of the issue (spondylosis and spondylolisthesis and their relation to claimant's injuries), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, claimant is not entitled to an attorney fee award for services on review defending the attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 16, 1993, is modified in part and affirmed in part. The Referee's attorney fee award of \$8,000 is modified. In lieu of the Referee's award, claimant's counsel is awarded a reasonable assessed attorney fee of \$5,000, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
ZANE E. PHILLIPS, Claimant
WCB Case No. 92-02387
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee T. Lavere Johnson's order which: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to award a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant has been employed by the current employer since December 1988 as a laborer and roofer. Claimant was required to carry bundles of shingles, weighing approximately 45 to 50 pounds, up a ladder to the roof. On December 2, 1991, claimant's back became sore after carrying several loads of shingles up a ladder to a roof.

Claimant was scheduled to work on December 6, 1991, but did not. That evening, the employer held a Christmas party which claimant attended.

On December 7, 1991, claimant went wood gathering with neighbors. Three pickup truck loads of firewood were gathered. Claimant drove a truck, but did not cut or load firewood.

On December 11, 1991, claimant saw Dr. Mang with complaints of low back, left hip and left leg pain. Dr. Mang treated claimant conservatively for lumbar strain with sciatica involving the left hip and leg. (Exs. 2, 3, 4, 5). Radiographic studies on May 20, 1992 revealed an L5-S1 disc herniation on the left and moderate disc bulging at L4-L5. (Ex. 18). On July 30, 1992, Dr. Bert performed low back surgery. (Ex. 24).

On December 11, or 12, 1991, claimant and the owner of the business, John Hammond, had a conversation about claimant's back. Claimant stated that his back was sore, but he was unsure whether the back problem was attributable to work activities. Hammond told him that if the back problem was not due to work, the employer's medical insurance would cover the doctor bills. Claimant did not ask for an 801 form at that time. A few days later, claimant's ex-wife called and informed the employer that claimant would be filing a workers' compensation claim.

On December 17, 1991, claimant filed an 801 form, alleging that he had injured his back by hand-carrying bundles of shingles up a ladder to the roof.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant, based on demeanor, appeared to be a credible witness. The Referee also concluded, however, that claimant was not a reliable witness and, therefore, afforded his testimony little weight. We do not find the Referee's demeanor-based credibility finding to be inconsistent with his conclusion that claimant was unreliable. Even though claimant may not have been a completely reliable witness, after our de novo review of the entire record and testimony, we do not find any incidents of unreliability to be material to the outcome of this case. Furthermore, we find claimant's and the witnesses' testimony to be consistent with a finding of a compensable injury.

Claimant contends that his back condition arose over a relatively short, discrete period of time. Based on our review of the medical and lay evidence, we concur. Thus, we analyze the claim as an industrial injury. See Valtinson v. SAIF, 56 Or App 184 (1982). Claimant, therefore, must establish that the injury arose out of and in the course of employment which was a material contributing cause of his disability or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

Claimant's back began bothering him on December 2, 1991, after many trips carrying bundles of shingles up a ladder to a roof. Claimant continued to work with a sore back until December 10, 1991, when he had to leave work due to back pain. The next day, he sought treatment from Dr. Mang.

Dr. Mang obtained a history of claimant's back beginning to be sore after packing shingles up to a roof on December 2, 1991. (Ex. 4). Dr. Mang treated claimant conservatively, but then referred claimant to Dr. Bernstein, neurologist, when, over the period of a week, claimant's condition worsened. (Ex. 3).

Dr. Bernstein continued to treat claimant, but noted little improvement. (Ex. 17A). Bernstein requested an MRI which indicated an L-5/S-1 disc herniation on the left side. (Ex. 18). He then opined that, absent any medical evidence to the contrary, claimant's December 2, 1991 injury was the major contributing cause of his disc herniation. (Ex. 16, 19-16). The medical record contains no evidence to the contrary.

Accordingly, we are persuaded that claimant sustained a back injury on December 2, 1991 while performing his work activities and that the injury was a material contributing cause of his disability or need for treatment. Consequently, SAIF's denial shall be set aside.

Penalty and Attorney Fees

We adopt the Referee's conclusion with regard to this issue.

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 compensability is \$3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and the hearing record), the value of the interest involved, the complexity of the issue, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated December 28, 1992 is reversed in part and affirmed in part. That portion of the order which upheld the SAIF Corporation's compensability denial is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed attorney fee of \$3,000, payable by SAIF. The remainder of the order is affirmed.

November 3, 1993

Cite as 45 Van Natta 2112 (1993)

In the Matter of the Compensation of
JOSEPH FISHER, Claimant
 Own Motion No. 93-0496M
 OWN MOTION ORDER

Emmons, et al., Claimant Attorneys
 Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable neck and right shoulder injury. Claimant's aggravation rights expired on October 8, 1986. SAIF opposes the reopening of the claim on the grounds that surgery or hospitalization is not reasonable and necessary for the compensable injury, that claimant has not sustained a worsening of the compensable injury, and that claimant was not in the work force at the time of the current worsening. SAIF also stated in their September 7, 1993 cover letter that claimant has not been hospitalized for surgery, although he participated in a pain center treatment program.

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.

Accordingly, the Board has the authority to reopen a claim for pain center treatment requiring inpatient hospitalization. We may also reopen a claim for pain center treatment on an outpatient basis where overnight accommodation away from home is necessary to obtain maximum benefits from the treatment. Under these circumstances, pain center treatment is treated as hospitalization. Lenne Butcher, 41 Van Natta 2084 (1989).

However, there is no medical opinion as to why claimant required overnight accommodation away from home to obtain maximum benefit from the pain center treatment. We might assume that the reason for the stay in a Portland hotel during the pain center treatment is that daily travel from claimant's home in Salem to the pain center in Portland would aggravate his compensable neck condition. However, the record contains no medical opinion as to the reason for the overnight accommodation. We may not supply that medical opinion on the basis of an assumption. Furthermore, another assumption that is equally reasonable is that the overnight accommodation was not a matter of medical need but rather a matter of convenience.

Thus, on this record, claimant has not demonstrated that the pain center treatment satisfied the above criteria which would enable us to treat it as hospitalization. As a result, we are not authorized to grant claimant's request for temporary disability compensation. Consequently, we need not address the issues of whether claimant's pain center treatment constitutes a worsening of his compensable condition and whether claimant was in the work force at the time of his admittance into the treatment program.

The record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim. Accordingly, we deny the request for own motion relief. Id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

November 3, 1993

Cite as 45 Van Natta 2113 (1993)

In the Matter of the Compensation of
MOWENA J. MARTIN, Claimant
WCB Case No. C3-01663
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Westmoreland & Shebley, Claimant Attorneys
Liberty Northwest, Insurance Carrier

Reviewed by Board Member Neidig and Gunn.

On September 1, 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.

Here, the proposed agreement provides that "[s]uch 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." Although the first sentence quoted above may have been provided for informational purposes only, we have routinely held that CDA's may dispose of only accepted conditions. See Frederick M. Peterson, 43 Van Natta 1067 (1991). Furthermore, the second sentence, referring to "reasonable and necessary medical services" could be interpreted to limit a claimant's right to medical services. See Ronald A. Murphy, 45 Van Natta 1781 (1993); Kenneth D. McDonald, 42 Van Natta 2307 (1990).

Consequently, by letter of September 8, 1993, we requested an addendum to correct these matters. 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 proposed disposition has been disapproved, the insurer or self-insured employer 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.

November 4, 1993

Cite as 45 Van Natta 2114 (1993)

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

Farmers Insurance Group requested reconsideration of our July 29, 1993 Order on Review. Specifically, Farmers objected 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 low back condition. Claimant cross-requested reconsideration of that portion of our order that declined to award an assessed attorney fee pursuant to ORS 656.382(1). On August 16, 1993, we abated our July 29, 1993 Order on Review. We have received SAIF's response to claimant's motion, and have allowed sufficient opportunity for Liberty to respond to Farmers' motion. We grant the motion for reconsideration and replace our prior order with the following order.

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 was responsible for claimant's current low back condition (which included the disc herniation at L5-S1 and need for surgery). This conclusion was based on the

finding that claimant had experienced a "new injury" or, in the alternative, a "new occupational disease" while Liberty was on the risk. Liberty requested Board review of the Referee's order. In our prior order, we found that Farmers had failed to carry its burden of proof in establishing either a "new injury" or "new occupational disease" in order to shift responsibility under ORS 656.308(1). Thus, we concluded that Farmers, as the last carrier with a previous claim for claimant's low back condition, remained responsible.

On reconsideration, Farmers contends that ORS 656.308(1) is not applicable because the L5-S1 disc herniation is not the "same condition" as the compensable low back condition for which Farmers is responsible. Thus, Farmers argues that the law in effect before the 1990 amendments applies.

In the alternative, Farmers asserts that ORS 656.308(1) was applied incorrectly. Farmers further argues that the Board erroneously required it to prove that claimant's work activities during Liberty's discrete period of coverage was the major contributing cause of claimant's current condition. Farmers contends that it was only required to prove that work activities subsequent to its period of coverage were the major contributing cause of claimant's condition, and that it was under no duty to prove the proportional contribution from successive employment exposures.

We consider first whether ORS 656.308(1) applies to this claim. To answer this question we need to determine if claimant's current condition for which he seeks compensation is the "same condition" as the prior accepted low back claim processed by Farmers. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993); Beverly R. Tillery, 43 Van Natta 2470 (1991).

Here, claimant has an accepted low back condition with Farmers stemming from a 1982 claim. In 1986, claimant was experiencing left S1 radiculopathy. An October 1986 MRI revealed protrusions at the L4-5 and L5-S1 levels. This prompted further work up by claimant's then attending physician, Dr. Frank. A myelogram and CT scan were performed. These tests confirmed the presence of disc protrusions at L4-5 and L5-S1. Dr. Frank was of the opinion that the L5-S1 disc was the more serious of the two protrusions, but concluded that surgical intervention was not warranted. (Exs. 59-66). Apparently these medical services were processed as an aggravation by Farmers of the 1982 claim. (Ex. 68). The claim closed by Determination Order in November 1988. Claimant's permanent disability award included the two bulging discs. (Ex. 82). Thereafter, in 1989 and 1990, claimant continued to experience low back symptoms.

Claimant continued to work for the same employer as a truck driver. Claimant testified that in addition to the driving he was required to lift and move heavy drums. During this period claimant's employer was insured by SAIF from December 1986 to December 1990. Later, the employer was insured by Liberty from January 1991 through the date of hearing.

In early 1991 claimant's left leg symptoms worsened. He sought medical care from Dr. Lee, and thereafter with Dr. Rosenbaum. A repeat MRI was performed in November 1991 which revealed a "gross herniation" at the L5-S1 level on the left. (Ex. 92). Based on these findings, Dr. Rosenbaum recommended surgery. (Exs. 94-95). It was the opinion of Dr. Rosenbaum that claimant had left S1 radiculopathy secondary to a herniated disc at L5-S1. It was further his opinion that claimant's current condition was identical to his initial complaints and previous diagnostic evaluations. (Ex. 99).

Based on this evidence, we find claimant's current condition is the "same condition" as the condition for which Farmers is responsible. Therefore, amended ORS 656.308(1) is applicable to this claim. Under that statute, Farmers remains responsible for claimant's future compensable medical services and disability relating to the compensable condition unless claimant sustains a "new compensable injury" involving the same condition. Id; SAIF v. Drews, 318 Or 1 (1993).

In the context of assigning responsibility among successive employers for multiple injuries, the Supreme Court has held that ORS 656.005(7)(a)(B) is applicable when determining whether responsibility shifts to a subsequent employer under ORS 656.308(1). SAIF v. Drews, supra. In other words, the Court has reasoned that if an accidental injury at a subsequent employer combines with a preexisting condition (for which a prior employer is responsible), responsibility for future compensable medical services and disability shifts to the subsequent employer if the injury is found to be "the major contributing cause of the disability or need for treatment." Conversely, if the accidental injury is not the

major contributing cause, the Supreme Court has further determined that responsibility would not shift to the subsequent employer because the claimant would not have suffered a "new compensable injury involving the same condition" under ORS 656.308(1).

ORS 656.308 is also intended to encompass occupational disease claims. Liberty Northwest Insurance Corporation v. Senters, 119 Or App 314 (1993). Thus, in order to establish a new occupational disease, the carrier with an accepted claim has the burden of establishing that subsequent work activities were the major contributing cause of the claimant's disease or its worsening. See ORS 656.802(2); Senters, supra; Donald C. Moon, 43 Van Natta 2595, 2596 n. 1 (1991).

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).

Here, 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 Referee found that Farmers had carried its burden of proving a "new compensable injury." We disagree. The medical record consists of two opinions concerning the cause of claimant's current low back condition. It was the opinion of the Orthopaedic Consultants that claimant had suffered no new discrete injury at work or at home. (Ex 102). Dr. Rosenbaum also concluded that claimant's low back condition was not the result of a discrete injury. (Ex 101). Based on this medical evidence, we do not analyze this responsibility determination under a "successive injury" theory. Consequently, Farmers cannot shift responsibility to a subsequent insurer on that basis.

However, we agree with the Referee's alternative finding that Farmers has carried its burden of proof in establishing a "new occupational disease." Dr. Rosenbaum, claimant's attending orthopedist, acknowledged that without the compensable injury, it was not likely that claimant's current work activity would have caused a disk herniation. Nevertheless, Dr. Rosenbaum concluded that assuming claimant's work activities required the heavy lifting and moving of heavy drums over the span of the last four years, the major contributing cause of claimant's current condition and need for surgery would be his recent work activity. (Ex. 104). Dr. Rosenbaum's history was consistent with claimant's credible testimony concerning his work activities.

It was the opinion of the Orthopaedic Consultants that claimant's current need for surgery was a combination of his compensable 1982 injury and ongoing work activities as a truck driver. In weighing the two causal factors, the panel assigned the major contributing cause at 50 percent to each factor. However, in making this determination the panel explained that although the compensable injury "started the disc protrusion process," it was the "continued work" which was responsible for the "increased protrusion such that now there is enough nerve irritation that surgery would seem to be indicated." (See Ex. 102-4-5).

We find the opinion of Dr. Rosenbaum and the opinion of the Orthopaedic Consultants to be similar. To the extent that the opinions are contradictory, we give greater weight to the conclusions of claimant's attending physician absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 610 (1982). In this case, Dr. Rosenbaum had a greater opportunity to examine claimant. He also saw claimant in October 1986 as well as in November 1991. We find no reason not to rely on the opinion of Dr. Rosenbaum. Therefore, we give his opinion greater weight than that of the Orthopaedic Consultants.

Based on this evidence, we find that claimant's current low back condition, the L5-S1 herniation and need for surgery, to be a pathological worsening of the original injury since the last claim closure in November 1988. We further find that the major contributing cause of this worsening was the subsequent work activities. Therefore, we find Farmers has carried its burden of proving a "new occupational disease," and thus, responsibility for claimant's condition shifts. See ORS 656.308(1).

ORS 656.308(1), however, addresses only shifting of responsibility, not its initial assignment. Here, we have found that claimant has a "new occupational disease" which no carrier has accepted. Consequently, the question remains as to which subsequent carrier for the employer, SAIF or Liberty, is responsible for claimant's L5-S1 disc herniation and related surgery. To resolve this question, we apply the last injurious exposure rule which governs the initial assignment of responsibility for conditions arising from an occupational disease which has not been previously accepted. See Ronda J. Styles, 44 Van Natta 1496 (1992); Fred A. Nutter, 44 Van Natta 854 (1992).

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. See Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. See Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

Here, the evidence indicates that claimant's employment while both SAIF and Liberty were on the risk contributed to claimant's current low back condition. Claimant first sought treatment for the L5-S1 herniated disc in November 1991. However, despite symptoms, he was able to continue working. Accordingly, we find that the "onset of disability" was in November 1991. During this time claimant's employer was insured by Liberty.

Consequently, responsibility for the occupational disease is initially assigned to Liberty, the carrier on the risk during the potentially causal employment exposure prior to the onset of disability. See Boise Cascade Corp. v. Starbuck, *supra*. Liberty can shift responsibility to SAIF, the prior insurer, by showing that claimant's work exposure while SAIF was on the risk was the sole cause of claimant's L5-S1 herniation and need for surgery, or that it was impossible for conditions while Liberty was on the risk to have caused the current low back condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, *on recon* 73 Or App 223, *rev den* 299 Or 203 (1985). In light of Dr. Rosenbaum's opinion that claimant's work activities over the prior four years (a period that spanned both SAIF's and Liberty's coverages) were likely the major contributing cause of the current condition and need for surgery, we conclude that Liberty has established neither fact. Accordingly, responsibility for claimant's "new occupational disease" claim remains with Liberty.

Penalties and related attorney fees for an unreasonable denial of compensability by SAIF

Claimant asserts that SAIF should be penalized for unreasonably denying compensability of his low back condition. A penalty may be assessed against a nonresponsible insurer 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 insurer. See Michael P. Yauger, 45 Van Natta 419 (1993); Steven R. Holmes, 45 Van Natta 330 (1993).

The reasonableness of an insurer's denial of compensation must be gauged based upon the information available to the insurer at the time of the denial. See Brown v. Argonaut Ins. Co., 93 Or App 588 (1988). Here, the evidence establishes that claimant's current low back condition was compensable. Although there may have been a question as to the responsible insurer, SAIF had no legitimate basis to doubt compensability as to some insurer at the time of its denial. Thus, SAIF's denial of compensability was unreasonable.

However, there is no evidence of any "amounts then due" at the time of hearing upon which to base a penalty pursuant to ORS 656.262(10). Claimant testified he continued working. Nor is there evidence of outstanding medical bills. Nonetheless, SAIF's denial of compensability precluded the possibility of the designation of a paying agent pursuant to ORS 656.307, and therefore, delayed claimant's back surgery. We find that issuance of the compensability denial by SAIF constituted an unreasonable delay in the payment of compensation. See Yauger, *supra*; Holmes, *supra*.

Where a carrier has unreasonably resisted the payment of compensation, we may assess an attorney fee in the absence of "amounts then due." See ORS 656.382(1); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Accordingly, we find claimant is entitled to an assessed attorney fee.

SAIF, however, argues that claimant's request for an assessed attorney fee under ORS 656.382(1) was not properly raised for Board review. SAIF contends that because claimant's request for an assessed fee was raised for the first time on reconsideration, the issue was not timely raised. However, we find that under these particular circumstances, the issue of an attorney fee under ORS 656.382(1) is part and parcel of the penalty issue. See Martinez v. Dallas Nursing Home, supra; Ronald A. Stock, 43 Van Natta 1889 (1991). SAIF has not argued that the penalty issue was not properly raised by claimant. Accordingly, we find the issue was timely raised.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services regarding the penalty issue is \$750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Assessed attorney fees at hearing pursuant to ORS 656.386(1)

Claimant contends that he is entitled to an assessed attorney fee, payable by Liberty, for prevailing over its responsibility denial. A claimant is entitled to an assessed attorney fee under ORS 656.386(1) only if the insurer denies the claim for compensation. If the insurer denies responsibility, but not compensability, it has not denied a claim for compensation. Here, Liberty denied responsibility only. Accordingly, claimant is not entitled to an assessed attorney fee pursuant to ORS 656.386(1) for services at hearing payable by Liberty. See Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992).

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 declined to award an assessed attorney fee pursuant to ORS 656.382(1) is reversed. Claimant's counsel is awarded an assessed attorney fee of \$750, payable by the SAIF Corporation. The remainder of the Referee's order is affirmed.

November 4, 1993

Cite as 45 Van Natta 2118 (1993)

In the Matter of the Compensation of
JAMES A. CARLING, Claimant
 WCB Case No. 89-08425
 ORDER ON REMAND
 Peter O. Hansen, Claimant Attorney
 Julie Bolt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Carling v. SAIF, 119 Or App 466 (1993). Our prior order upheld the SAIF Corporation's denial of claimant's alleged adjustment disorder with depression. Applying the law in existence prior to the 1990 statutory amendments, we reasoned that claimant must prove that his compensable injury was a material cause of his disorder. Noting that claimant could prevail by proving that the injury materially contributed to his symptoms (as opposed to a specific psychological condition), the court has reversed and remanded for reconsideration.

After conducting our reconsideration of this case, we adhere to the reasoning and conclusions contained in our prior order with the following supplementation and modification.

As the court has held, claimant is not required to prove that the compensable injury caused a specific psychological condition. Instead, under the pre-1990 law, to establish compensability, claimant need only prove that the injury materially contributed to his psychological symptoms. Carling v. SAIF, supra at 469; Grace v. SAIF, 76 Or App 511, 517 (1985).

Applying that standard, we are not persuaded that claimant has met his burden of proof. Based upon the persuasive medical evidence, we continue to conclude that claimant has not established that his compensable injury is a material contributing cause of his psychological symptoms.

In reaching this conclusion, we rely on the well-reasoned opinion of neuropsychologist, Dr. Labs. It was Dr. Labs' opinion that claimant had chronic psychological difficulties which predated his industrial injury. When Dr. Labs first evaluated claimant in January 1989, she found that claimant suffered from an adjustment disorder. However, Dr. Labs did not attribute that disorder to claimant's compensable injury. Rather, Labs opined that claimant's symptoms, such as subjective sleep disturbance, anxiety and increased irritability, were present prior to the compensable injury. (Ex. 12). Moreover, when Dr. Labs re-evaluated claimant in March 1989, she found that claimant no longer suffered from an adjustment disorder and she reiterated that claimant's psychological problems were in no way related to his industrial injury. (Ex. 14).

Although Ms. Henry, a social worker who treated claimant with psychotherapy, related claimant's psychological symptoms to the compensable injury, we continue to conclude that her opinion is less persuasive than that of Dr. Labs. Specifically, Ms. Henry's report, (Ex. 18), does not acknowledge or discuss claimant's problem with drug and alcohol abuse and is conclusory and lacking in explanation and analysis. Accordingly, we accord Ms. Henry's opinion less weight and consider Dr. Labs' observations to be more persuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Somers v. SAIF, 77 Or App 259, 263 (1986).

Accordingly, on reconsideration, as supplemented and modified herein, we continue to adhere to our June 28, 1991 order.

IT IS SO ORDERED.

November 4, 1993

Cite as 45 Van Natta 2119 (1993)

In the Matter of the Compensation of
JAMES R. GOINGS, Claimant
WCB Case Nos. 93-02452 & 93-03846
ORDER DENYING MOTION TO DISMISS
Williams, Zografos, et al., Defense Attorneys

The self-insured employer has moved the Board for an order dismissing claimant's request for Board review. Contending that neither it nor its claim processing agent received a copy of claimant's request, the employer seeks dismissal of the request for Board review. We deny the motion.

FINDINGS OF FACT

On August 5, 1993, the Referee issued an Opinion and Order, which (among other things) upheld the employer's partial denial of claimant's seizure disorders. On August 16, 1993, the Referee issued an Order to Abate to consider the employer's motion for reconsideration. On August 30, 1993, the Referee issued an Order on Reconsideration, which modified a finding of fact but otherwise reissued the August 5, 1993 order.

On August 30, 1993, the Board received claimant's request for Board review which objected to the Referee's upholding of the employer's denial.¹ Claimant's request indicated that copies had been provided to the Referee, the Board, and to the employer's attorney. The request did not indicate that a copy had been provided to the employer or its claim processing agent.

¹ Claimant's letter requesting Board review specifically referred to the Referee's August 5, 1993 "denial." Since the Referee's August 5, 1993 order had been abated and then reissued in its entirety (save for a modified finding of fact) pursuant to the Referee's August 30, 1993 order, it is apparent that claimant was objecting to the Referee's decision which had upheld the employer's denial. Since that decision was the Referee's August 30, 1993 order, we interpret claimant's request as an appeal of that order.

On September 2, 1993, the Board mailed a computer-generated letter to all parties acknowledging claimant's request.

Thereafter, the employer's counsel moved for dismissal of claimant's request for Board review contending that neither the employer nor its claim processing agent received a copy of claimant's request. The employer's counsel did not contest claimant's representation that a copy of the request for Board review had been provided to the employer's counsel. In fact, the employer's counsel's motion to dismiss was accompanied by a copy of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).²

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20). Attorneys are not included within the statutory definition of "party." Berliner v. Weyerhaeuser Company, 92 Or App 264, 266 n 1 (1988); Frank F. Pucher, 41 Van Natta 794 (1989). Nevertheless, in the absence of a showing of prejudice to a party, timely service of a request for Board review on a party's attorney is adequate compliance with ORS 656.295(2). See Argonaut Insurance v. King, *supra*; Nollen v. SAIE, 23 Or App 420, 423 (1975); Allasandra O'Reilly, 40 Van Natta 1180 (1988).

Here, neither the employer nor its claim processing agent received copies of claimant's request for review. However, computer-generated letters acknowledging the request were mailed to all parties to the proceeding on September 2, 1993. Since the Board's acknowledgment letter was mailed to all parties to the hearing within 3 days after the Referee's August 30, 1993 order, we conclude that it is more probable than not that the other parties received actual notice of claimant's request for review within the statutory 30-day period. See Wayne V. Pointer, 44 Van Natta 539 (1992); Denise M. Bowman, 40 Van Natta 363 (1988); John D. Francisco, 39 Van Natta 332 (1987).

² In support of its dismissal motion, the employer relies on Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992). The Mosley holding does not control the outcome of this case.

In Mosley, the court affirmed the Board's dismissal of a claimant's request for review because the claimant had not provided timely notice to all parties to the proceeding before the Referee. In reaching its conclusion, the court did not discuss the questions of whether the parties in Mosley had received actual notice of the claimant's appeal via the Board's acknowledgment letter or whether the other parties' attorneys had received notice of the appeal. Thus, the Mosley holding is readily distinguishable.

Moreover, the Board's order in Mosley cited Argonaut Insurance Co. v. King, *supra*, in holding that because not all parties had received notice of the claimant's request within 30 days of the Referee's order, the request must be dismissed. Emma G. Mosley, 43 Van Natta 510, 611 (1991) (Emphasis supplied). The Board order in Mosley did not specifically discuss whether that notice was by receipt of a copy of the request or by other means. However, as cited previously in our order, Argonaut Insurance Co. v. King, holds that 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. Thus, it is apparent that the Board's dismissal in Mosley was based on the conclusion that not all of the parties had either received a copy of the appeal or received actual notice of the appeal within the 30-day period.

Since we are persuaded that each party received actual notice of claimant's appeal within the statutory 30-day period, the Mosley holding is not applicable. Instead, resolution of this issue is determined under the rationale set forth in Argonaut Insurance Co. v. King, *supra*. Applying that rationale, for the reasons discussed in our decision, we conclude that all parties received actual notice of claimant's request for Board review in a timely manner.

Moreover, the employer's attorney does not contest the representation contained in claimant's request for review that a copy of his request was provided to the attorney. In fact, the employer's attorney included a copy of claimant's request with the motion to dismiss. In light of such circumstances, we are persuaded that the employer's attorney received notice of claimant's appeal within 30 days of the Referee's order. Finding no prejudice from the employer's and its claims processing agent's failure to receive a copy of claimant's request for Board review, we conclude that such notice is sufficient to vest this forum with jurisdiction.

Accordingly, we deny the employer's motion to dismiss. As a result of this decision, it will be necessary to revise the briefing schedule. Claimant's appellant's brief has been received. Therefore, the employer's respondent's brief shall be due 21 days from the date of this order. Claimant's reply brief shall be due 14 days from the date of mailing of the employer's respondent's brief. Thereafter, this case shall be docketed for Board review.

IT IS SO ORDERED.

November 4, 1993

Cite as 45 Van Natta 2121 (1993)

In the Matter of the Compensation of
DORIS A. PACE, Claimant
WCB Case No. 90-08372
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Claimant requests reconsideration of our October 21, 1993 Order on Remand that: (1) awarded interim compensation from January 18, 1990 to April 16, 1990, whereas we had previously awarded interim compensation from January 18, 1990 to July 11, 1990; and (2) assessed a 25 percent penalty (to be shared equally by claimant and her counsel) based on the interim compensation award, whereas our prior order had assessed a 25 percent penalty based on our previous interim compensation award. Contending that she is entitled to an attorney fee award for services rendered in prevailing against the self-insured employer's request for Board review and petition for judicial review, claimant seeks reconsideration of our order for additional attorney fee awards.

In order to further consider claimant's request, we withdraw our October 21, 1993 order. In addition, we grant each party an opportunity to submit their respective positions. Specifically, the employer's supplemental response shall be due 14 days from the date of this order. Claimant's supplemental reply shall be due 14 days from the date of mailing of the employer's response. Thereafter, we shall take this matter under advisement. In submitting their respective positions, the parties are requested to discuss the effect, if any, the Board's holding in Cleo I. Beswick, 43 Van Natta 876 (1991), on recon 43 Van Natta 1314 (1991), has on this dispute.

IT IS SO ORDERED.

In the Matter of the Compensation of
RITA M. PARKE, Claimant
WCB Case No. 91-04995
ORDER ON REMAND
Francesconi & Associates, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Parke v. Oregon Health Sciences University, 122 Or App 298 (1993). The court reversed our prior order, Rita M. Parke, 44 Van Natta 1612 (1992), which set aside the SAIF Corporation's denial of claimant's low back injury claim, but upheld its denial of claimant's current "resultant" condition. Citing Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's preexisting noncompensable degenerative conditions combined with her January 25, 1991 work injury, resulting in claimant's subsequent low back disability and need for treatment. Determining that these preexisting conditions were the major contributing cause of the resultant condition, the Referee concluded that the claim was not compensable. See ORS 656.005(7)(a)(B).

In our prior order, we found that claimant's January 25, 1991 work activities were a material contributing cause of her lumbosacral strain injury and, thus, the injury claim was compensable. Rita M. Parke, supra. However, we further found that the compensable injury combined with the degenerative disease and that the major contributing cause of the resultant condition was the degenerative condition. Relying on Bahman N. Nazari, 43 Van Natta 2368 (1991), we concluded that such findings established that the claim for a "current back condition" was not compensable.

Subsequent to our order, the court reversed our decision in Nazari. Interpreting ORS 656.005(7)(a)(B), the court reasoned as follows:

"If, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an initial claim, 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." Tektronix, Inc. v. Nazari, on recon at 594.

Citing Nazari, supra, the court has reversed our prior order and remanded for reconsideration.

The record does not support a conclusion that claimant's low back problems are due to the January 1991 work injury alone. Rather, the record establishes that claimant's disability and need for treatment for her low back resulted from a combination of the work injury and a preexisting noncompensable condition. (See Exs. 3B-1, 5-1, 7A).¹ Thus, because claimant's January 1991 condition arises not from the work injury alone, but from the injury combined with a preexisting noncompensable condition, claimant bears the burden of proving that the work injury was the major contributing cause of the resultant condition. See Nazari, supra.

¹ In reaching this conclusion, we note, as did the Referee, that claimant was treating for low back pain (which began with a noncompensable November 1990 injury) up to January 24, 1991, the day before the injury presently claimed.

In reaching this conclusion, we continue to find the opinion of Dr. Peterson, examining orthopedist, to be the most persuasive. Peterson characterized claimant's low back pain as an "ongoing injury." (Ex. 7A-6). Considering the recurrent nature of claimant's low back symptoms, Peterson concluded that claimant suffers from a lumbosacral strain superimposed on degenerative disc disease and that her preexisting degenerative condition was the major contributing cause of her continuing disability and need for treatment. (*Id.*) We find Peterson's conclusion in this regard to be well-reasoned and consistent with claimant's history of recurrent back strains. See Somers v. SAIF, 77 Or App 259 (1986).

Under these circumstances, we rely on Peterson's opinion and conclude that claimant has not proven that her January 25, 1991 work activities were the major contributing cause of her resultant disability and need for treatment for her low back. See ORS 656.005(7)(a)(B); Tektronix v. Nazari, supra. Consequently, SAIF's denials are upheld in their entirety.

Accordingly, on reconsideration, we affirm the Referee's order dated September 30, 1991.

IT IS SO ORDERED.

November 4, 1993

Cite as 45 Van Natta 2123 (1993)

In the Matter of the Compensation of
ROBERT J. SHEWEY, Claimant
WCB Case No. 93-00150
ORDER OF DISMISSAL (REMANDING)
David C. Force, Claimant Attorney
Donald Landes, Attorney

William D. Lewis, an alleged employer, has requested Board review of Referee Howell's September 30, 1993 "Order," which denied Lewis' motion to dismiss claimant's request for hearing for a failure to provide discovery. We have reviewed the request to determine whether we have authority to consider this matter. Because we conclude that the Referee's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

Claimant requested a hearing contesting the Department's determination that he was not a subject worker at the time of his injury. Prior to the scheduled hearing, Lewis moved to dismiss claimant's request for hearing on the ground claimant failed to provide discovery. On July 9, 1993, Referee Howell denied the motion to dismiss.

On September 15, 1993, Lewis filed a "Motion for Reconsideration and Motion to Compel Discovery from Claimant." Contending that claimant should be required to provide discovery of medical records and submit to a deposition, Lewis again sought dismissal of claimant's hearing request for his failure to take such actions.

On September 30, 1993, the Referee issued an "Order," denying Lewis' motions for reconsideration, discovery, and dismissal. In doing so, the Referee reasoned that claimant could be examined under oath at the hearing. In addition, the Referee noted that a continuance of the hearing could be granted upon a showing of surprise.

The Referee's order contained a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3). On October 19, 1993, the Board received Lewis' request for Board review of the Referee's September 30, 1993 order.

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 September 30, 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 inclusion of a statement explaining the parties' rights of appeal, the order was preliminary in nature. The order expressly denied Lewis' pre-hearing motions to dismiss claimant's request for hearing and provide discovery.

Inasmuch as the Referee's order pertained to pre-hearing matters, we hold that the order was not final. In short, as noted in the Referee's order, further proceedings will be required to determine claimant's entitlement to and/or the amount of, compensation; *i.e.*, a hearing regarding claimant's objection to the Department's "subjectivity" determination. 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. *Shirley J. Davis*, 44 Van Natta 762 (1992); *Jeanne C. Rusch*, 43 Van Natta 1966 (1991). Consequently, we currently lack jurisdiction to consider Lewis' request for Board review.

Accordingly, this case is returned to Referee Howell for further action consistent with this order and his September 30, 1993 order. In other words, the scheduling of a hearing.

IT IS SO ORDERED.

November 4, 1993

Cite as 45 Van Natta 2124 (1993)

In the Matter of the Compensation of
ROGER I. VIGUERIA, Claimant
 WCB Case No. 92-13538
 ORDER ON REVIEW
 Malagon, et al., Claimant Attorneys
 Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee McWilliams' order that: (1) found that claimant had perfected an aggravation claim prior to the expiration of his aggravation rights; (2) set aside its denial of claimant's aggravation claim for a left arm condition; (3) found that claimant was entitled to interim compensation beginning September 28, 1992; and (4) assessed a penalty for an allegedly unreasonable "de facto" denial. On review, the issues are timeliness of the aggravation claim, aggravation, interim compensation and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Aggravation Claim/Aggravation

We adopt the conclusions and reasoning concerning the timeliness and aggravation issues as set forth in the Referee's order with the following supplementation.

SAIF contends that even if claimant's aggravation claim was timely, he must establish that his worsening occurred prior to the expiration of his aggravation rights. SAIF cites *Robert F. Curtis*, 44 Van Natta 2268, *on recon* 44 Van Natta 2413 (1992) in support of its argument. Because we find that the record establishes that claimant's worsening occurred prior to the expiration of his aggravation rights, we need not address SAIF's contention.

Claimant's aggravation rights expired on April 20, 1992. Dr. Cassell opined that claimant's condition worsened between his examinations in 1989 and February 1992. Dr. Cassell last saw claimant in August 1989, just prior to the last arrangement of compensation (a September 1989 Opinion and Order). In the absence of contrary evidence, we are persuaded by Dr. Cassell's opinion that claimant's condition had worsened by February 1992.

Interim Compensation

We adopt the conclusions and reasoning concerning the interim compensation issue as set forth in the Referee's order with the following supplementation.

The Referee awarded claimant interim compensation from September 28, 1992. On review, SAIF argues that claimant did not satisfy the requirements for entitlement to interim compensation. We disagree.

Claimant's entitlement to interim compensation in the form of temporary disability benefits depends on whether the employer received notice or knowledge of a medically verified inability to work in a medical report that constitutes prima facie evidence in the form of objective findings that claimant's compensable condition had worsened. See ORS 656.273(6); Stanley Smith Security v. Pace, 118 Or App 602 (1993).

We agree with the Referee that, by September 28, 1992, SAIF had sufficient notice of claimant's medically verified inability to work due to a compensable worsening. On that date SAIF had the following documents in its possession: (1) Dr. Butters' January 16, 1992 report, which records that claimant experienced increasing elbow pain with swelling and decreasing range of motion and notes that claimant had been employed "doing mechanical work over the last three months" (Ex. 38); (2) Dr. Cassell's February 25, 1992 chart notes reflecting that by this date claimant was no longer employed (Ex. 37-1); (3) Dr. Butters' January 27, 1992 letter documenting decreased range of motion and reporting that claimant states he is unable to work due to elbow pain (Ex. 39); (4) Dr. Cassell's March 18, 1992 letters which document a progressive loss of use of claimant's left upper extremity (Exs. 40, 41); (5) the June 19, 1992 independent medical examination which records that claimant states he is not able to function well because of chronic discomfort in the elbow if he does too much, especially work which is moderately heavy (Ex. 42-2); and (6) Dr. Cassell's August 30, 1992 letter which clearly states that due to a worsening of claimant's compensable injury claimant is not capable of doing "any jobs requiring manual repetitive use of his left upper extremity" (Ex. 44).

We find that these reports constitute prima facie evidence, supported by objective findings, that claimant's condition had worsened since the previous award of permanent disability and that the worsening was more than waxing and waning of symptoms contemplated by the prior award. See Stanley Smith Security v. Pace, *supra*, at 609. We further find that the evidence indicates a medically verified inability to work. See Michael C. Dewbre, 45 Van Natta 1097 (1993). Accordingly, SAIF was statutorily required to begin the payment of interim compensation no later than the 14th day after receipt of Dr. Cassell's September 28, 1992 letter. See ORS 656.273(6).

Penalties and Attorney Fees

We adopt the Referee's reasoning and conclusions concerning the penalty/fee issue with the following modification.

The Referee ordered SAIF to pay claimant a penalty equal to 12.5 percent of all compensation due on the date of hearing. In addition, the Referee ordered SAIF to pay claimant's counsel a separate attorney fee equal to 12.5 percent of all compensation due on the date of hearing. On review, SAIF contends that the Referee improperly assessed a penalty and separate fee for the same conduct.

The Referee's order could be interpreted as awarding claimant a penalty under ORS 656.262(10) and an attorney fee under ORS 656.382(1) for the same unreasonable conduct. Under such circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10), that claimant's attorney receive one half the penalty in lieu of an attorney fee under ORS 656.382(1). Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

However, we find it was not the intention of the Referee to award a separate fee under ORS 656.382(1), but rather to award a 25 percent penalty under ORS 656.262(10). Therefore, for purposes of clarity, we modify the Referee's penalty assessment as follows. A penalty of 25 percent of the compensation "then due" at the time of hearing is assessed against SAIF. One half of the additional amount shall be paid to claimant's attorney, in lieu of an attorney fee. The other half of the additional amount shall be paid to claimant. See ORS 656.262(10); Martinez v. Dallas Nursing Home, *supra*.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation and interim compensation issues is \$1,050, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's statement of services), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 9, 1993 is affirmed in part and modified in part. In lieu of the Referee's penalty and attorney fee assessment under ORS 656.262(10), claimant is awarded a penalty of 25 percent of the amounts then due at the time of hearing. Claimant's attorney shall receive one-half of that penalty in lieu of an attorney fee. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded \$1,050, payable by SAIF.

November 5, 1993

Cite as 45 Van Natta 2126 (1993)

In the Matter of the Compensation of
MICHAEL A. BRACKEN, Claimant

WCB Case No. 92-03323

ORDER ON REVIEW

Robert G. Dolton, Claimant Attorney

Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Westerband and Haynes.

The self-insured employer requests review of Referee Michael Johnson's order that set aside its denial of claimant's aggravation claim for a current low back condition. On review, the issues are compensability and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's current low back problems are materially related to his compensable October 1990 injury, based on claimant's credible testimony and the opinion of Dr. Balmer, treating physician. We disagree.

Considering the variety of explanations and diagnoses given for claimant's current back problems and the passage of time since his original strain injury, we conclude that the causation issue is a complex medical question which must be resolved by medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993). 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 such reasons.

Dr. Balmer, treating physician, provides the only expert evidence arguably supporting the current claim. However, Balmer initially stated that he could "offer no conclusive or persuasive argument to connect the October 90 & October 91 complaints, but I do accept that it may be possible that his injury of 10/90 set in motion the sequence of events that have resulted in a herniated lumbar disc." (Ex. 24A). Balmer explained his hesitation in this regard:

"It is unfortunate that this patient has complained principally of thoracic paravertebral muscle spasm since I saw him first on 10/4/91, because his only objective findings (on CT) are in the lumbar spine area. . . The difficulty is further complicated by the apparent paucity of complaints from '90 until his ER visit of 10/91. . .and the principal complaint of thoracic and to a much lesser extent and far less frequent complaint of lumbar pain." (Id.).

About 5 months later, Balmer wrote to claimant's attorney:

"[Y]ou brought to my attention that [the employer] had in fact accepted a workers [sic] claim for a lumbar injury, when [claimant] injured his lower back at work. In the year between his initial justified work injury & the start of his complaints of thoracic & lumbar pain, there was no other history of injury. This argues strongly for an association between his work related lumbar injury of 10/90 and his subsequently diagnosed herniated lumbar disc and I consider it more likely than not that the two are related." (Ex. 26).

Balmer also checked a box indicating concurrence with a statement that it is medically probably that the October 1990 work injury is the major contributing cause of claimant's subsequently diagnosed herniated disc. (Ex. 27). We do not find Balmer's opinions persuasive, for the following reasons.

First, to the extent that Balmer's conclusion depends on a lack of evidence of off-work causes, it is not proof of causation. See ORS 656.266. Further, Balmer's April 1992 inability to offer a "persuasive argument" connecting claimant's 1991 condition with the 1990 work injury does not support this claim; neither does the doctor's acceptance of a possibility that the 1990 injury "set in motion the sequence of events" leading to the present problems. See Gormley v. SAIF, 52 Or App 1055 (1981). Moreover, when Balmer changed his opinion in October 1992, he did not explain away the circumstances which previously caused doubts. Since Balmer did not offer a reasonable explanation for his change of opinion, we attach little probative value to it. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or App 630 (1987). Lastly, Balmer clearly considered significant that the employer had accepted the 1990 lumbar injury claim. However, that rationale sheds no light on the complex medical question presented. Accordingly, we find no persuasive medical evidence of a causal relationship between the 1990 work injury and claimant's current condition. Therefore, we conclude that claimant has not carried his burden of proof. Because of this conclusion, we do not reach the aggravation issue.

ORDER

The Referee's order dated November 23, 1992 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's \$3,000 attorney fee award is reversed.

In the Matter of the Compensation of
FELIPE J. CASAS, Claimant
WCB Case No. 92-04754
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of those portions of Referee Michael V. Johnson's order which: (1) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable miscalculation of the rate of claimant's temporary disability; (2) declined to direct the insurer to pay claimant's counsel an "out-of-compensation" attorney fee from previously paid temporary disability; (3) found that the insurer was authorized to unilaterally terminate claimant's temporary disability pursuant to ORS 656.268(3); and (4) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable unilateral termination. On review, the issues are claim processing, 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

Reasonableness of miscalculation of temporary disability

On January 7, 1992, the insurer accepted claimant's claim. In calculating claimant's temporary disability, the insurer averaged claimant's earnings during his nine-week employment from August 21, 1991 through October 21, 1991. Claimant had been laid off for one month of this period (September 13, 1991 to October 14, 1991).

Thereafter, claimant's attorney sought resolution of this temporary disability dispute with Compliance Division of the Department of Insurance and Finance (DIF). Claimant's attorney did not include an executed retainer agreement with his request. (Ex. 17). The Director ordered the insurer to recalculate claimant's temporary disability considering the average weekly wage for the 5 weeks during which claimant actually worked, rather than 9 weeks (i.e., excluding the 4 weeks during which claimant was laid off). See OAR 436-60-025(5)(a). (Ex. 21). The Director's order did not award an "out-of-compensation" attorney fee. About three weeks later, the insurer paid the temporary disability due claimant as a result of its miscalculation. (See Exs. 22, 25).

Claimant requested a hearing seeking (among other things) penalties and attorney fees for the insurer's allegedly unreasonable miscalculation of his temporary disability. Reasoning that the insurer's reliance on erroneous legal advice made the insurer's error "not unreasonable," the Referee concluded that the insurer's miscalculation did not warrant a penalty. We disagree.

A penalty may be assessed for unreasonable delay or refusal to pay compensation. The standard for evaluating the reasonableness of the insurer's conduct is whether, from a legal standpoint, the insurer had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

OAR 436-60-025 provides, in relevant part:

"(5) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. * * *

"(a) For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. * * * *"
(Emphasis added).

Under the rule, when earnings are irregular (on call, piece work, or varying hours/shifts), a worker's temporary disability is based on wages earned during the 26 weeks preceding injury unless there is an "extended gap" in earnings. See Dena L. Barnett, 43 Van Natta 1776 (1991) (Whether extended gaps exist in a claimant's employment should be determined on a case-by-case basis).

Here, claimant worked irregularly for the employer, for a total of about 33 days between August 21 and October 24, 1991. (See Tr. 10; Exs. 21, 22). In addition, claimant was laid off from September 13, 1991 to October 14, 1991 during this period. We find no evidence that the irregularity of claimant's employment or his lay-off were within the reasonable expectations of claimant and the employer. Compare Adam J. Delfel, 44 Van Natta 524, 525 (1992). Under such circumstances, we conclude that the insurer did not have a legitimate doubt that claimant's earnings were irregular or that the one month lay-off, during the two month employment, constituted an "extended gap." We further hold that the insurer had no legitimate doubt that claimant's temporary disability should have been calculated by averaging claimant's weekly wage using no less than the previous four weeks of his employment. See OAR 436-60-025(5)(a).

Consequently, we find that the insurer's miscalculation was unreasonable. In reaching this conclusion, we acknowledge the insurer's contention that its conduct was based on erroneous legal advice. Generally, an employer may not rely on the incorrect advice of legal counsel, its agent. International Paper Co. v. Huntley, 106 Or App 107, 110 (1991), citing Free v. Wilmar I. Helric Co., 70 Or App 40 (1984), rev den 298 Or 553 (1985). However, such legal counsel may reasonably explain a claim processing error, if there is "some confusion in the state of the law at the time." Weyerhaeuser Co. v. Kepford, 100 Or App 410, 415 (1990). Here, in light of the aforementioned administrative rule and Board holdings regarding "extended gaps," we do not consider there to be confusion concerning the insurer's obligation. See Steven B. Caldwell, 44 Van Natta 2565 (1992); Adam J. Delfel, supra.

Ordinarily, we would assess a penalty under ORS 656.262(10) based on the insurer's miscalculation. However, the Referee already assessed a 25 percent penalty based on that compensation for the insurer's untimely payment once the miscalculation was identified. Since there are no other amounts due, no additional penalty may be assessed on that amount. See Robert A. Brooks, Jr., 44 Van Natta 1105 (1992) (There is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due).

Although claimant is not entitled to a second penalty on a single amount then due, he may be awarded an attorney fee if the insurer's miscalculation constituted different unreasonable conduct from that which supported the penalty. See Oliver v. Norstar, 116 Or 333 (1992); compare Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992) (When the factual basis supporting the penalty under ORS 656.262(10) is identical to the factual basis for which an attorney fee under ORS 656.382(1) might be awarded, a separate attorney fee is not assessable).

Here, because the insurer's unreasonable miscalculation constituted unreasonable resistance to the payment of compensation and different unreasonable conduct from its untimely payment of that compensation, claimant is entitled to an attorney fee based on the miscalculation as well as a penalty based on the untimely payment. See ORS 656.382(1); Oliver v. Norstar, supra.

Having considered the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable insurer-paid fee for claimant's counsel's services concerning the insurer's miscalculation of claimant's temporary disability rate is \$500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as reflected by the record), the complexity of the issue, and the value to claimant of the interest involved.

"Out-of-compensation" attorney fee

Claimant contends that the insurer should pay an "out-of-compensation" attorney fee based on increased temporary disability benefits ordered paid by the Director and paid in full directly to claimant. However, there is no record that claimant's fee request to the Director was accompanied by a copy of an executed retainer agreement.

On March 27, 1992, DIF ordered the insurer to recalculate claimant's temporary disability rate, but awarded no attorney fee. On April 16, 1992, the insurer paid claimant's recalculated (increased) temporary disability compensation to claimant.

The Referee noted that claimant's counsel was entitled to 25 percent of the additional temporary disability compensation obtained for claimant. However, because the entire amount of the increased compensation had already been paid to claimant, the Referee held that claimant's attorney must look to claimant for payment of that fee. We agree.

We have held that, where there was preventive action that claimant's attorney could have taken to secure the "out of compensation" fee before the insurer paid the full amount of increased compensation directly to claimant and claimant's counsel failed to take such action, claimant's attorney must look to claimant for his "out-of-compensation" fee. Gabriel M. Gonzales, 44 Van Natta 2399 (1992); see Nancy E. O'Neal, 45 Van Natta 1591 (1993), on recon 45 Van Natta 2081 (1993) (It would be inequitable to require carriers to reimburse claimants' counsel (and create an overpayment), if there was some action which claimant's attorney could have taken to secure the "out-of-compensation" fee).

Here, claimant's attorney could have secured an "out-of-compensation" fee by submitting a copy of his retainer agreement to the Director when he requested increased compensation for claimant. Because he did not take such preventive action, we conclude that it would be inequitable to require the insurer to reimburse claimant's counsel after it paid the increased compensation directly to claimant in accord with DIF's order. See Gabriel M. Gonzales, supra.

Termination of temporary disability/reasonableness

We adopt the Referee's opinion on these issues.

ORDER

The Referee's order dated October 30, 1992 is reversed in part and affirmed in part. That portion of the order that denied claimant's request for an attorney fee based on the insurer's failure to accurately compute claimant's temporary disability compensation is reversed. For services rendered concerning the insurer's unreasonable miscalculation of claimant's temporary disability, claimant's counsel is awarded an attorney fee of \$500, payable by the insurer. The remainder of the order is affirmed.

November 5, 1993

Cite as 45 Van Natta 2130 (1993)

In the Matter of the Compensation of
LINDA M. CROSS, Claimant
 WCB Case No. 92-11314
 ORDER ON REVIEW
 Popick & Merkel, Claimant Attorneys
 Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn, Haynes, Neidig, and Westerband.

Claimant requests review of Referee Menashe's order that: (1) found that her back injury claim was not prematurely closed; and (2) "remanded" the claim to the Appellate Unit for completion of the reconsideration process. On review, the issues are premature closure and claim processing. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant suffered a compensable back injury in January 1992. The claim was closed by a July 24, 1992 Notice of Closure that awarded only temporary disability. On July 29, 1992, claimant requested reconsideration of the Notice of Closure. (Ex. 29). In her request for reconsideration, claimant objected to the impairment findings used in rating her disability at the time of claim closure. Claimant also raised the issues of premature claim closure, temporary disability, and unscheduled permanent disability.

On April 14, 1992, the Department issued an Order on Reconsideration which found that claimant's claim had been prematurely closed and rescinded the Notice of Closure. (Ex. 36). Because the Department found that the claim was prematurely closed, no medical arbiter was appointed.

The employer requested a hearing challenging the Order on Reconsideration's finding that the claim had been prematurely closed. On December 9, 1992, following a hearing, the Referee found that the claim had not been prematurely closed and reinstated the Notice of Closure. Because no medical arbiter had been appointed, the Referee "remanded" the claim to the Appellate Unit to complete the reconsideration process.

On January 11, 1993, the Department advised the parties that the Referee's December 9, 1992 order had been interpreted as a request to schedule a medical arbiter examination for use at further hearing proceedings. The parties were further notified that an arbiter examination would be scheduled and the examination findings would be forwarded to the parties for use at a later hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the Order on Reconsideration which found that claimant's claim was prematurely closed. In addition, the Referee "remanded" the claim to the Appellate Unit for appointment of a medical arbiter. On review, claimant contends that the Order on Reconsideration correctly set aside the Notice of Closure as premature. In the alternative, claimant contends that this claim should be remanded for a medical arbiter examination so that the extent of permanent disability may be rated.

Premature Closure

We adopt the Referee's reasoning and conclusion concerning the premature closure issue as set forth in his order.

Remand to the Department/Extent of Permanent Disability

Since claimant requested reconsideration of the Notice of Closure after October 1, 1991, amended ORS 656.268(6)(a) applies to this case. See Anne M. Younger, 45 Van Natta 68 (1993). That statute provides that any 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.

In addition, subsequent to the Referee's order, the Court of Appeals has held that the Board and Hearings Division lack authority to "remand" a claim to the Department. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Rather, where the medical arbiter's report is not reviewed by the Department, the court has reasoned that the appropriate procedure is for the referee to hear the case and admit and consider the arbiter's report in rating the extent of a worker's permanent disability. Id. The court has further concluded that ORS 656.268(7) prohibits the admission of evidence developed after the medical arbiter's report, but does not prohibit admission of the medical arbiter's report, itself.

Here, in requesting reconsideration of the July 24, 1992 Notice of Closure, claimant challenged the impairment findings used at claim closure. Under such circumstances, claimant is entitled to a medical arbiter examination. ORS 656.268(7). However, in light of the Appellate Unit's conclusion on reconsideration that the claim was prematurely closed, no medical arbiter was ever appointed and therefore no medical arbiter report was available for the Referee to consider at the hearing.

Thus, to accommodate ORS 656.268(7) and the Pacheco-Gonzalez rationale, we conclude that the following actions should have been taken in processing such a claim. Where a referee finds that a claim has not been prematurely closed and a medical arbiter should have been, but was not appointed by the Department because of its "premature closure" finding, the referee should assign a new WCB Case Number to the extent of permanent disability issue. This method will allow the referee to issue a final, appealable order resolving the premature closure issue while still preserving the extent of disability issue until such time as a medical arbiter's report is received. When a medical arbiter report is received, the deferred extent of disability issue may then proceed to hearing under the separate WCB Case Number. Under such a method, the parties would be responsible for advising the Director of a referee's decision that a claim has not been prematurely closed and for requesting that the Director schedule a medical arbiter examination (a copy of the referee's order should also be forwarded to the Appellate Unit).

Applying these principles to the case at hand, we reach the following conclusions. In order to resolve the extent of permanent disability issue, the Central Files Section of the Hearings Division is directed to assign a new WCB Case Number. Litigation of this new case will be deferred until such time as a medical arbiter's report is received by the parties. The parties should contact the Director to make arrangements for the medical arbiter examination.

When the parties are ready to proceed to hearing on the extent of permanent disability issue (including consideration of the medical arbiter report), they shall contact Referee Menashe. Thereafter, the Referee shall conduct further proceedings in any manner that, in the Referee's discretion, achieves substantial justice.

ORDER

The Referee's order dated December 9, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which "remanded" the claim to the Department is reversed. The remainder of the order is affirmed.

November 5, 1993

Cite as 45 Van Natta 2132 (1993)

In the Matter of the Compensation of
GEORGE M. HUNTLEY, Claimant
WCB Case Nos. 92-15397 & 92-16364
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Holtan's order that upheld the SAIF Corporation's partial denial of claimant's injury claim for a degenerative spurring condition. On review, the issue is claims processing (propriety of the partial denial).

We affirm and adopt the Referee's order. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989) (An insurer is free to partially deny any condition which it reasonably believes could be a claim); Calvin E. Bigelow, 45 Van Natta 1577 (1993).

ORDER

The Referee's order dated March 2, 1993 is affirmed.

In the Matter of the Compensation of
EARL D. LESPERANCE, Claimant
WCB Case No. 92-02491
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lindsay, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Thye's order that declined to reduce claimant's award of permanent total disability as awarded by an Order on Reconsideration. On review, the issue is permanent total disability.

We affirm and adopt the order of the Referee as supplemented. When a carrier requests a hearing contesting an Order on Reconsideration which has awarded claimant permanent total disability pursuant to ORS 656.268, it is seeking to alter the status quo; *i.e.*, eliminate claimant's permanent total disability award. As the proponent of that fact or position, it is the carrier's burden to prove that claimant is not permanently and totally disabled. See Harris v. SAIF, 292 Or 683, 690 (1982); Fernandez v. M&M Reforestation, 124 Or App 38 (1993).

Here, proceedings were initiated by the employer, thus the employer bears the burden of establishing entitlement to the relief requested. Applying this principle to the facts of this case, we find, as did the Referee, that the employer has failed to satisfy its burden of proving that claimant was not permanently and totally disabled. See Patricia A. Anderson, 35 Van Natta 1057 (1983).

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 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 November 20, 1992 is affirmed. For services on Board review claimant's counsel is awarded as assessed attorney fee of \$1,000 payable by the employer.

Board Member Haynes specially concurring.

In this case the employer has appealed an Order on Reconsideration awarding claimant permanent total disability. On appeal, the employer's sole argument is that claimant is not entitled to permanent total disability because he has failed to demonstrate that, "but for the compensable injury, the claimant would have returned to work." See SAIF v. Stephen, 308 Or 41, 48 (1989). As the proponent, the employer had the burden of proof in this matter.

The employer argues that there is compelling evidence to suggest that claimant was not willing to work. Specifically, the fact claimant makes more money being retired than he did as a pipelayer indicates there is no financial incentive for claimant to work. It was the testimony of the vocational expert that as a pipelayer claimant made between \$28,000 to \$30,000 a year before taxes. (Ex. 11-42). At the time of hearing, claimant testified that his current income was roughly \$34,000 a year, some of which is tax free. (Tr. 8-10). This does give one pause to wonder whether or not claimant would return to work as a pipelayer if he was able to.

The employer also contends that claimant is not motivated to work for anything less than his wage at injury, in this case \$14.79 an hour. (Ex. 1-2, Tr. 13). Apparently it was claimant's belief that he should not have to accept anything below "union wage" which he had previously testified to as around \$14 an hour. (Tr. 18-19). In this day and age and considering the current economic climate in this state, that attitude is neither realistic nor reasonable.

Finally, there is evidence that suggests that claimant's retirement is voluntary and not the result of the compensable injury. Apparently, pipelayers routinely retire at an early age. Claimant stated he was not aware of any pipelayer over 60 years old (the oldest pipelayer he ever worked with was 51 years old). At the time of hearing claimant was 62. (Tr. 17). It is probable that even without the compensable injury claimant would have voluntarily retired.

Although admittedly this evidence is suggestive that claimant is not willing to work, prior case law makes clear that those facts alone do not preclude an award of permanent total disability where the facts otherwise show claimant to be motivated. See Majorie I. Janisch, 43 Van Natta 1423 (1991); Stanley B. Benson, 41 Van Natta 394 (1989) (claimant's receipt of retirement benefits or decision to retire does not preclude him from an award of permanent total disability).

By its very nature the "willingness to work" standard is a broad legal standard that defies mechanical application. Thus, determinations of "willingness to work" are invariably fact specific. Nonetheless, the Board in its deliberations of this issue has consistently evaluated certain factors: (1) whether or not claimant has looked for work; (2) if released to work, whether or not claimant has attempted to return to work; (3) the presence or absence of a long work history at the time of the compensable injury; (4) efforts and attitude in vocational rehabilitation programs; (5) whether or not claimant has voluntarily retired from the work force; (6) claimant's medical limitations to do work; (7) the reluctance of claimant to work for any wage below the wage at the time of injury; (8) whether or not there is a financial incentive to work; and (9) claimant's testimony at hearing. No one single factor or even combination of factors is dispositive. Rather, case law suggests the totality of claimant's personal situation is considered.

Assuming a vocational consultant had actually found and offered claimant gainful and suitable employment within his physical and mental capabilities, and claimant then refused this offer, this would be persuasive evidence that claimant's decision not to work is a voluntary choice.

This further assumes, however, that the actual job offer is "gainful and suitable" employment. "Suitable" employment is work that the injured worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation. ORS 656.206(1). Whether work is "gainful" is the more complicated question.

ORS 656.206(1)(a) provides that "permanent total disability" means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. (Emphasis supplied).

In Tee v. Albertsons Inc., 314 Or 633, 643 (1992), the Court held that the term "gainful occupation" in ORS 656.206(1)(a) concerns remuneration as it relates to the earnings that the worker can obtain by working at a "suitable occupation." More specifically, the Court held that the term "gainful occupation" contained in ORS 656.206(1)(a) means profitable remuneration. In so holding, the Court considered and rejected an approach which would have required post-injury employment to produce a wage comparable to a worker's pre-injury wage in permanent total disability determinations. See Tee v. Albertsons Inc., *supra*.

In my view, employment for "profitable remuneration" is that employment wherein claimant receives a wage taking into consideration any expenditures that claimant would realize were he to accept such employment (for example, transportation costs, supplies/uniforms, child/dependent care costs, etc.). Once those "costs" are "subtracted" out, whatever remains is deemed profit. See Fred D. Justice, 45 Van Natta 971 (n. 1)(1993). Thus, whether or not the proposed wage is personally acceptable to claimant is likewise not relevant. The only relevant test is whether or not the wage is a benefit to claimant.¹

In this case, that type of evidence was not presented by the employer. Therefore, I find the Referee did not err in concluding that the employer did not meet its burden of proving that claimant was not permanently and totally disabled. However, that is not to say that subsequent redeterminations of claimant's permanent total disability status pursuant to ORS 656.206(5), may decide otherwise.

¹ I note the Director has chosen to define "gainful occupation" as those occupations, full time and part-time, which pay wages equivalent to, or greater than, state and federal mandated minimum wage. See OAR 436-30-055(1)(c). At present, state and federal minimum wage is \$4.75 a hour.

In the Matter of the Compensation of
RUSSELL D. OSBORNE, Claimant
WCB Case No. 92-11752
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Nielsen's order that affirmed an Order on Reconsideration that awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of claimant's left knee. In her brief, claimant argues that the Referee erred in refusing to consider a post-closure medical report by claimant's treating physician. On review, the issues are evidence and extent of scheduled permanent disability.

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

The Referee admitted all exhibits offered at hearing, including Exhibit 13, Dr. Schachner's July 27, 1992 report, which issued after the March 13, 1992 Determination Order. (See Tr. 1-2). However, the Referee ruled that Exhibit 13 is not "admissible" for purposes of reviewing claimant's permanent disability award, because it is not evidence that should have been submitted at the time of claim closure and does not clarify or correct the earlier medical record. See ORS 656.268(5). We disagree.

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.

Thus, pursuant to Smith and Luciani, ORS 656.268(5) is not applicable to evidence submitted at hearing. Accordingly, we do not adopt the portion of the Referee's opinion which reaches a contrary conclusion. Since there is no other basis for preventing admission of this attending physician's "post-closure" report, we conclude that it was properly admitted. However, after considering the entire record, we agree with the Referee that claimant has not established entitlement to permanent disability compensation for an injury-related chronic left knee condition. See ORS 656.214(2).

ORDER

The Referee's order dated January 7, 1993 is affirmed.

Board Member Haynes specially concurring.

I agree that the attending physician's post-closure report is admissible in this case because it issued prior to the Order on Reconsideration. This result is compelled by the court's decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993).

However, I write to express my ongoing concerns about allowing the same issue to be decided on different evidence on reconsideration and at hearing. In this regard, I direct the parties to my special concurrence in Kelly R. Baker, 45 Van Natta 2097 (1993) and Chair Neidig's special concurrence in Cynthia L. Luciani, 45 Van Natta 1735 (1993).

In the Matter of the Compensation of
LESTER M. SMITH, Claimant
WCB Case No. 92-13387
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of claimant's injury claim for a left shoulder 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 found that claimant's disability and need for treatment for his left shoulder resulted from a May 21, 1992 off-work injury, rather than from a May 28, 1992 incident at work. Accordingly, the Referee concluded that claimant failed to prove compensability. We reach the same result, based on the following reasoning.

The causation question is somewhat complicated, because claimant suffered two left shoulder injuries, one at home and one at work, only a week apart. Moreover, because claimant's left shoulder was not clearly symptom-free at the time of the work incident and claimant did not immediately report the work injury to a superior, we conclude that the causation issue is a complex medical question which must be resolved by medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993).

In a case such as this, where the medical evidence concerning causation 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). In this case, we find such reasons.

Dr. Thomas, treating physician, provides the only medical evidence relating claimant's current left shoulder problems to the May 28, 1992 work incident. (See Ex. 16). Thomas learned about the May 21, 1992 off-work pushing injury by reading the Western Medical Examiners' August 28, 1992 report. Thereafter, claimant advised Thomas that the off-work incident resulted in "no pain." (Id.). Based on claimant's history, Thomas concluded that claimant's onset of symptoms occurred on May 28, 1992. (Ex. 16). Because claimant previously informed the employer and numerous doctors that the off-work incident did cause symptoms, we cannot say that Thomas' opinion is based on an accurate and complete history. Accordingly, in the absence of persuasive medical evidence supporting the claim, we agree with the Referee that the claim fails.

ORDER

The Referee's order dated February 11, 1993 is affirmed.

In the Matter of the Compensation of
HARTMUT KARL, Claimant
WCB Case No. 92-04048
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Michael V. Johnson's order that: (1) declined to address the insurer's responsibility for certain medical bills; and (2) affirmed a Director's order which found that claimant was not entitled to vocational assistance. On August 3, 1993, we approved a Claim Disposition Agreement (CDA), in which claimant released his rights to workers' compensation benefits (including vocational assistance), except medical services, for his compensable injury. WCB Case No. C3-01796. In light of the approved CDA, we conclude that the vocational assistance issue has been resolved. On review, the issue is medical services. We reinstate claimant's hearing request and set aside the insurer's "de facto" denial of medical services.

FINDINGS OF FACT

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

Claimant appealed Referee Leahy's January 31, 1992 order which found that claimant had not established compensability of his left knee condition as an aggravation. In a December 31, 1992 Order on Review, we reversed Referee Leahy's order and found claimant's left knee condition compensable as an aggravation of his April 1990 industrial injury. In reaching this conclusion, we specifically found claimant's left knee condition causally related to his compensable injury. Our order has not been appealed.

CONCLUSIONS OF LAW AND OPINION

The causation of claimant's current left knee condition has previously been litigated. On September 30, 1991, the insurer issued a denial which denied both that claimant had suffered a worsening and that claimant's current condition was causally related to the 1990 injury. Claimant requested a hearing contesting that denial. In a January 31, 1992 order, Referee Leahy upheld the insurer's denial and found that claimant had not established a compensable aggravation. Claimant requested Board review.

On Board review of Referee Leahy's order, we determined that claimant's current left knee condition was causally related to his April 1990 industrial injury and that claimant had established a compensable aggravation. Consequently, we set aside the insurer's denial and remanded the claim for processing in accordance with law. The insurer did not appeal our decision.

Meanwhile, claimant requested another hearing seeking payment of certain medical bills for his left knee condition. At the hearing, the insurer contended that the prior litigation before Referee Leahy precluded claimant from seeking payment of the bills. Alternatively, the insurer asserted that resolution of this "palliative treatment" dispute rested with the Director's jurisdiction, not the Board.

Determining that Referee Leahy's order pertained to claimant's aggravation claim, Referee Michael Johnson held that the first proceeding did not preclude litigation concerning claimant's medical bills. However, reasoning that it was unclear whether the bills were contested on a causal relationship or propriety ground, Referee Johnson held that jurisdiction could not be determined. Therefore, claimant's hearing request was dismissed.

We disagree with Referee Johnson's conclusion that the prior litigation regarding the insurer's aggravation denial had no preclusive effect on this dispute. As conceded by the insurer at hearing, the previous hearing involved its denial of a causal relationship between claimant's current left knee condition/treatment and his compensable injury. Moreover, our Order on Review of Referee Leahy's order expressly found a causal relationship between the condition/treatment and the compensable

injury. In light of such circumstances, we hold that the disputed medical bills are related to claimant's current left knee condition which we have previously found to be causally related to the April 1990 compensable injury. Since there is no contention that the disputed medical bills pertain to treatment not covered by the denial, we conclude that the prior litigation precludes the insurer from now asserting that the medical bills are not compensably related to the April 1990 injury. Accordingly, the insurer is responsible for the payment of those bills pursuant to our previous order which set aside its aggravation denial.

Claimant is entitled to a reasonable attorney fee for prevailing on this 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 Board review is \$2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's response on review), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 2, 1992 is reversed. Claimant's hearing request is reinstated. The insurer is responsible for processing the medical bills in accordance with our prior order which set aside its aggravation denial. For services at hearing and on review, claimant's attorney is awarded \$2,500, payable by the insurer.

November 2, 1993

Cite as 45 Van Natta 2138 (1993)

In the Matter of the Compensation of
HARTMUT KARL, Claimant
 WCB Case No. 92-04048
 ORDER OF ABATEMENT
 Bottini, et al., Claimant Attorneys
 Lundeen, et al., Defense Attorneys

The insurer requests reconsideration of our October 4, 1993 order that: (1) found that the insurer was responsible for claimant's medical bills in accordance with an earlier Board order which had set aside the insurer's aggravation denial; and (2) awarded claimant's counsel a \$2,500 attorney fee. Contending that this dispute pertained to medical bills and that the compensability of those medical services was resolved by the earlier Board order (for which claimant's counsel received an attorney fee award), the insurer asserts that claimant is not entitled to another attorney fee award.

In order to further consider the insurer's request, we withdraw our October 4, 1993 order. In addition, we implement the following supplemental briefing schedule. Claimant's supplemental response shall be due within 14 days from the date of this order. The insurer's supplemental reply shall be due within 14 days from the date of mailing of claimant's response. Thereafter, we shall proceed with our reconsideration.

In submitting their respective positions, the parties are requested to discuss the effect, if any, the court's recent holding in SAIF v. Allen, 124 Or App 183 (1993), has on this dispute. (In Allen, the court held that the Board erred in awarding an attorney fee under ORS 656.386(1) when the subject of claimant's hearing request was not the compensability of claimant's injury claim, but rather the payment of medical bills related to a compensable claim).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT G. VANDOLAH, Claimant
WCB Case No. C3-02509
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On September 27, 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.

On October 7, 1993, the Board requested that the parties submit an addendum eliminating a reference to claimant's attorney's "out-of-pocket" costs on page four of the CDA. On October 11, 1993, the Board received an addendum stating that it was necessary, for the purpose of Social Security benefits, to retain the reference to claimant's attorney's costs in the CDA.

By order dated October 29, 1993, the Board disapproved the parties' CDA on the basis that the agreement contained a reference to costs which the Board has held is not a matter for disposition under ORS 656.236. See Debbie K. Ziebert, 44 Van Natta 51 (1992); Janelle I. Neal, 40 Van Natta 359 (1988). Accordingly, because the costs in question in this CDA concerned a matter outside ORS Chapter 656, the CDA was found unreasonable as a matter of law.

Claimant has requested reconsideration of our order by submitting a modified disposition. Here, the disapproval was mailed on October 29, 1993, and claimant's request for reconsideration was filed on November 1, 1993. Thus, we find claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2). Moreover, upon review of the addendum, we find good cause for allowing the additional submission. Accordingly, we will reconsider this CDA. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

Claimant has submitted a modified disposition that specifically eliminates the reference to claimant's attorney's "out-of-pocket" costs. Accordingly, on reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition is approved for a total consideration of \$10,000, with \$7,500 of the proceeds to be paid to claimant. An attorney fee of \$2,500, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY BERGQUIST, Claimant
WCB Case No. 92-14459
ORDER ON REVIEW (REMANDING)
Whitehead & Klosterman, Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Daughtry's order that dismissed his request for hearing concerning the self-insured employer's denial and its alleged "de facto" denial of claimant's wrist condition. On review, the issues are dismissal and compensability. We reinstate claimant's request for hearing and remand.

FINDINGS OF FACT

On September 25, 1991, claimant completed and filed his employer's "Preliminary Accident Report of Employee Injury" form, describing a right wrist strain injury while performing his work activities. (Ex. 2C). On the form, claimant identified his treating physician and October 1, 1991 as the date of treatment. (Id). There is no evidence that claimant sought medical treatment on October 1, 1991 or any time until August 1992.

Subsequently, the employer prepared an 801 form. (Ex. 1). Claimant did not sign the 801 form; instead, the "Preliminary Accident Report of Employee Injury" form was attached to the 801 form. (Id; see also Tr. 9).

On December 23, 1991, the employer issued a denial letter. (Ex. 2). Denying the claim for lack of medical substantiation, the employer noted that if necessary medical information was received, "a reconsideration may be made." (Id). Claimant did not challenge the denial within 180 days of its mailing.

On August 26, 1992, Dr. Wilson, consulting orthopedist, examined claimant. Dr. Wilson diagnosed "[s]capholunate dissociation, symptomatic, right wrist, chronic," which he related by history to the 1991 work injury, and recommended surgery. (Ex. 2B).

On September 15, 1992, claimant retained legal counsel. On October 21, 1992, claimant's attorney submitted Dr. Wilson's report to the employer, requesting reconsideration of the December 23, 1991 denial. (Ex. 3). Shortly thereafter, relying on its December 1991 denial, the employer declined claimant's request. (Ex. 4).

Claimant's attorney then filed a request for hearing, challenging the December 23, 1991 denial and the employer's "de facto" denial.

At the hearing, the employer moved to dismiss claimant's request for hearing, alleging that the request was untimely filed. The Referee took no testimony and allowed the motion to dismiss.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to timely challenge the December 23, 1991 denial. In addition, the Referee concluded that the employer's rejection of claimant's request to "reconsider" did not constitute a "denial." Consequently, the Referee dismissed claimant's hearing request. We conclude that claimant was entitled to present evidence at the hearing before the Referee ruled on the motion to dismiss. Therefore, we vacate the Referee's order and remand for a hearing.

Arguing that the employer should be estopped from asserting its denial, claimant offered to present evidence at the hearing to prove the elements of equitable estoppel. Alternatively, claimant contended that the denial was invalid either because it was not a "final" determination, or because no claim had been filed. Specifically, claimant asserted that he did not require medical services or incur disability prior to the December 1991 denial.

The Referee concluded that a claim had been filed. In doing so, the Referee reasoned that claimant's need for medical treatment was relevant only to the compensability issue, not to whether or not a claim had been filed. We disagree.

If there is no claim, a denial is a nullity and has no effect. William E. Hamilton, 41 Van Natta 2195, 2198 (1989). In order for a claim to exist, a worker must have asserted a right to workers' compensation benefits, or a potentially work-related injury must have come to the employer's attention. Donna J. Halsey, 39 Van Natta 116, 118 (1987). "Compensation" means "all benefits, including medical services, provided for a compensable injury. . . pursuant to [chapter 656]." ORS 656.005(8). A "compensable injury" is defined as an "accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." ORS 656.005(7)(a).

Here, claimant contends that he did not make a claim for workers' compensation benefits prior to the December 23, 1991 denial, because he required no medical services and incurred no disability at that time. As noted above, a claim is defined in terms of an asserted right to compensation, and compensation includes medical and disability benefits. Thus, whether claimant required medical treatment or incurred disability is relevant to establishing whether a claim existed prior to the December 23, 1991 denial. However, because the Referee dismissed claimant's request for hearing without taking any testimony, the parties had no opportunity to present evidence to support their respective positions concerning whether claimant filed a claim and whether the employer's denial was valid.

If claimant had established that no claim existed prior to the December 1991 denial, the denial would have had no effect, and there would be no basis to dismiss the request for hearing as untimely filed. Instead, the Referee found, without allowing either party to present evidence at a hearing, that a claim had been filed, and that claimant's request for hearing was untimely. Likewise, the Referee held, without allowing testimony which claimant asserts would have established the elements of estoppel, that the employer was not estopped from asserting the denial.

Had evidence been admitted and a hearing convened, the record would likely have been sufficiently developed for the Referee to determine whether claimant had filed a claim, the validity of the employer's denial, and whether the motion to dismiss was warranted. However, it was not appropriate for the Referee to reach the merits of the denial and dismiss claimant's hearing request for failure to file a timely hearing request without taking any evidence. See Ana R. Sanchez, 45 Van Natta 753 (1993) (Referee erred in dismissing hearing request on finding that the claimant was not a subject worker without taking any evidence). Consequently, we reinstate claimant's request for hearing.

Furthermore, claimant challenged not only the December 1991 denial, but also a November 1992 "de facto" denial. Claimant sought medical treatment for his right wrist condition in 1992, and allegedly tried to make a claim for his condition in July 1992. (See Tr. 10-12; Ex. 2B). We note, without deciding, that even if claimant were precluded from challenging the December 1991 denial, he is not precluded from asserting that his condition in 1992 had changed since the time of the denial, and was now compensable. See Gabriele H. Flores-Linsner, 45 Van Natta 307 (1993), aff'd mem 123 Or App 642 (1993). However, because the Referee dismissed his hearing request, claimant was precluded from going forward with his claim for an alleged "de facto" denial of his 1992 claim. In other words, even if the Referee finds that the December 1991 denial has become final, claimant is not barred from presenting evidence that could not have been presented earlier to prove that his condition has worsened. See Liberty Northwest Corp. v. Bird, 99 Or App 560, 563-64 (1989), rev den 309 Or 645 (1990); Flores-Linsner, supra.

In light of these circumstances, we consider the current record to be incompletely and insufficiently developed. See ORS 656.295(5). Moreover, considering that claimant has been precluded from presenting evidence on the alleged "de facto" denial of his current condition, we conclude that there are compelling reasons to remand. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Accordingly, we remand this matter to Referee Daughtry for further proceedings consistent with this order, to be conducted in any manner that will achieve substantial justice to all parties. Following completion of these further proceedings, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated February 19, 1993 is vacated. The matter is remanded to Referee Daughtry for further proceedings consistent with this order.

In the Matter of the Compensation of
EVA R. BILLINGS, Claimant
WCB Case Nos. 92-13295, 92-13294, 92-11944 & 92-13293
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Priscilla Taylor, Defense Attorney
Lundeen, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The CNA Insurance Companies, on behalf of Auto Data Processing, requests review of Arbitrator Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome and left deQuervain's tenosynovitis conditions; (2) upheld Liberty Northwest Insurance Corporation's denial, issued on behalf of Finlay McMartin & Company, for the same condition; (3) upheld Liberty Northwest Insurance Corporation's denial, issued on behalf of Data Brokers, for the same condition; and (4) awarded an assessed attorney fee payable by Auto Data Processing pursuant to ORS 656.307(5). On review, the issues are responsibility and attorney fees.

We affirm the Arbitrator's order with the following supplementation.

In this case, claimant has neither requested nor cross-requested review of the Arbitrator's responsibility determination, and in fact, seeks its affirmance. Because claimant challenges no aspect of the Arbitrator's decision affecting claimant's right to receive compensation or the amount thereof, no matter concerning a claim is directly in issue before us. Therefore, we review the Arbitrator's responsibility determination for questions of law only. ORS 656.307(2); see Jack W. Sanford, 45 Van Natta 52 (1993).

As a finding of fact the Arbitrator found that the major contributing cause of claimant's bilateral carpal tunnel syndrome and left deQuervain's tenosynovitis condition was claimant's work activities at Auto Data Processing. Thus, because he found that claim's occupational disease was actually caused by the work at Auto Data Processing, the Arbitrator concluded it was not necessary to resort to "any rule of assignment of responsibility." Therefore, the Arbitrator concluded that Auto Data Processing was responsible for the claim.

On review, Auto Data Processing argues that the Arbitrator applied the incorrect legal standard. Noting that claimant was employed concurrently by all three employers on the date of disability, Auto Data Processing contends that responsibility for the claim should have been apportioned between the three employers rather than assigning sole responsibility for the claim to Auto Data Processing. (For authority Auto Data Processing relies on Colwell v. Trotman, 47 Or App 855 (1980); Tina R. Flansberg, 44 Van Natta 2380 (1992), on recon 45 Van Natta 1031 (1993); Mary I. Joseph-Duby, 44 Van Natta 2272 (1992); and Loretta J. O'Rourke, 44 Van Natta 2264 (1992)).

Here, there is no prior accepted claim for the same condition and a determination must be made concerning the assignment of initial responsibility for a compensable condition between multiple employers. Accordingly, ORS 656.308(1) is not applicable. See Fred A. Nutter, 44 Van Natta 854 (1992).

Claimant's condition was properly characterized by the Arbitrator as an occupational disease. ORS 656.802. In an occupational disease context, the decisive event for fixing liability is the "onset of disability." Bracke v. Bazar, 293 Or 239, 247-248 (1982). The onset of disability in this case is May 20, 1992, the date when claimant first sought medical treatment for her condition. On that date, claimant was working full time for Auto Data Processing doing data entry keypunch work. She was also performing data entry keypunch work part-time, two days a month, at Finlay McMartin & Company, and part-time, on a sporadic basis, at Data Brokers. In 1992 through the end of May it was estimated that claimant's data entry keypunch work consisted of 810 hours at Auto Data Processing, 285 hours at Finlay McMartin, and 184 hours at Data Brokers. Thus, at the time of disability claimant's employment was concurrent.

In situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition, the last injurious exposure rule is applied. Where, however, actual causation is proved with respect to a specific employer the last injurious exposure rule is not applied. See Runft v. SAIF, 303 Or

493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-245 (1984); Bracke v. Baza'r, supra at 249-250.

In Colwell, the claimant had been also concurrently employed by two different employers as a dental hygienist for eight years when she developed an elbow condition. As a result of the condition she quit both employments and filed occupational disease claims against both. The fact finder in that case found that both employments had contributed to her condition. No finding was made that one employment was the major contributing cause of the condition. Colwell v. Trotman, supra at 857. The issue in Colwell was application of the last injurious exposure rule.

The Colwell court stated that the last injurious exposure rule was judicially created to place full responsibility for an occupational disease on the last of successive employers in whose service a worker was exposed to conditions contributing to the disease. The court explained that the adoption of the rule was necessary to relieve workers of the potentially impossible burden of proving the date of actual contraction of an occupational disease. Colwell v. Trotman, supra at 858.

The Colwell court stated, however, that the aforementioned rationale does not support application of the last injurious exposure rule to concurrent employment exposures, *i.e.*, where the worker was exposed to conditions which contributed to an occupational disease in two or more separate, but simultaneous employments. See Colwell v. Trotman, supra. In such concurrent employment situations, the employers are held jointly responsible for the claim. The precise apportionment of compensation is determined upon petition by the parties of the Director in accordance with the procedures set forth in OAR 436-60-195.

In applying the "concurrent employment" rule of assignment we have held that this analysis applies only to those unique employment situations where the last injurious exposure rule can not be applied. See Tina R. Flansberg, supra, 45 Van Natta 1031, 1032 Fn 1 (1993).

In this case, however, there is no necessity to rely on either rule of assignment. As previously discussed, reference to either rule is only applicable when the trier of fact is unsure which employer caused the condition. Based on a review of the medical evidence, the Arbitrator was convinced that the work activities at Auto Data Processing was the major contributing cause of the compensable condition and that the evidence was not in equipoise.

In making this finding the Arbitrator found that the work at Auto Data Processing when compared with the other two employments was more demanding and was longer in duration. The Arbitrator relied on the medical opinion of the attending physician, Dr. Farris and independent medical examiner, Dr. Button, that the major contributing cause of claimant's condition was Auto Data Processing. The Arbitrator also relied on the opinion of independent medical examiner, Dr. Colletti, that claimant's work at Auto Data Processing, was the exclusive cause of her condition.

Thus, actual causation with respect to a specific identifiable employer was proven. Therefore, it was not necessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments in determining responsibility. See Runft v. SAIF, supra at 502; Boise Cascade Corp. v. Starbuck, supra at 244-245 (1984); Bracke v. Baza'r, supra at 249-250.

The O'Rourke case cited and relied on by Auto Data Processing is distinguishable from this case in that in O'Rourke a specific employment was not identified as being the major contributing cause of the injured worker's condition. Because actual causation was not proved, the Board in O'Rourke relied on a judicially created rule of assignment to determine the responsibility question. Thus, we do not find O'Rourke controlling here. See Loretta J. O'Rourke, supra.

The final issue presented is whether the Arbitrator properly awarded an assessed attorney fee payable by Auto Data Processing for services rendered in this responsibility case. Given our conclusion above that the "concurrent employment" analysis is not appropriate in this case, we find, as did the Arbitrator, that claimant's counsel's attorney fee was payable by the employer found responsible for the claim. ORS 656.307(5). In this case, that employer is Auto Data Processing.

ORDER

The Arbitrator's order dated March 9, 1993 is affirmed.

In the Matter of the Compensation of
CHARLES A. BOSTON, Claimant
 WCB Case No. TP-93009
 ORDER ON RECONSIDERATION
 Jolles, et al., Claimant Attorneys
 Roberts, et al., Defense Attorneys

On October 27, 1993, we withdrew our September 27, 1993 Third Party Distribution Order which concluded that Safeco Insurance Company was not entitled to a share of claimant's settlement proceeds. We took this action to retain jurisdiction to consider the parties' proposed stipulation.

We have now received the aforementioned stipulation, which is designed to resolve this matter. Specifically, the parties agree that Safeco shall receive \$375 from claimant's \$7,500 settlement in full satisfaction of its third party lien.

We have approved the parties' stipulation, thereby full and finally resolving this matter. Inasmuch as a dispute regarding the distribution of third party settlement proceeds no longer exists, this matter is dismissed.

IT IS SO ORDERED.

November 9, 1993

Cite as 45 Van Natta 2144 (1993)

In the Matter of the Compensation of
ROLLIE CLARK, Claimant
 WCB Case No. 92-15620
 ORDER ON REVIEW
 Philip H. Garrow, Claimant Attorney
 Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of Referee Crumme's order which set aside its denial of claimant's bilateral heel condition. On review, the issue is compensability.

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

We agree with the Referee's determination that this is not a complex case which requires expert medical opinion in order to establish causation. Claimant's delay in seeking medical treatment does not, in itself, under the facts of this case, establish the need for medical evidence of causation. See Uris v. Compensation Department, 247 Or 420, 427 (1967); Barnett v. SAIE, 122 Or App 279 (1993).

Moreover, we find that the chart notes of treating orthopedist Dr. Holmboe support a finding that the work injury was at least a material contributing cause of claimant's bilateral heel condition, and that Dr. Holmboe's records, medical records that stand uncontroverted, combined with claimant's credible testimony, are sufficient to establish causation. Accordingly, we affirm and adopt the Referee's order finding claimant's bilateral heel condition to be 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 compensability issue is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 22, 1993 is affirmed. Claimant's attorney is awarded \$750 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
MAUREEN C. COLE, Claimant
WCB Case No. 92-03427
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of that portion of Referee Livesley's order that upheld the SAIF Corporation's partial denial of her medical services claim for her current eye condition. In its brief, SAIF challenges the Referee's evidentiary ruling excluding Dr. Haines' deposition. On review, the issues are evidence and medical services. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee did not abuse his discretion in declining to admit Dr. Haines' deposition into evidence. See Rodney D. Jacobs, 44 Van Natta 417 (1992); Renia Broyles, 42 Van Natta 1203 (1990). Accordingly, we adopt the Referee's reasoning and conclusion on this issue.

Compensability of Medical Services

We adopt the Referee's reasoning and conclusion on this issue, with the exception of the first and last paragraphs, with the following supplementation.

ORS 656.245(1)(a) requires that an insurer provide medical services for conditions resulting from the compensable injury. An injury is compensable if work activities are a material contributing cause of disability or the need for medical treatment. ORS 656.005(7)(a). Mark N. Wiedle, 43 Van Natta 855 (1991). However, an injury occurring as a consequence of the original compensable injury is compensable only if the compensable injury is the major contributing cause of the consequential injury. ORS 656.005(7)(a)(A). Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). Consequential injuries do not include conditions directly, though belatedly, related to the original compensable event. Therefore, the material contributing cause test still applies to a condition or need for treatment that is directly caused by an industrial accident. Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant contends that her dry eye syndrome was belatedly caused by the 1984 industrial injury. Therefore, she asserts that she need only show that the compensable injury is a material contributing cause of her current eye condition. Alternatively, claimant contends that she has proved that the compensable injury is the major contributing cause of her consequential eye condition. On this record, we find that claimant has failed to establish that her eye condition is even materially related to the compensable injury.

Claimant relies on the May 7, 1992 report from treating eye specialist Haines. After reviewing the contemporaneous medical records, Dr. Haines opined that claimant's current eye condition is not related to the 1984 exposure to chemical fumes. Subsequently, claimant advised Dr. Haines that not only had she been exposed to chemical fumes, but that she had touched her neck and actually rubbed the chemical agent into her eyes. After she showed Dr. Haines a discolored area on the left side of her neck, Dr. Haines reported:

"The hypopigmentation of the area of the neck certainly attests to the caustic nature of the chemical agent. With this information, I feel that she indeed has some substantiating evidence that this was attributable to her dry eyes. . . . I believe there is a medical probability that the caustic agent that she came in contact with is responsible" (emphasis supplied).

Thus, Dr. Haines' most recent opinion is premised on claimant's reporting to him that some chemical came into direct contact with her skin and eyes, as evidenced by the discolored area on her neck. At hearing, claimant testified that she had no "flaws" on her neck before the 1984 accident. Afterwards, she testified, "[t]here was little bubbles, like, and I used ointment and I popped them, and they dried up," leaving a discolored area.

Claimant's testimony and reporting to Dr. Haines on this critical point is, however, inconsistent with both the pre-injury and post-injury medical records. Dr. Bradley was claimant's treating physician in 1983 and 1984. Dr. Bradley's June 20, 1983 chart note reveals that claimant had a small carbuncle ("bubble") on the left side of her neck seven months before the compensable injury. Further, when claimant was examined on the date of injury in the emergency room, and on the next day by Dr. Bradley, and thereafter by Dr. Bradley, no injury to the skin was noted. There is no reliable evidence that claimant came into direct contact with the cleaning solvent. As Dr. Haines' most recent opinion is based on an inaccurate history of direct contact, we do not find it persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Instead, we rely on his earlier opinions that there is no relationship between the 1984 exposure to chemical fumes and claimant's current eye condition.

Thus, for the above reasons, as well as those discussed by the Referee, we find that claimant's eye condition is not even materially related to the compensable injury. Accordingly, treatment for claimant's dry eye syndrome is not compensable.

ORDER

The Referee's order dated November 12, 1992, as reconsidered January 22, 1993 is affirmed.

November 9, 1993

Cite as 45 Van Natta 2146 (1993)

In the Matter of the Compensation of
CLARENCE J. DIERINGER, Claimant
 WCB Case Nos. 92-01760 & 91-16163
ORDER ON REVIEW
 Empey & Dartt, Claimant Attorneys
 Williams, et al., Defense Attorneys
 Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Haynes and Westerland.

Liberty Northwest Insurance Corporation, on behalf of Agripac, Inc. (Liberty/Agripac), requests review of Referee Baker's order which: (1) set aside its denial of claimant's current right knee condition and need for surgery; and (2) upheld the denial by Liberty Northwest Insurance Corporation, on behalf of General Foods (Liberty/GF), for the same condition. On review, the issues are compensability and responsibility.

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

In addition to the findings of fact made by the Referee, we make the following finding. In November 1983, Liberty/GF accepted a nondisabling claim for injury to claimant's right knee, for a condition characterized as a "bruise." (Ex. 10).

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which has not been previously accepted. Fred A. Nutter, 44 Van Natta 854 (1992). Under that rule, if a worker proves that an occupational disease was caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

The onset of disability is the triggering date for the determination of which employment is the last potentially causal employment. Bracke v. Bazar, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition, or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986).

Here, the Referee found that claimant's current right knee condition is compensable as an occupational disease. Specifically, the Referee found that claimant's work activities at both General Foods and Agripac were the major contributing cause of the worsening of his preexisting degenerative joint disease. See ORS 656.802(2).

In addition, the Referee found that claimant's arthritic condition had not been previously accepted as part of the 1983 Liberty/GF claim. Liberty/Agripac contends that because Liberty/GF failed to issue a specific, written acceptance in 1983, it cannot now argue that it did not accept the degenerative condition. We disagree.

Liberty/GF specifically accepted a nondisabling injury claim for a right knee bruise, as indicated on the 801 form. (Ex. 10). There is no evidence that the bruise was a symptom of claimant's underlying degenerative disease. (See Ex. 47-41). Therefore, Liberty/GF's acceptance of a "bruise" does not imply acceptance of the preexisting arthritic condition. Compare Georgia-Pacific v. Piwowar, 305 Or 494, 501 (1988). Silence regarding one aspect of a claim implies neither acceptance nor denial. See Johnson v. Spectra Physics, 303 Or 49, 55 (1987). Therefore, we find that Liberty/GF accepted only a "bruise" in 1983, which did not include acceptance of claimant's underlying degenerative disease.

In assigning responsibility for claimant's current degenerative condition, the Referee properly applied the last injurious exposure rule. Because claimant first became disabled while working for Agripac, and because claimant's work activities at Agripac could have contributed to the worsening, we find that the Referee correctly assigned responsibility to Liberty/Agripac.

Liberty/Agripac contends that ORS 656.308 governs the assignment of responsibility in this case, and that Liberty/GF failed to prove that claimant sustained a new injury or occupational disease while working for Agripac. Therefore, because Liberty/GF has the last accepted claim for a right knee condition, it remains responsible for claimant's current knee condition. We disagree.

ORS 656.308(1) provides, in part:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

The statute applies equally to a new occupational disease. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993); Donald C. Moon, 43 Van Natta 2595 (1991). However, in order to apply ORS 656.308(1), claimant's current right knee condition must involve the "same condition" as his 1983 compensable injury. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993).

Claimant's current condition was diagnosed as degenerative joint disease of his right knee. (Ex. 27-1). The 1983 injury was accepted as a "bruise." (Ex. 10). Dr. Hayhurst, claimant's treating orthopedist, opined that the 1950 noncompensable right knee injury and subsequent surgery triggered the development of claimant's degenerative joint disease, and that his work activities at General Foods and Agripac were a significant factor in accelerating the deterioration of the right knee. He explained that a bruise, on the other hand, "is an echymosis, which means it's bleeding into the soft tissues around. . . . That in itself isn't going to do anything to your bones." (Ex. 47-41). We find no medical evidence to support a finding that claimant's current knee condition (a worsening of his preexisting degenerative joint disease) involves the same condition (a bruise) that Liberty/GF accepted in 1983. Therefore, ORS 656.308(1) is not applicable in this case. See Smurfit Newsprint v. DeRossett, *supra*.¹

Accordingly, we affirm the Referee's order finding that claimant's current right knee condition is compensable and that Liberty/Agripac is responsible.

¹ Because ORS 656.308 does not apply, we need not address the issue of Liberty/GF's failure to issue a disclaimer of responsibility pursuant to ORS 656.308(2).

Because compensability was at issue at hearing and remained an issue on review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 114 Or App 248 (1992), mod on recon 119 Or App 447 (1993). Consequently, claimant is entitled to an attorney fee for services on review, payable by Liberty/Agripac.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$1,000 is a reasonable assessed fee for claimant's counsel's services 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, and the value of the interest involved.

ORDER

The Referee's order dated December 4, 1992 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the responsible insurer, Liberty/Agripac.

November 9, 1993

Cite as 45 Van Natta 2148 (1993)

In the Matter of the Compensation of

ROZETTA M. ELSTOEN, Claimant

WCB Case No. 92-10944

ORDER ON REVIEW

Pozzi, et al., Claimant Attorneys

Carrol Smith (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that affirmed an Order on Reconsideration which awarded 24 percent (76.8 degrees) unscheduled permanent disability for her low back condition. In its brief, the SAIF Corporation contends that claimant waived her right to contest her permanent disability award when she applied for a lump sum payment of her award. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings," with the exception of the last sentence in that section. We add the following supplementation.

We take official notice of the fact that, on December 10, 1992, claimant signed a form requesting Director approval of a lump sum payment of her permanent disability award. On December 15, 1992, SAIF's representative signed the request and the form was received by the Workers' Compensation Division (WCD) on December 17, 1992.

Board review of the Referee's order was requested by claimant on December 21, 1992.

On December 22, 1992, WCD issued an order approving claimant's request for lump sum payment of her permanent disability award.

CONCLUSIONS OF LAW AND OPINION

Lump Sum Payment

On review, SAIF argues that, by requesting and receiving approval of a lump sum settlement of her permanent disability award, claimant has waived her right to appeal the amount of the award. We disagree.

SAIF relies upon ORS 656.230(1), which provides that:

"Where a worker has been awarded compensation for permanent partial disability and the award has become final by operation of law or waiver of the right to appeal its adequacy, the director may, in the director's discretion, upon the worker's application order all or any part of the remaining unpaid award to be paid to the worker in a lump sum. Any remaining balance shall be paid pursuant to ORS 656.216."

SAIF also argues that it is clear that claimant waived her right to appeal her award because the WCD order provides that "[b]oth the worker and the insurer have waived their right to appeal the award."

In Landriscina v. Raygo-Wagner, 53 Or App 558 (1981), the court addressed the issue of whether a claimant's application for a lump sum payment pursuant to ORS 656.230 constituted a waiver of his right to appeal his permanent disability award. The court first concluded that the facts of the case did not establish that the claimant intentionally relinquished a known right when he applied for a lump sum payment.

The court also found that the Department's rule required an investigation of an application for lump sum payment. However, in the claimant's case, at the time the application was approved, the Compliance Division was unaware that the Evaluation Division was in the process of reconsidering the claimant's award. The application was approved under a mistaken belief that the reconsideration process had been completed. Accordingly, the court held that, because the Department did not follow its rules requiring an investigation of the claimant's application, the decision to approve the application was erroneous and should be set aside. Landriscina, *id* at 565.

Here, we are unable to conclude that claimant intentionally relinquished a known right (*i.e.*, her right to appeal the amount of her permanent disability award) when she applied for a lump sum payment of her award. Furthermore, even if claimant was aware that she was waiving her right to appeal the amount of the award when she applied for a lump sum payment, we conclude that, similar to the Landriscina case, the Department did not follow its rules when it approved the lump sum request. Specifically, OAR 436-60-060(7), which was in effect at the time of claimant's application, provided that:

"Compliance will not approve an application for lump sum payment when the worker is actively enrolled and engaged in a vocational training program under OAR 436-120; has temporarily withdrawn from such a program; or, the worker is involved in litigation affecting a permanent partial disability award." (Emphasis added).

Here, claimant had requested Board review prior to WCD's order approving the lump sum. Consequently, because claimant was involved in litigation over her permanent disability award but the Department nonetheless proceeded to approve her application, we conclude that WCD did not follow its rule in approving the application. Therefore, we give the WCD order no effect. See Landriscina.

Extent of Unscheduled Permanent Disability

Because we have found that claimant did not waive her right to appeal her permanent disability award, we now address the merits of her claim.

The Referee concluded that, because claimant was released to return to regular work, she was not entitled to a value for adaptability. 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 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 her regular work following a compensable injury. See Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

Amended OAR 436-35-310(1) provides that a worker's adaptability is based upon "a comparison of the highest prior strength preceding the time of determination as compared to the worker's maximum residual capacity at time of determination." Maximum residual functional capacity (RFC) is the greatest capacity evidenced by: (1) the attending physician's release; (2) a preponderance of medical opinion; or (3) the strength of any job at which a worker has returned to work. OAR 436-35-270(3)(d).

In the ten years prior to determination, claimant has worked as a store owner and a grocery store clerk. The Dictionary of Occupational Titles lists sales clerk as light work. (DOT# 290.477-014). Claimant argues that her job was actually that of a stock clerk (DOT# 299.367-014), which is listed as heavy work. We disagree.

The job of a stock clerk involves taking inventory, opening and unpacking crates of merchandise, stamping or changing price tags, stocking storage areas, packing customer purchases in bags or cartons, and transporting packages to customer vehicles. DOT# 299.367-014. On the other hand, the sales clerk job is described as making change for customers, stocking shelves, arranging merchandise, assisting customers, bagging merchandise, cleaning shelves and counters. DOT# 290.477-014.

Here, claimant described her job on a work history form as that of "clerk." She listed her job duties as "wait on customers, make ice cream, cook, clean, mop floors, stock shelves, stock pop, beer, juices." Under the circumstances, we find that the DOT title of Sales Clerk most accurately describes claimant's duties. OAR 436-35-300(3)(a). Therefore, claimant's highest prior strength preceding the determination is light. Additionally, we agree with the Referee that claimant's treating doctor was aware of her job duties and released her to regular work. Therefore, claimant is entitled to an adaptability value of 1. OAR 436-35-310(2)(Temporary Rules, WCD Admin. Order 93-052).

The parties do not dispute the Order on Reconsideration's assigned value of 4 for claimant's age and education. Moreover, the parties do not disagree that claimant's impairment value is 24 percent for her low back. We conclude that those values are appropriate and we, therefore, assemble the factors to compute claimant's award.

Claimant's education value of 4 is multiplied by her adaptability factor of 1, for a product of 4. That product is then added to the impairment value of 24, for a total of 28 percent. Claimant is entitled to 28 percent unscheduled permanent disability for her low back condition.

ORDER

The Referee's order dated December 8, 1992 is modified. In addition to the Order on Reconsideration award of 24 percent (76.8 degrees), claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, for a total award to date of 28 percent (89.6 degrees) unscheduled permanent disability. Claimant's counsel is awarded an attorney fee of 25 percent of the increased compensation created by this order, not to exceed \$3,800.

November 9, 1993

Cite as 45 Van Natta 2150 (1993)

In the Matter of the Compensation of

HELENJANE S. ENNISS, Claimant

WCB Case No. 92-07068

ORDER ON REVIEW

Foss, Whitty, et al., Claimant Attorneys

Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerland.

Claimant requests that portion of Referee Black's order that upheld the SAIF Corporation's partial denial of her claim for a low back condition. On review, the issue is compensability.

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

On review, claimant contends that her low back condition should have been analyzed under an occupational disease theory. She relies on Dr. Bert's opinion that her work activities as a case bank worker, particularly prolonged sitting, were the major contributing cause of her low back condition. (Ex. 35A).

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). Here, claimant testified that she had no low back problems during the year preceding the 1989 injury. (Tr. 18-19). She further testified that she had low back pain immediately after the injury and reported it to Dr. Sinnott on the date of injury. (Tr. 14-15).

Based on claimant's testimony, we find that her low back condition arose suddenly and unexpectedly. Therefore, we conclude that the Referee properly analyzed her low back claim as an injury claim.

Claimant also contends that the Referee erred in analyzing the compensability of her low back injury claim based on her condition in late 1991, following a Thanksgiving incident when claimant developed severe back pain after stepping off a curb, rather than her condition following the March 14, 1989 industrial injury. We disagree.

Claimant testified that she had low back pain following the 1989 injury and reported it to Dr. Sinnott. She added that the pain "wasn't that bad" and she was more concerned about her left elbow problems. (Tr. 15). The first medical report of back pain following the injury was Dr. Sinnott's August 25, 1989 chart note, which stated that "[claimant's] back has been hurting." (Ex. 15A-1). There is no follow-up report concerning low back problems and no treatment was required until the Thanksgiving incident. After that incident, an MRI scan revealed a free fragment at L3 which eventually required surgery in January 1992. (Exs. 22, 23, 26).

Based on this record, therefore, we find no indication that claimant was disabled from or required treatment for her low back condition until late 1991 following the Thanksgiving incident. Inasmuch as a compensable injury, by definition, requires medical services or results in disability or death, see ORS 656.005(7)(a), we conclude that the Referee properly analyzed the low back injury claim based on claimant's condition following the Thanksgiving incident.

ORDER

The Referee's order dated January 8, 1993 is affirmed.

November 9, 1993

Cite as 45 Van Natta 2151 (1993)

In the Matter of the Compensation of
JOSEPH R. FLORES, Claimant
WCB Case No. 92-06415 & 92-04926
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Oregon Asphaltic Paving Company (Asphaltic), requests review of those portions of Referee T. Lavere Johnson's order which: (1) set aside its "new injury/occupational disease" denial of claimant's current low back condition; and (2) upheld Liberty's denial, on behalf of Double A Incorporated (Double A), of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities at Asphaltic were the major contributing cause of his current low back condition. We do not agree. Although some medical evidence suggests that claimant's subsequent work activities at Asphaltic may have contributed to his disability and need for treatment for his current low back condition, we are unable to conclude that those work activities at Asphaltic were the major contributing cause of a worsening of his underlying low back condition. See ORS 656.802(1), (2).

As used in ORS 656.308, the phrase "new compensable injury" also includes a new occupational disease. See Liberty Northwest Insurance Corporation v. Senters, 119 Or App 314 (1993); Donald C. Moon, 43 Van Natta 2595 (1991). Accordingly, in the present case, Double A, as the initially responsible employer, remains responsible for claimant's continued or increased disability during his employment with the later employer (Asphaltic), unless claimant sustains a new injury or occupational disease involving the same condition during the subsequent coverage. See ORS 656.308(1).

The evidence shows that claimant's current low back condition did not result from a discrete incident or period of work activity after Asphaltic went on the risk. Thus, claimant's work exposure at Asphaltic is analyzed under an occupational disease theory. Valtinson v. SAIF, 56 Or App 184 (1992). Accordingly, Double A must prove that his work activities at Asphaltic are the major contributing cause of the worsening of his low back condition. ORS 656.802(1), (2); Randy L. Dare, 44 Van Natta 1868 (1992).

Claimant injured his low back on January 10, 1990 while working for Double A. X-rays revealed spondylolisthesis, Grade I, L-4 on L-3. The initial diagnosis was low back strain, aggravating preexisting degenerative back problems. (Ex. 3). Claimant did not work between February 1990 and July 29, 1991. (Tr. 15). On July 29, 1991, he began working at Asphaltic. His job involved manual labor, which included raking/shoveling asphalt and heavy lifting.

Claimant had continuing pain following the January 1990 injury. (Exs. 13-2, 17-1, 28-1, 30; Tr. 15, 19). On October 21, 1991, he returned to Dr. Gurney, his family physician, complaining of increasing back pain for quite some time. (Ex. 3-3). Gurney referred him to Dr. Bert, orthopedist, who became claimant's treating physician for the low back condition.

On December 13, 1991, Dr. Bert saw claimant primarily for an evaluation of back pain. Bert ordered an MRI and, after noting that claimant had an extruded disc at L4-5, recommended urgent decompression surgery. (Ex. 26). Subsequently, Dr. Bert stated that, based on claimant's history of his back problems and other medical reports, claimant's January 1990 injury was the major contributing cause of his current disability and need for surgery. (Ex. 54-21, 22).

In explaining his reasoning, Dr. Bert stated:

"[T]he herniation was a dynamic process. [Claimant] may have had no herniation with his initial injury, but a significant tear in the annulus fibrosis, which is most likely from his history of what happened, and that the herniation of significance, at least, occurred as an ongoing process later on, which was, in my opinion, aggravated by his work shoveling." (Ex. 54-43, 44).

After obtaining the MRI results and making his diagnosis, Dr. Bert referred claimant to Dr. Karasek, neurologist, for further evaluation. Following a myelogram, Karasek diagnosed profound L-5 and S-1 musculature weakness, secondary to L4-5 stenosis. (Ex. 28-3). He concluded that the problem was clearly related to claimant's 1990 back injury. (Ex. 28-2).

On November 18, 1991, Dr. Bufton examined claimant on referral from Dr. Gurney. Initially, Dr. Bufton diagnosed peroneal palsy. Later, after reviewing other medical reports and radiographic studies, Bufton altered her diagnosis to L5-S1 nerve root compression. (Ex. 47B). In a subsequent deposition, Dr. Bufton stated that claimant's January 1990 injury was the major contributing cause of his current need for surgery. (Ex. 52-19 to 22).

After conducting our de novo review, we are not persuaded that claimant's work activities at Asphaltic were the major contributing cause of a worsening of his low back condition. As concluded by Dr. Bert (and confirmed by several other examining physicians), the major contributing cause of claimant's low back condition and need for surgery was his January 1990 injury. Thus, because Double A has not established that claimant sustained a new occupational disease, Double A remains responsible for claimant's current condition.

Because compensability was at issue at hearing, it remained a potential issue on review. Therefore, 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 attorney fee for services on review, payable by Liberty/Double A, the insurer who is 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 \$1,000 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 April 30, 1993 is reversed. Liberty/Asphaltic's denial is reinstated and upheld. Liberty/Double A's denial is set aside and the claim is remanded to Liberty/Double A for processing according to law. The Referee's attorney fee award shall be paid by Liberty/Double A. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$1,000, payable by Liberty/Double A.

November 9, 1993

Cite as 45 Van Natta 2153 (1993)

In the Matter of the Compensation of
LARRY D. GILBERTSON, Claimant
WCB Case No. 92-16332
SECOND ORDER OF DISMISSAL
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On October 8, 1993, we withdrew our September 20, 1993 order for reconsideration. We took this action to consider claimant's contention that our order erroneously altered the Referee's order. Inasmuch as the time for the insurer to respond to claimant's motion has now expired, we proceed with our reconsideration.

The insurer had requested review of the Referee's order which found that claimant's low back claim had been prematurely closed. Following approval of the parties' Claim Disposition Agreement (CDA), we dismissed the insurer's request for Board review. In doing so, we reinstated and affirmed the Order on Reconsideration. We reasoned that the benefits arising from the premature closure issue (temporary and permanent disability) had been resolved pursuant to the parties' approved CDA.

Claimant has objected to our modification of the Referee's order, asserting that it was not the parties' intention to disturb the Referee's premature closure finding. Consequently, he seeks reinstatement of the Referee's order. Inasmuch as the insurer has not rebutted claimant's representation pertaining to the parties' intentions concerning the effect of the CDA on this dispute, we conclude that the CDA has no impact on the Referee's premature closure finding.

Accordingly, in lieu of our September 20, 1993 order, we issue the following order. The insurer's request for Board review of the Referee's order is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RENE G. GONZALEZ, Claimant
WCB Case Nos. 91-15031, 92-01891, 92-03786 & 92-04940
ORDER ON REVIEW

Phillip H. Garrow, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorney
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee McWilliams' order that: (1) upheld Liberty Northwest Insurance Corporation's denial (on behalf of Fircrest Farms) of claimant's occupational disease claim for his bilateral elbow arthritis condition; (2) upheld Liberty's denial (on behalf of Cavel West, Inc.) of claimant's occupational disease claim for the same condition; and (3) upheld Liberty's denial (on behalf of Cavel West) of claimant's aggravation claim for his current left elbow condition. On review, the issues are compensability and responsibility.

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

On review, claimant contends that the Referee erroneously assigned initial responsibility to Mid Oregon Labor Contractors, Inc. (Mid Oregon).¹ Claimant argues that he was first disabled in May 1990, while working for Cavel West. We disagree.

The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition. (Emphasis added). Progress Quarries v. Vaandering, 80 Or App 160 (1986). Here, the compensable condition at issue is a bilateral arthritis condition of the elbows. During claimant's employment with Cavel West, Dr. Wilkens took claimant off work for "left elbow strain/tendonitis" in May 1990. (Ex. 27). It was not until September 1991, however, that Dr. Wigle, M.D., took claimant off work due to his osteoarthritis condition, and opined that claimant would not be able to return to either millwork or work as a butcher. (Ex. 47).

Accordingly, because claimant was working for Mid Oregon in September 1991, when he first became disabled as a result of the compensable condition, we agree with the Referee's assignment of liability. Furthermore, after reviewing the record, we agree with the Referee's conclusion that it has not been established that work conditions with the prior employers were the sole cause of the worsening of claimant's underlying condition, or that it was impossible for work conditions at Mid Oregon to have caused the disease. See FMC Corporation v. Liberty Mutual Ins. Co., 73 Or App 223 (1985); Ronald J. Stull, 44 Van Natta 2235 (1992). Therefore, responsibility cannot be shifted to either Cavel West or Fircrest Farms.

ORDER

The Referee's order dated January 15, 1993 is affirmed.

¹ Since Mid Oregon was not a party to the proceeding, the Referee reasoned, and we concur, that the Referee was without authority to assign responsibility for the claim to Mid Oregon.

In the Matter of the Compensation of
MARGARET GOODWIN, Claimant
WCB Case No. 91-18289
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Hazelett's order which upheld the self-insured employer's denial of claimant's current respiratory condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In December 1980, claimant suffered from a respiratory problem, diagnosed as bronchitis, as a result of which she was off work for over two weeks. She sought medical treatment. Anti-asthma medication, along with other medications, was prescribed. Claimant was released to return to work on January 6, 1981.

In May and October 1991, claimant sought medical treatment for asthma.

In November 1991, Dr. Bardana performed an independent medical examination at the employer's request.

On December 27, 1991, the employer denied the compensability of claimant's current bronchial asthma condition.

We adopt the Referee's first finding of ultimate fact, but not the second.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had a respiratory condition which existed before the date of her inhalation injury on January 10, 1981. He further found that claimant's work injury was no longer the major contributing cause of her current bronchial asthma condition. Accordingly, pursuant to ORS 656.005(7)(a)(B), the Referee upheld the employer's current condition denial.

We agree with the Referee's finding that claimant had a preexisting respiratory condition prior to her 1981 work injury. We further find that claimant's work injury, which resulted from inhaling chlorine gas, combined with her preexisting respiratory condition to cause or prolong her need for medical treatment. Therefore, in order for her current condition to be compensable, claimant must establish that her compensable injury of 1981 remains the major contributing cause of her current condition and need for medical treatment. ORS 656.005(7)(a)(B). We disagree, however, with the Referee's conclusion that the work injury is no longer the major contributing cause of claimant's current condition and need for medical treatment.

The only medical opinions concerning the relationship between claimant's current respiratory condition, which the employer denied in December 1991, and her compensable 1981 work injury are from Drs. Fisher, Keppel and Bardana. We do not consider the opinions of Drs. Danner, Stein, Mack and Handke to be relevant to this issue, for the following reasons.

Dr. Danner provided initial emergency treatment following claimant's inhalation injury. He opined that claimant's diagnosis is probably "a severe acute exacerbation of bronchial spasm, secondary to the chlorine, superimposed upon preexisting disease." (Ex 10-4). He provided no further treatment for claimant, nor did he author any subsequent reports.

Dr. Stein, D.O., provided follow-up treatment until approximately March 1981 when claimant moved from Hermiston, Oregon to Vancouver, Washington. She believed that claimant's "acute chemically induced laryngotracheobronchitis" had resolved by January 23, 1981. (Ex. 12-1). Dr. Stein also treated claimant's acute bronchitis episode in December 1980. (See Ex. 15, Tr. 16). Subsequently, in July 1992, Dr. Stein opined that claimant suffered from recurrent bronchial asthma prior to her chlorine gas exposure in January 1981. (Ex. 55).

Dr. Mack, internist, conducted an independent medical examination in August 1981. (See Exs. 19, 20, 21). He concluded that the effects of claimant's chlorine gas inhalation had probably lasted only a few days, and that claimant's ongoing problem was asthma, which Dr. Mack believed she had had for many years. (Exs. 20, 21-2). Dr. Mack did not again examine claimant, nor did he author a subsequent report.

Dr. Handke treated claimant's pulmonary condition in 1985 when she moved to Nevada. (See Exs. 37, 38, 39). He opined in November 1985 that claimant's then-current need for treatment was related to her occupational exposure in 1981. (Ex. 43). Subsequently, the employer agreed, by stipulation, to pay claimant's medical expenses incurred in Nevada. (Ex. 44E). There is no evidence of any further treatment or reports by Dr. Handke.

Drs. Danner, Stein and Mack believed claimant suffered from a preexisting respiratory condition, and we consider their opinions to that extent.

We also examine the medical record for direct evidence of a preexisting respiratory condition. After doing so, we adopt the Referee's finding that claimant was prescribed medication in 1978 and 1980 which is used to treat asthma. (See Exs. 4-1, 6-2, 53-3, 56-64). We also find that claimant had occasional episodes of wheezing between 1947 and 1965, which were not specifically treated. (See Ex. 2). In 1978 and in December 1980, claimant was treated for bronchitis with antibiotics as well as asthma medication. (See Exs. 4-1, 6-2). However, prior to January 1981, claimant was never diagnosed as having asthma. (See Ex. 56-34 to -35). Based on the medical records prior to January 1981, we conclude that claimant had a preexisting respiratory condition, which manifested occasionally over a 30-year period, but which did not require regular medical intervention during that period.

Because Drs. Danner, Stein, Mack and Handke did not treat or examine claimant for her current condition in 1991, and they did not offer opinions regarding the relationship of claimant's 1981 work exposure to her current condition in 1991, we do not consider their reports in resolving this question.

We turn now to the opinions of Drs. Fisher, Keppel and Bardana regarding the issue of causation of claimant's current condition.

Dr. Fisher

Dr. Fisher has treated claimant's respiratory condition since March 1981. (See Ex. 3-1; Tr. 14-15). In his initial history, Dr. Fisher noted that claimant had had acute bronchitis prior to the inhalation incident at work for which she was off work for two weeks, that she had a prior history of "occasional wheezing episodes only with upper respiratory infections," and that she had used the medication Theolair in the past "without any apparent result." (Ex. 3-1).

Dr. Fisher believed that the effects of the chlorine gas inhalation had not resolved, because after the work incident claimant has required chronic medication and has had persisting symptoms. (Ex. 3-3). He further opined that claimant not only had her asthma exacerbated by the chlorine gas, but "that the exposure may have caused enough irritation of the irritant and cough receptors that her previous asthmatic tendency is now made more difficult to treat." (Ex. 22). Finally, Dr. Fisher opined that because claimant has required medications to treat her symptoms since the 1981 exposure, there was "a significant change in her bronchial reactivity following the inhalation injury and that the exposure significantly contributes to the patient's current condition and requirement for ongoing medication." (Ex. 55A, Dr. Keppel deposition Ex. 2; see also, Ex. 52).

We find Dr. Fisher's opinion to be based on an accurate medical history, which includes knowledge of claimant's December 1980 illness and treatment with asthma medications, as well as approximately 10 years of treatment following the 1981 injury. We find his opinion to be well-reasoned and internally consistent. Ordinarily, we defer to the treating doctor's opinion absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find none in this case. Accordingly, we find that Dr. Fisher's opinion establishes that claimant had a preexisting respiratory condition which was exacerbated by the 1981 exposure, resulting in a change in her bronchial reactivity such that the 1981 exposure continues to significantly contribute to claimant's current condition and ongoing need for medication.

Dr. Keppel

Dr. Keppel, pulmonologist, examined claimant in October 1981 and testified by deposition in 1992. After his examination in 1981, Dr. Keppel noted that claimant's premorbid condition included hay fever and occasional exacerbation with viral infection, but that she had not been markedly limited by pulmonary disease. He explained that in January 1981, claimant inhaled "a severe airway irritant. This led to bronchospasm in a susceptible host." He opined that claimant's "airway irritation has persisted with an intrinsic form of reactive airways disease." (Ex. 23). He noted that since the January 1981 exposure, claimant has required medication at a high dose on a regular basis, and that her airways continued to be "very twitchy." (Ex. 27-2). He believed that claimant had "some degree of reactive airways disease which was probably rekindled by the chlorine exposure," but that pulmonary function tests in late 1981 showed that she still had residuals from her inhalation injury. (Ex. 27-3).

In 1992, Dr. Keppel opined that, as a result of the January 1981 exposure, claimant's disease worsened, so that "she's required ongoing continuous medication as a result of that exposure," and the exposure remains the major contributing cause of claimant's present need for medications. (Ex. 55A, page 15).

In support of his position, Dr. Keppel observed that claimant was severely affected by the inhalation incident, such that she required on-scene resuscitation and hospitalization for six days; in addition, arterial blood gas tests showed a low oxygen level. (Ex. 55A, page 16). Dr. Keppel believed the severity of claimant's exposure was consistent with the exposures cited in a 1985 Cincinnati study, which suggested that such exposure causes a physiologic change that leaves the patient with persistent wheezing, which the study termed "reactive airways disease syndrome" (RADS). (Ex. 55A, pages 15-16; see also Ex. 55A, Deposition Exhibit 1).

He further opined that claimant's need for continual asthma medication since January 1981 indicates a more persistent and severe asthma, which was started by the 1981 incident. (Ex. 55A, page 19). He discounted the role of claimant's December 1980 flu-like illness in causing her current chronic asthma condition, since claimant had had previous episodes of wheezing associated with illness, and he believed the December 1980 episode was similar to such previous episodes. (Ex. 55A, page 18).

We find Dr. Keppel's opinion to be well-reasoned, based on a complete medical history, and internally consistent. We find that Dr. Keppel did not change his view from 1981 to 1992 regarding the presence of some type of preexisting respiratory condition. (See Ex. 55A, page 28). Accordingly, we are persuaded by Dr. Keppel's opinion that the 1981 inhalation injury remains the major contributing cause of claimant's current condition and need for treatment.

Dr. Bardana

Dr. Bardana, an allergist and immunologist, performed independent medical examinations in April 1982 and November 1991. (See Exs. 29, 50). He also testified by deposition in 1992. (Ex. 56). In his 1991 report, Dr. Bardana opined that claimant had preexisting asthma in adulthood, associated with viral infections; that claimant's December 1980 flu-like illness exacerbated her bronchial asthma condition; and that, by March or April 1981, claimant's condition had returned to her premorbid level "consistent with the flare that she had in December, 1980." (Ex. 50-8). Dr. Bardana reasoned that since claimant had lifelong asthma, she would likely have it indefinitely. Therefore, he concluded that the 1981 industrial exposure was no longer the major contributing cause of claimant's asthma and her continued need for medications. (Ex. 50-8 to -9; see also, Ex. 56-23).

After reviewing claimant's pre-1981 medical records, Dr. Bardana concluded that claimant's current asthma condition "is not the result of her chlorine exposure, but is the result of her atopic condition which manifested itself early with allergic rhinitis and conjunctivitis as well as bronchial asthma." (Ex. 53-4). In his 1992 deposition, Dr. Bardana adhered to his earlier opinions. However, he further opined that the December 1980 viral infection which exacerbated claimant's preexisting bronchial asthma was the more likely cause of her current, chronic asthma condition than the exposure to chlorine gas in 1981. (Ex. 56-21 to -22).

We do not find Dr. Bardana's opinion persuasive, in that he fails to adequately account for the change in claimant's need for medications to control her asthma after the 1981 exposure, as compared with her need for medications before 1981. In addition, we are not persuaded by Dr. Bardana's conclusory reasoning that because claimant's lifelong asthma likely will continue indefinitely, the 1981

injury, therefore, is no longer the major contributing cause of her current asthma condition. (See Ex. 50-8 to -9). Finally, we are not persuaded by Dr. Bardana's one-sentence opinion that the more likely cause of claimant's chronic asthma condition was the December 1980 flu-like illness. Dr. Bardana fails to explain why claimant has required continuous asthma medication after January 1981, when previously she had experienced respiratory symptoms associated with upper respiratory infections which resolved without the need for ongoing treatment. For the above-cited reasons, we do not find Dr. Bardana's opinion persuasive.

After considering the record as a whole, we find the opinions of Drs. Fisher and Keppel to be more persuasive than the opinion of Dr. Bardana. Relying on the opinions of Drs. Fisher and Keppel, we find that claimant had a preexisting respiratory condition which combined with her January 1981 inhalation injury to cause or prolong her disability and need for treatment. Furthermore, we find that claimant has established, by a preponderance of the evidence, that the 1981 work exposure remains the major contributing cause of her current bronchial asthma condition and need for treatment. Accordingly, we set aside the employer's December 17, 1991 denial.

Because of our disposition of this case, we find it unnecessary to address claimant's "law of the case" argument.

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

ORDER

The Referee's order dated September 16, 1992 is reversed. The self-insured employer's denial of December 27, 1991 is set aside. The claim is remanded to the self-insured employer for processing in accordance with the law. Claimant's attorney is awarded \$4,000 for services at hearing and on Board review, to be paid by the self-insured employer.

November 9, 1993

Cite as 45 Van Natta 2158 (1993)

In the Matter of the Compensation of
SANDY R. GRIFFIN, Claimant
 WCB Case No. 92-12218
 ORDER ON REVIEW
 Coons, et al., Claimant Attorneys
 Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Nielsen's order which: (1) upheld the SAIF Corporation's "de facto" denial of claimant's injury claim for carpal tunnel syndrome (CTS); and (2) declined to assess a penalty for an allegedly unreasonable "de facto" denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant's entire right arm, including the hand, was numb after the work-related motor vehicle accident (MVA). Her right hand began to tingle almost immediately.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had failed to establish that her September 18, 1991 MVA was a material contributing cause of her current right wrist condition. We disagree.

Claimant was compensably injured in a MVA when the car she was driving was hit from behind at a high speed on the freeway. Claimant was gripping the steering wheel with both hands and, on impact, her right shoulder was thrown forward and to the left. (Tr. 10, 11). Claimant contends that her right wrist condition was directly caused by her MVA.

The medical evidence demonstrates that claimant's current condition arose from the September 1991 MVA, as opposed to being a "consequence" of the injuries she sustained in the accident. We thus conclude that claimant's condition is a primary consequence of the MVA. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Accordingly, claimant must prove that the September 1991 MVA was a material contributing cause of her current condition in order for her claim to be compensable. We conclude that claimant has carried her burden of proof.

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

During claimant's initial examination following the MVA, the emergency room physician reported that claimant's right arm felt "heavy" and the arm had a numb feeling throughout. (Ex. 2). Claimant subsequently reported to her treating physician, Dr. Jewell, hand surgeon, that her right hand began tingling almost immediately after the MVA. (Ex. 13).

On September 24, 1991, Dr. Jones, orthopedic surgeon, examined claimant. He diagnosed right shoulder bursitis. SAIF accepted the claim. (Exs. 4, 6). Jones found claimant medically stationary from the bursitis condition on October 22, 1991, although he noted occasional pain shooting down into her elbow. (Ex. 5).

On December 5, 1991, claimant returned to Dr. Jones, stating that the pain in her elbow had continued and was especially significant over the past two or three weeks. (Ex. 7). He noted tenderness over the medial epicondyle and ulna radiating into the fifth finger. He also noted a positive Tinel's sign.

Dr. Jones referred claimant for electrodiagnostic studies of the right ulnar nerve. (Ex. 8). Those studies did not demonstrate abnormalities of the ulnar nerve, but did demonstrate an abnormality of the right median nerve at the wrist. They also revealed a mild abnormality in the left median nerve.

On April 29, 1992, Dr. Jones recommended carpal tunnel release, stating that further conservative treatment would be ineffective. (Ex. 9). Dr. Jones also stated that he had seen carpal tunnel syndrome develop as the result of an impact injury, such as claimant suffered while grasping the steering wheel during the MVA. (Ex. 10). Dr. Jones subsequently reiterated that it was not unreasonable to believe that claimant's MVA was contributory to her carpal tunnel syndrome (CTS) symptoms. (Ex. 23-2).

Also in April 1992, claimant was examined by Dr. Levy on referral from Dr. Jones. Dr. Levy reported that claimant had a negative Tinel's and Phalen's test. However, he diagnosed wrist flexor tendinitis and medial and lateral epicondylitis, caused by the MVA. (Ex. 12).

In June 1992, claimant began treating with Dr. Jewell, her current treating physician. Dr. Jewell related claimant's right arm complaints to her MVA, but stated that claimant had more than CTS, and that a carpal tunnel release alone would not suffice. (Ex. 13).

In July 1992, Dr. Jewell referred claimant to Dr. Goins, neurologist, who had performed the previous electrodiagnostic studies on claimant's wrist. (Ex. 15). Dr. Goins was unclear as to how much of claimant's arm symptoms were related to CTS. He did, however, relate claimant's right arm problems to her MVA.

In August 1992, claimant was examined by Medical Consultants Northwest. The physicians noted that their examination was not suggestive of CTS; however, they noted the possibility of right wrist tendinitis. (Ex. 18-6). The physicians admitted that a MVA could cause CTS to develop, but concluded that claimant's MVA is not the major contributing cause of her right wrist condition.

In November 1992, Dr. Jewell stated in a letter to SAIF's claims adjuster that, after following claimant since June, he still believed that her CTS was related to the MVA. He stated that the specific cause was either the impact of the arm on the steering wheel during the accident, or the CTS had developed as a result of the musculoskeletal upper extremity pain that was claimant's current problem. (Exs. 25-1, 26). Subsequently, Dr. Jewell stated that the MVA was the major contributing cause of claimant's CTS. (Ex. 27).

When the medical evidence is divided, we give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we are persuaded by the opinions of Dr. Jewell, claimant's treating physician, and Dr. Jones, who treated claimant for the period of approximately a year, that claimant's September 18, 1991 MVA is a material contributing cause of her current right wrist condition, tentatively diagnosed as CTS. See Albany General Hospital v. Gasperino, *supra*. Drs. Jewell, Jones, and Levy, are familiar with the history of claimant's right arm complaints, and all related claimant's condition to her MVA. Moreover, even though the Medical Consultants opined that the MVA was not the major contributing cause of claimant's wrist condition, they admitted it was possible for a MVA to cause CTS. Finally, as noted above, claimant had the burden to prove only that her work-related MVA was a material contributing cause of her right wrist condition. The Consultants did not address that standard of proof. Accordingly, we reverse the Referee's order which upheld SAIF's denials.

Penalty/ Attorney Fee

A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991).

Here, claimant contends that a February 27, 1992 letter to SAIF from Dr. Jones, in conjunction with prior electrodiagnostic reports suggesting CTS, notified SAIF of a CTS claim. Thus, by not accepting or denying the claim until October 7, 1992, SAIF had "de facto" denied the claim. See ORS 656.262(6). We agree.

In his letter, Dr. Jones, who had treated claimant for her accepted condition, stated that he was investigating claimant's right wrist condition, trying to come to a diagnosis. He related claimant's continuing elbow and shoulder symptoms to CTS, and also stated that CTS can develop from a mechanism such as occurred during claimant's MVA. Thus, based on the above-mentioned information provided to SAIF by Dr. Jones, we conclude that the letter was a claim for CTS. See ORS 656.005(6). Consequently, SAIF's failure to accept or deny the claim within 90 days was an unreasonable delay. Accordingly, we assess a penalty equal to 25 percent of any compensation due at the time of hearing as a result of this order, to be paid in equal shares to claimant and her attorney. See ORS 656.262(10).

Moreover, claimant's attorney 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 concerning the compensability issue is \$3,000. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 27, 1993 is reversed. The SAIF Corporation's "de facto" 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 as a result of this order, to be paid in equal shares to claimant and her attorney. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded an assessed attorney fee of \$3,000, payable by SAIF.

In the Matter of the Compensation of
TRACY E. HACKER, Claimant
WCB Case No. 92-10519
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of those portions of Referee Podnar's order that: (1) set aside its partial denial of claimant's current low back condition; and (2) awarded claimant's attorney an assessed fee for his efforts in setting aside the denial. Claimant cross-requests review of that portion of the Referee's order that reversed the Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability. On review, the issues are compensability, attorney fees 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 exception of the first sentence of the second paragraph and the fourth and fifth paragraphs on page 3.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in April 1992. Dr. Vonder Reith, chiropractor, treated him conservatively and released him to regular work without restriction on May 14, 1992. On May 27, 1992, the insurer accepted an "acute lumbar strain" and closed the claim with no award of permanent disability. Claimant requested reconsideration and an arbiter examination. The arbiter, Dr. Dinneen, orthopedist, found reduced range of motion in claimant's low back and opined that claimant could perform light/medium work. However, Dinneen attributed any decrease in claimant's abilities to degenerative changes rather than the accepted injury. Nevertheless, despite this attribution of claimant's impairment to a non-compensable cause, the July 1992 Order on Reconsideration awarded 24 percent unscheduled permanent partial disability based on the arbiter's findings.

In August 1992, the insurer requested a hearing on the award of unscheduled permanent disability. Then, in October 1992, after clarifying the cause of claimant's impairment with Dr. Dinneen, the insurer issued a denial which states: "The medical evidence establishes that any impairment in your low back is due to a preexisting degenerative condition rather than the industrial injury of April 18, 1992. Therefore, we must respectfully deny compensability of such impairment, or the resulting disability."

Claimant cross-requested a hearing on the denial.

Compensability

The Referee concluded, on the merits, that claimant failed to prove compensability pursuant to ORS 656.005(7)(a)(B). The Referee nevertheless set aside the denial as unreasonable, on the bases that the issues it raised concerning the extent of disability had been raised by the request for hearing on the Order on Reconsideration, that no claims were pending, and that the insurer stipulated that the original injury claim was not being denied.

On review, the insurer contends that the denial is a proper current condition denial that should be upheld. We agree.

First, the ultimate question raised by the denial is compensability of the current low back condition. Consequently, the extent of disability issue raised at hearing did not dispose of the issue raised by the denial. In other words, we conclude that the compensability issue raised by the denial was not mooted by the insurer's request for hearing on the Order on Reconsideration.

Second, 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). However, if a claimant contends that, in fact, he or she is not making a claim for the denied condition, the denial will be set aside as prospective and ineffective until such time as claimant actually makes a claim for such a condition. Shannon M. Evans, 42 Van Natta 227 (1990); Alvin H. Despain, 40 Van Natta 1823 (1988).

A claimant makes a "claim" for a condition when the claimant chooses to litigate the merits of a condition at hearing, even if until that point the denial could be challenged and set aside as premature. Proceeding to litigate the merits is a waiver of the procedural defect of a premature denial. Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990), citing Thomas v. SAIF, 64 Or App 193 (1983). Here, claimant contended that the accepted claim consisted of both the acute lumbar strain plus the underlying degenerative condition, (Tr. 7), and proceeded to litigate the merits of the denial. Accordingly, since claimant did not raise the issue of premature denial, and since claimant proceeded to litigate the merits of the insurer's partial denial in its entirety, the Referee erred in concluding that no claim was pending. Dorothy Jackson-Duncan, *supra*.

On review, claimant argues that the denial should be set aside as an improper "back-up" denial of his accepted condition. As noted by the Referee, the insurer stipulated at hearing that the original accepted acute lumbar strain injury had not been denied by the denial letter. Therefore, we conclude that the denial was not an improper "back-up" denial and should not have been set aside on this basis.

We conclude that the denial is a partial denial of the compensability of claimant's current condition, based on the alleged lack of causal contribution by the injury, and that the insurer properly issued such a denial. ORS 656.005(7)(a)(B); Weyerhaeuser Co. v. Warrilow, *supra*; Dorothy Jackson-Duncan, *supra*.

We now turn to the merits of the partial denial.

ORS 656.005(7)(a)(B) provides that, if a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment. In April 1992, Dr. Vonder Reith noted that claimant had a preexisting L4-5 disc narrowing. In October 1992, he opined that claimant's acute traumatic lumbar strain was complicated by and aggravated claimant's preexisting degenerative changes in the lumbar spine. (Ex. 19-2). We accordingly conclude that the medical evidence indicates that claimant's injury combined with a preexisting condition to cause a need for treatment.

The next question is whether the compensable injury remained the major contributing cause of claimant's disability or need for treatment. On July 13, 1992, Dr. Dinneen opined that any decrease in claimant's work ability pursuant to the measured ranges of motion were due to degenerative type physiologic changes, not the April 1992 injury. (Exs. 12 and 17). Dr. Vonder Reith explained that the only evidence available to Dr. Dinneen of a degenerative change was based on x-ray findings of disc space narrowing, evidence of early degenerative change. However, Vonder Reith does not express an opinion as to whether the injury remained the major contributing cause of claimant's disability at that time. (Ex. 19-2). Accordingly, claimant failed to prove that his resultant condition remained compensable. We therefore uphold the insurer's partial denial of claimant's current condition.

Finally, claimant also contends that the denial denies the compensability of an occupational disease. This issue was not raised at hearing. Therefore, we do not consider it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Attorney Fees

The Referee awarded claimant's counsel a reasonable fee for his efforts in having the denial set aside. Because we uphold the denial on the merits, we reverse the attorney fee award.

Extent

We affirm and adopt the Referee's opinion on this issue.

ORDER

The Referee's order dated December 9, 1992 is reversed in part and affirmed in part. That portion of the order setting aside the October 12, 1992 partial denial is reversed. The partial denial is reinstated and upheld. The Referee's assessed attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARY A. HAILE, Claimant
WCB Case No. 92-05137
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
Scott H. Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Crumme's order that: (1) found that it was not prejudiced by claimant's untimely claim filing; (2) found that claimant's injury occurred in the course and scope of her employment; and (3) set aside its denial of claimant's left hand injury claim. On review, the issues are untimely claim filing, course and scope, and compensability.

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

Course and Scope of Employment

On review, the employer renews its contention that claimant was injured while going to work. Thus, it argues, the Referee should have applied the "going and coming" rule. We disagree. As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). In the instant case, however, claimant was no longer traveling to her workplace when the accident occurred. Rather, she had arrived at work and was engaged in an activity "preparatory" to her employment.

In Jackie J. Freeny, 43 Van Natta 1363 (1991), we held that an injury occurring as a result of the claimant's act of preparing for work within a reasonable interval before working hours began was compensable. In so holding, we found guidance in 1A Larson, Workmen's Compensation Law 12.60, 5-42 et seq (1985). Larson states that the course of employment, for employees having a fixed time and place of work, embraces a reasonable interval before and after working hours while the employee is on the premises engaged in preparatory or incidental acts. The rule is not confined to activities that are necessary; it is sufficient if they are reasonably incidental to the work. Id. at 5-42. See Rogers v. SAIF, 289 Or 633 (1980) (if an injury has sufficient work relationship it arises out of and in the course of employment).

Here, it was time for claimant's work shift to begin. She was at the assigned work site and was entering the time clock room in order to "punch in," as directed by the employer. Accordingly, we conclude that "punching" the time clock was an activity reasonably preparatory to claimant's employment.

Compensability of Ligamentous Hand Injury

Claimant has preexisting arthritis at the base of the left thumb. Her disability and need for medical treatment are due to a combination of her preexisting condition and the ligamentous hand injury. Accordingly, claimant must prove that the compensable injury is the major contributing cause of the disability or need for treatment. ORS 656.007(a)(B). Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993).

The employer argues that the opinion of Dr. Nathan, independent hand specialist, is more persuasive than that of Dr. Lyman, treating hand specialist. We do not agree.

First, Dr. Nathan merely performed a records review at the request of the employer. He never examined claimant. In addition, his brief report does not address the issue presented by this case. Instead, Dr. Nathan opines that the hand injury did not cause or worsen claimant's underlying arthritic condition, for which claimant has made no claim. Moreover, while Dr. Nathan concluded that claimant's arthritis involving the left thumb "is the major contributing cause for [claimant] seeking care now," that opinion was authored ten months after claimant's injury. It does not speak to whether claimant required care at the time of injury. Finally, Dr. Nathan offered no opinion concerning the causation of claimant's ligamentous hand injury.

For these reasons, as well as those expressed by the Referee, we do not find Dr. Nathan's opinion to be persuasive, particularly when compared to the opinion of treating physician Lyman. Consequently, we agree with the Referee's conclusion that claimant's left hand claim is compensable.

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 defending against the employer's appeal is \$2,000. See ORS 656.382(2). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and Statement of Services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 4, 1993 is affirmed. For services on review, claimant is awarded a reasonable attorney fee of \$2,000; to be paid by the self-insured employer.

November 9, 1993

Cite as 45 Van Natta 2164 (1993)

In the Matter of the Compensation of
JOHN W. HARBERT, Claimant
 WCB Case Nos. 91-09469 & 91-04201
ORDER ON REVIEW
 Schneider, et al., Claimant Attorneys
 Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of those portions of Referee Menashe's order which: (1) dismissed his request for a hearing in WCB case number 91-04201 for unjustified failure to appear at a scheduled hearing; and (2) upheld the insurer's denial of a popliteal cyst in his right knee in WCB case number 91-09469. If his request for hearing is reinstated, claimant contends that his December 1990 right calf injury claim is compensable. On review, the issues are dismissal and compensability.

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

In April 1991, claimant, acting *pro se*, requested a hearing from the insurer's denial of his December 1990 right calf injury claim. A hearing was scheduled on July 5, 1991 before Referee Leahy. Claimant failed to appear, and Referee Leahy dismissed his hearing request on the ground that claimant had abandoned it. Claimant obtained counsel and requested review of Referee Leahy's order. We interpreted claimant's request as a motion for postponement. (See Ex. 62-3). We remanded the matter to Referee Menashe to determine whether claimant's request for a postponement was justified. (*Id.*)

A scheduled hearing may be postponed only by an order of a referee "upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. "Extraordinary circumstances" do not include a party's unavailability due to personal or professional business or appointments. OAR 438-06-081(2).

Here, claimant testified that he attempted to postpone the hearing because of a planned vacation over the July 4th holiday weekend. (Tr. 27-28). However, he also testified that he could have rescheduled his vacation and that he didn't "have to go." (Tr. 28, 31). Under these circumstances, we find that claimant failed to establish "extraordinary circumstances" sufficient to justify postponement of a scheduled hearing. Furthermore, after our review of the record, we agree with the Referee's determination that claimant's failure to appear at the July 5, 1991 hearing was unjustified, in that he was aware that his case had not been postponed prior to his vacation. (See Tr. 29-30). Accordingly, we affirm the Referee's order dismissing the request for hearing in WCB case number 91-04201.

Furthermore, after our review of the record, we affirm and adopt the Referee's order finding that claimant failed to establish that his compensable February 1990 right knee injury and subsequent surgery were the major contributing cause of his popliteal cyst. Accordingly, the insurer's May 16, 1991 denial is upheld.

ORDER

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

In the Matter of the Compensation of
HERMAN T. HARRAL, Claimant
WCB Case No. 91-15732
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of those portions of Referee Hoguet's order that: (1) found that he had jurisdiction over the issue of extent of permanent disability; (2) reinstated claimant's permanent total disability award; and (3) awarded claimant's counsel an attorney fee pursuant to ORS 656.382(2). In its brief, SAIF also contends that the Referee should not have permitted an out-of-state vocational counselor to testify at hearing. On review, the issues are jurisdiction, evidence, permanent total disability, 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

Jurisdiction

The Referee found that, although the October 24, 1991 Determination Order did not provide a medically stationary date, the record as a whole established that claimant's medically stationary date was February 21, 1983. We agree that the record establishes a medically stationary date of February 21, 1983. Therefore, the Referee had jurisdiction over this matter, regardless of the fact that there was no reconsideration of the Determination Order.

Evidence

On review, SAIF contends that the Referee should not have permitted Dr. Rollins, a vocational expert, to testify at hearing. SAIF argues that, pursuant to OAR 436-35-055(4), Dr. Rollins is not a certified counselor in the state of Oregon, and therefore, his testimony should not be considered.

We agree with the Referee that it is not necessary to reach the issue of Dr. Rollins' competence to testify. Here, the Referee found, and we agree, that claimant is permanently and totally disabled on a medical basis. Neither we nor the Referee have relied upon Dr. Rollins' testimony in reaching our conclusion. Accordingly, we decline to address the evidentiary issue raised by SAIF.

Permanent Total Disability

We adopt the Referee's "Conclusions and Opinion" on the issue of permanent total disability.

Attorney Fees/Hearing Level

The Referee awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.382(2) for services at hearing. On review, SAIF argues that, if claimant prevails on the issue of permanent total disability, his counsel is entitled to an out-of-compensation fee, rather than an assessed fee. We agree.

In Delmer Seal, 39 Van Natta 113 (1987), we concluded that a claimant was not entitled to an assessed attorney fee where the insurer was required to reexamine the claimant's permanent total disability claim, pursuant to ORS 656.206(5). In Seal, we determined that, by complying with the statute, the insurer did not initiate the reduction in the claimant's permanent total disability award. Rather, the reduction of the award was at the discretion of the Evaluation Division. In such cases, we concluded that the claimant's attorney fee award should be paid out of compensation, pursuant to ORS 656.386(2). Delmer Seal, *supra*.

We conclude that the Seal case is dispositive on the issue of claimant's entitlement to an attorney fee. In the present case, SAIF reexamined claimant's permanent total disability claim and forwarded the results to the Director, pursuant to ORS 656.206(5). Thereafter, the Evaluation Division found that claimant was no longer entitled to permanent total disability benefits, and claimant requested a hearing from the Determination Order.

Under the circumstances, we conclude that SAIF did not initiate a request for hearing seeking reduction or disallowance of claimant's award. Therefore, the Referee's assessed attorney fee award is reversed. In lieu of the Referee's award, claimant's counsel is awarded an approved fee, pursuant to ORS 656.386(2). In other words, 25 percent of the increased compensation created by the Referee's permanent total disability award, not to exceed \$4,600. OAR 436-15-040(2).

Attorney Fees/Board Level

Claimant is entitled to an assessed fee for services on review concerning the issue of permanent total disability, to be paid by SAIF. ORS 656.382(2). After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that \$1,000 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 case, as represented by claimant's respondent's brief. (Although we find that claimant's respondent's brief is well-written and voluminous in nature, we note that the brief was primarily prepared for the hearing and was submitted to the Referee in the form of written closing argument. We take this factor into account for purposes of determining which services have been provided on review. Additionally, no attorney fee is available for that portion of the respondent's brief which is devoted to the issue of attorney fees. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).) We also have considered the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 18, 1993 is affirmed in part and reversed in part. That portion of the Referee's order which awarded claimant's counsel an assessed attorney fee is reversed. In lieu of the Referee's award of an assessed fee, claimant's counsel is awarded an approved fee of 25 percent of the increased compensation created by the Referee's order, not to exceed \$4,600. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of \$1,000, also payable by SAIF.

Board Member Haynes specially concurring.

I concur with the majority's opinion that, in this case involving termination of claimant's permanent total disability award, SAIF has failed its burden of proof. Here, the Department's redetermination of claimant's permanent total disability award was apparently based solely upon the written reports of Emanuel Pain Center, Rehabilitation Associates, Inc., and the Northwest Medical Consultants. On their face, these reports were extremely persuasive and supported the Department's redetermination, reducing claimant's award from permanent total disability to 35 percent unscheduled permanent disability and 4 percent scheduled permanent disability.

However, at hearing, numerous witnesses credibly testified to claimant's worsened condition since the prior Opinion and Order which found claimant permanently and totally disabled. Therefore, I can only agree with the Referee that the record, as supported by the uncontroverted lay testimony, establishes that claimant's condition has not improved. Therefore, SAIF has failed to prove a change of circumstances sufficient to warrant terminating the prior permanent total disability award.

In the Matter of the Compensation of
MICHAEL D. HOLLAND, Claimant
WCB Case No. 92-07166
ORDER ON REVIEW
Foss, Whitty, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Brown's order that affirmed an Order on Reconsideration, which set aside a Determination Order as premature. Claimant cross-requests review of those portions of the Referee's order which: (1) upheld SAIF's denial of claimant's current neck and low back conditions; and (2) upheld SAIF's "de facto" denial of his bilateral shoulder condition. On review, the issues are premature claim closure and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

The Referee concluded that claimant's claim was prematurely closed because the November 29, 1991 Determination Order failed to consider claimant's subsequently accepted epigastric condition; and therefore, claimant was entitled to be rated for that condition. We agree that the claim was prematurely closed, but base our conclusion on the following reasons.

SAIF contends that the epigastric condition is a subsequently developed condition that cannot be considered to determine whether claimant's claim was prematurely closed. We disagree.

Although post-closure changes in claimant's condition cannot be considered, the epigastric condition is not a subsequent change in claimant's previously accepted low back strain condition, but rather is a separate condition resulting from that condition. As such, claimant must be medically stationary as to the epigastric condition before his claim may be closed. Therefore, claimant's injury-related epigastric condition should be considered in determining whether the claim was properly closed. See Mary J. McKenzie, 44 Van Natta 2301 (1992) (claimant must be medically stationary from all conditions resulting from the compensable injury before his claim may be closed); Saura C. Stewart, 44 Van Natta 2595 (1992) (claim prematurely closed where determination order failed to consider psychological condition, although psychological condition diagnosed after claim closure).

However, the issue remains whether claimant's epigastric condition was medically stationary at the time of claim closure. In Glenn L. Gatliff, 45 Van Natta 107 (1993), we found the claim properly closed where the claimant did not seek treatment for a psychological condition prior to claim closure, nor was there persuasive evidence that claimant even had a psychological condition at the time of claim closure.

In this case, claimant sought treatment for his epigastric condition on December 13, 1991, 14 days after claim closure. When claimant sought treatment, he had had abdominal pain for approximately two weeks. Claimant's condition was diagnosed as abdominal pain of uncertain etiology. Medication was prescribed and claimant referred for an upper GI exam, which was normal. When claimant sought treatment on January 13, 1992 for his accepted low back condition, claimant's treating physician obtained a history of claimant's gastric episode, noting that it had resolved. Claimant underwent a gastroenterology examination on February 17, 1992, at the request of SAIF. Dr. Heinonen, gastroenterologist, opined that claimant's abdominal condition was medically stationary with minimal complaints. Based on the persistence of abdominal pain on and after the date of claim closure, as well as Dr. Heinonen's post-closure "medically stationary" conclusion, we conclude that claimant was not medically stationary at the time of claim closure with regard to his epigastric condition.

Compensability

On March 26, 1992, SAIF denied claimant's claim for cervical sprain, aggravation of spondylosis at L5, disc bulge at L5-S1, and protruded disk at L4. The Referee upheld the denial, except for that portion which denied the aggravation of spondylosis. The Referee also upheld SAIF's "de facto" denial of claimant's bilateral shoulder condition.

We affirm and adopt the Referee's findings and conclusions regarding the compensability issues.

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 concerning the premature claim closure 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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 18, 1992 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the SAIF Corporation.

November 9, 1993

Cite as 45 Van Natta 2168 (1993)

In the Matter of the Compensation of
WILLIAM L. LARIMORE, Deceased, Claimant

WCB Case No. 92-05037

ORDER ON REVIEW

Pozzi, et al., Claimant Attorneys

Lindsay, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerbånd.

Claimant's beneficiary requests review of Referee Podnar's order which found that the deceased claimant was a nonsubject worker and that the employer was a nonsubject employer. On review, the issue is subjectivity.

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

Claimant was hired to work for the employer for an estimated eight hours on November 29, 1990. The pay was to be \$15 per hour. Claimant had worked approximately two hours before he was killed. The Referee concluded that claimant was a casual, nonsubject worker and that the employer was a nonsubject employer. See ORS 656.027(3)(a); 656.023.

Claimant's beneficiary argues that the Referee erred in finding that the employer's total labor cost was less than \$200. She contends that, because the employer had to hire Columbia Mechanical, paying it \$635 to complete the job after claimant's death, the total labor cost was greater than \$200. Thus, claimant's beneficiary asserts that claimant was not a casual worker pursuant to ORS 656.027(3)(a)(B)(b). We do not agree.

When the employer needed assistance on a particular job, he hired subcontractors. Columbia Mechanical is one of the subcontractors the employer used. Accordingly, the employees of Columbia Mechanical were not employees of the employer, thereby making claimant a subject employer. ORS 656.023. Furthermore, because Columbia Mechanical's employees were not employees of the employer, the amount paid to Columbia Mechanical was not part of the employer's total labor cost. ORS 656.027(3)(a)(B)(b); see John R. Dayton, 37 Van Natta 210, 215 (1985); Rodney R. Leech, 36 Van Natta 1303 (1984).

ORDER

The Referee's order dated January 15, 1993 is affirmed.

In the Matter of the Compensation of
CHARLES M. McCLELLAN, Claimant
WCB Case Nos. 92-06823 & 91-18011
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Tom Dzieman (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 partial denial of his claim for a herniated disc condition; and (2) upheld Harry & David, Inc.'s denial of his claim for the same condition. Claimant also contends that the Referee erred in refusing to reopen the record for an additional medical report. On review, the issues are compensability and evidence. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Harry & David became self-insured as of July 1, 1989.

The 1980 industrial accident with SAIF's insured was a material contributing cause of claimant's herniated disc condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish that his herniated L4-5 disc condition is compensably related to the 1980 low back injury accepted by SAIF. We disagree.

Claimant contends that the 1980 industrial accident directly caused his L4-5 disc injury; therefore, in order to establish compensability, claimant must prove that the 1980 accident was a material contributing cause of the disc condition. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

The October 6, 1980 accident occurred while claimant was lifting heavy equipment at work. He felt a "pop" in his low back and sought treatment for low back pain. The diagnosis was a low back strain. He was able to work and did not seek further treatment, though he continued to have intermittent back pain, especially with lifting and other activities involving the back. In 1988 claimant sought treatment for worsening low back pain. X-rays of the low back were interpreted as normal. Claimant did not seek treatment again until May 1990, when he saw Dr. Campagna for continuing low back pain. At that time, a myelogram and CT scan revealed disc herniation centrally and to the left at L4-5.

Consulting neurosurgeon Dr. McGirr opined that claimant's current disc condition resulted from the 1980 lifting incident, based on "[claimant's] history of continued pain all be it [sic] in a waxing and waning fashion consistent with a disc extrusion having occurred as a consequence of his [1980] work related injury." (Ex. 18-4). The Referee found Dr. McGirr's opinion to be unreliable, based on discrepancies in the documentary record and between the documentary record and claimant's testimony. We do not agree, however, that there are any discrepancies sufficient to undercut Dr. McGirr's opinion.

The discrepancies described by the Referee arise from claimant's description of his symptoms since the 1980 injury. At hearing, claimant testified that he first experienced right leg pain after seeing Dr. Leger (in 1988) and before seeing Dr. Campagna (in May 1990). (Tr. 13). That testimony is corroborated by the medical records. (See Exs. 5-8). However, the medical records also show that in June 1990 claimant denied having leg pain to Dr. Purtzer. (Ex. 9). This discrepancy, though unexplained, does not persuade us that Dr. McGirr had an inaccurate history in forming his opinion.

Dr. McGirr's report makes no mention of right leg pain. The report includes an accurate description of the history since the 1980 accident, as well as claimant's continuing complaints. Contrary to the Referee's finding, Dr. McGirr did not assume that claimant's symptoms had persisted without change. Rather, Dr. McGirr noted that claimant's symptoms waxed and waned since the injury. This is supported by the record, as well as claimant's testimony.

Dr. McGirr's opinion is more complete and better-reasoned than the other medical opinions. Drs. Campagna and Stanford both addressed the causation issue under the "major contributing cause" standard; they did not address the material contributing cause standard which applies in this case. For these reasons, we rely on Dr. McGirr's opinion in finding that the 1980 industrial accident was a material contributing cause of the current disc condition. We conclude, therefore, that the disc condition and the resultant need for treatment are compensable.

We agree with and adopt the Referee's conclusion that there is no persuasive evidence to establish that claimant sustained a new injury or occupational disease based on work exposure with Harry & David on or after July 1, 1989.

Given our conclusion that claimant's disc condition is compensably related to the accepted 1980 injury, we need not address the remand issue raised by claimant.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 3, 1992, as reconsidered January 29, 1993, is reversed in part and affirmed in part. The SAIF's Corporation's denials of claimant's claim are set aside and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded \$2,500 for services at hearing and on Board review, to be paid by SAIF.

November 9, 1993. Cite as 45 Van Natta 2170 (1993)

In the Matter of the Compensation of
PHILLIP J. MEYER, Claimant
WCB Case No. 92-08644
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee Black's order that upheld the SAIF Corporation's denial of his eye injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

The employer had asked Gene, who was subcontracting work to the employer, to put the pickup, which belonged to a customer, back together. The employer had given claimant the keys to the shop. The employer did not want Gene in the shop alone. Claimant and Gene were to agree on the time that the work on the pickup would be done so that claimant could let Gene into the shop and would be there while the work was being done. Claimant was to be paid a little extra to be there. The vehicle claimant was working on at the time he was injured, a Volkswagen, belonged to the employer, who was going to trade it to claimant for work he performed in the shop. The employer still has the car in his possession. (Tr. 9, 10, 11, 16, 21, 27, 34, 40, 41, 46).

Claimant injured his right eye on or about Saturday, November 9, 1991, shortly after midnight, while blow-drying a wheel bearing from the Volkswagen. Gene was working on the pickup at the time claimant was injured.

The employer and his mother testified that claimant had admitted to them that he had been working on his own vehicle on his own time at the time of the accident. (Tr. 43, 44, 45, 61).

We do not adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee properly examined the compensability issue under the seven-part "course and scope" test as put forth in Mellis v. McEven, Hanna, Givold, 74 Or App 571 (1985). The factors are:

- "a. Whether the activity was for the benefit of the employer ***;
- "b. Whether the activity was contemplated by the employer and employee either at the time of hiring or later ***;
- "c. Whether the activity was an ordinary risk of, and incidental to, the employment ***;
- "d. Whether the employee was paid for the activity ***;
- "e. Whether the activity was on the employer's premises ***;
- "f. Whether the activity was directed by or acquiesced in by the employer ***;
- "g. Whether the employee was on a personal mission of his own ***."

Claimant agrees with the Referee's analysis that he has met five of the seven factors, namely b through f. See O&O at 3 and 5. However, he contends that the activity that resulted in his eye injury was for the employer's benefit and that he was not on a personal mission when injured. We agree.

Claimant was initially hired to do cleanup at the employer's Volkswagen (VW) repair shop, with the expectation that he would become more involved with the mechanical work when he became more familiar with VW repairs. The employer provided claimant with the opportunity to familiarize himself with VW mechanics by providing claimant with a VW to work on. Even though the employer and his mother testified that claimant had admitted to them that he had been working on his own vehicle on his own time at the time of the accident, and even though the employer said he "gave" the vehicle to claimant, so that claimant was working on his "personal" vehicle at the time of injury, the vehicle actually belonged to the employer, who was going to trade it to claimant, after it was in working condition, for work he performed in the shop. Thus, the value of the work claimant was doing accrued to the employer, who would use the vehicle as compensation in kind for claimant's work. Furthermore, claimant never had title to the vehicle. It never left the shop and the employer still has it in his possession. We conclude that claimant was, in fact, working on the employer's vehicle at the time of injury.

Moreover, the employer stood to benefit from claimant's growing expertise and familiarity with the mechanics of VW's. Thus, through this work, the employer would gain a mechanic who could work on other VW's for the employer's business. In support of his value as a mechanic, we note that the employer offered claimant an opportunity to work as a mechanic during the two weeks that his full-time mechanic was going on vacation. (Tr. 44).

We concluded in April Mayberry, 42 Van Natta 527 (1990), that such an immediate benefit to the employer tips the scale toward a work connection, rather than a personal mission. In Mayberry, we concluded that, even though riding the employer's horse would increase the claimant's proficiency as a trainer, the employer had an immediate benefit from not having to pay someone else to train the horse, or to have the horse better prepared for training if someone else were to be hired as a trainer. Here, as noted above, claimant would be able to work on the employer's VW's and would be able to cover for a vacationing employee without the employer having to go outside his shop to hire a temporary mechanic. This benefit to the employer, along with the fact that claimant never had personal possession or held title to the vehicle, persuades us that the employer benefited from claimant's work on the employer's vehicle and that claimant was not on a personal mission at the time of injury.

We also note that claimant was on the premises at a late hour because the employer had given claimant the keys to the shop so that he could be there while Gene was doing a rush job for the employer on a customer's vehicle. The employer did not want Gene in the shop alone and claimant was to be paid a little extra to be there.

We adopt the Referee's conclusion that claimant has met factors b through f of the aforementioned Mellis test. Therefore, we find that claimant has satisfied all of the Mellis factors. We accordingly conclude that he was injured in the course and scope of his employment.

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

ORDER

The Referee's order dated November 13, 1992 is reversed. The SAIF Corporation's denial of claimant's eye injury claim is set aside and the claim remanded to SAIF for processing according to law. Claimant's attorney is awarded \$3,500 for services at hearing and on review, to be paid by SAIF.

November 9, 1993

Cite as 45 Van Natta 2172 (1993)

In the Matter of the Compensation of

DAVID G. REES, Claimant

WCB Case No. 92-06571

ORDER ON REVIEW

Dennis O'Malley, Claimant Attorney

Montgomery W. Cobb, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Crumme's order that increased claimant's unscheduled permanent disability for a right shoulder injury from 27 percent (86.4 degrees), as awarded by an Order on Reconsideration, to 49 percent (156.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

A September 24, 1991 Determination Order awarded claimant 34 percent unscheduled permanent disability, including a value of 19 percent for impairment. In requesting reconsideration, claimant indicated that he objected only to the adaptability rating. Nonetheless, the Department scheduled claimant for examination by a medical arbiter. Based on the medical arbiter's report, the Order on Reconsideration found that claimant was entitled to 12 percent impairment and an adaptability factor of 3, resulting in an award of 27 percent unscheduled permanent disability.

Claimant requested a hearing. The Referee first concluded that the Appellate Unit lacked "jurisdiction to reconsider issues that were not raised in the requests for reconsideration." Therefore, the Referee affirmed the value of 19 percent impairment awarded by the Determination Order. Furthermore, the Referee concluded that claimant was entitled to an adaptability factor of 6, resulting in an award of 49 percent unscheduled permanent disability. We modify.

The insurer first challenges the Referee's conclusion that the Department lacked jurisdiction to address claimant's impairment. Specifically, the insurer contends that the Department's scope of review is not limited to those issues raised by the party seeking reconsideration and that the Department had authority to modify the impairment value provided by the Determination Order.

Following the Referee's order, we issued our order in Darlene K. Bentley, 45 Van Natta 1719 (1993). In Bentley, the claimant specified that she objected only to impairment and the rating of scheduled permanent disability on her form requesting reconsideration. The Order on Reconsideration, however, assigned different values for the factors of education and adaptability, along with finding that the claimant was entitled to increased impairment.

In addressing whether the claimant in Bentley had waived her right to challenge at hearing the non-impairment factors considered on reconsideration, the Board first discussed and disavowed its holding in Raymond L. Mackey, 45 Van Natta 776 (1993). In Mackey, the Board held that a party was barred from raising at hearing an issue which stemmed 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). The Board reasoned that the holding in Mackey was inconsistent with the court's decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), that ORS 656.268(5) does not preclude the Referee from considering evidence at hearing that was not submitted on reconsideration. Accordingly, the Board held that under ORS 656.283(7), a party "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." 45 Van Natta at 1721. The Board additionally noted that the Department was within its authority to modify the education and adaptability values even though the claimant did not specify any disagreement with them. Id. at 1722.

Turning to this case, we agree with the insurer that the Department was authorized to modify the impairment value used in the Determination Order, even though in requesting reconsideration, claimant did not object to the value used by the Department. More importantly, we conclude that, at hearing, the parties may challenge any of the factors used by the Department in determining claimant's unscheduled permanent disability award. Darlene K. Bentley, supra. Because the Department considered and modified only the factors of impairment and adaptability, we proceed to an analysis of the appropriate values for adaptability and impairment.

Adaptability is a comparison of the highest prior strength based on the jobs the worker has performed during the ten years preceding the time of determination with the worker's maximum residual capacity. OAR 436-35-310(1) (WCD Admin. Order 93-052). Strength is derived from the strength category assigned in the DOT code for the job. OAR 436-35-310(1)(a), 436-35-300(3).

For the ten years prior to the date of the Determination Order, claimant worked as an electric cell operator, tending pots in the reduction of aluminum oxide to aluminum. (Ex. 1-2). Based on evidence regarding claimant's work activities, we find that this job most closely matches the description in DOT 512.382-018 of tin recovery worker (smelter and refining), which is classified as heavy.

Furthermore, we reject claimant's contention that his job should be classified as "very heavy." Claimant testified that he "sometimes" lifted objects weighing between 50 and 75 pounds, took slag or burnoffs out of the cells that sometimes weighed in excess of 100 pounds, and pushed or pulled carts containing weights in excess of 250 to 300 pounds. (Tr. 6). This testimony is not sufficient to prove "very heavy" work, which is defined in the standards as "lifting" objects in excess of 100 pounds and/or "frequent" (from 1/3 to 2/3 of a shift) carrying of objects weighing 50 pounds or more. See former OAR 436-35-270(3)(h)(E) (WCD Admin. Order 2-1991).

With regard to claimant's RFC, we first note that the insurer objects to the Referee's consideration of a portion of Exhibit 13, which consists of chartnotes from claimant's treating physician, Dr. McNeill, orthopedic surgeon, and Exhibit 37, a letter from Dr. McNeill to the claims representative, because this evidence was generated subsequent to the Order on Reconsideration and, therefore, not submitted during the reconsideration proceeding. We find no error. See Safeway Stores, Inc. v. Smith, supra. Furthermore, we agree with the Referee's conclusion that claimant's RFC is sedentary. (Exs. 13-4, 37). See former OAR 436-35-270(3)(h)(A). Therefore, claimant's adaptability value is 6. OAR 436-35-310(2).

With regard to impairment, the record contains evidence of claimant's range of motion and strength from Dr. McNeill, Dr. Bald, the medical arbiter and orthopedic surgeon, and James Weggenman, a physical therapist. We agree with the Referee that Mr. Weggenman's findings should be given no weight inasmuch as the record does not show the date of examination upon which the findings were based and they were rendered by a physical therapist who lacks the expertise of Drs. McNeill or Bald. Finally, neither physician concurred with those findings.

Furthermore, we find that Dr. Bald's range of motion findings and Dr. McNeill's strength findings are the most reliable since they were rendered closest to the date of reconsideration. See ORS 656.283(7); Safeway Stores, Inc. v. Smith, *supra*. Based on Dr. Bald's range of motion findings, claimant is entitled to .2 percent impairment. See former OAR 436-35-330(1), 436-35-330(3), 436-35-330(5), 436-35-330(7), 436-35-330(9), 436-35-330(11). That value is rounded down to 0 percent. See former 436-35-007(11). Based on Dr. McNeill's strength rating of 3/5, claimant is entitled to a value of 4.5 percent. See former OAR 436-35-007(17), 436-35-350(3). That value is rounded to 5 percent. See former OAR 436-35-007(11).

Combining those values with the stipulated values of 5 percent for resection of the clavicle, former OAR 436-35-330(13), and 5 percent for resection of the acromion, former OAR 436-35-330(14), results in total impairment of 14 percent. See former OAR 436-35-007(10).

We now compute claimant's unscheduled permanent disability. The parties do not dispute the age value of 1 or education value of 4. When the sum of those factors, 5, is multiplied by the adaptability factor of 6, the result is 30. OAR 436-35-280(6). When that value is added to claimant's impairment value of 14 percent, the result is 44 percent unscheduled permanent disability. OAR 436-35-280(7).

ORDER

The Referee's order dated August 31, 1992 is modified. In lieu of the Referee's award and in addition to the Order on Reconsideration award of 27 percent (86.4 degrees), claimant is awarded an additional 17 percent (54.4 degrees) unscheduled permanent disability for a total award to date of 44 percent (140.8 degrees) unscheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee award shall be adjusted accordingly.

November 9, 1993

Cite as 45 Van Natta 2174 (1993)

In the Matter of the Compensation of
TERESA A. SARTORIO, Claimant
 WCB Case No. 92-09958
ORDER ON REVIEW
 Terry & Wren, Claimant Attorneys
 Randolph B. Harris (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Peterson's order that upheld the SAIF Corporation's denial of claimant's low back injury claim. Claimant also moves for remand for admission of additional evidence. 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.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant moves for remand in order to admit the deposition transcript of claimant's current treating physician, Dr. Kwasman, orthopedic surgeon. We consider the proffered evidence only to determine whether remand is appropriate.

Prior to hearing, Dr. Kwasman opined that claimant's symptoms were due to a previous injury claimant sustained in November 1991 and did not represent a new injury. (Ex. 34-2). On April 6, 1993, following the issuance of the Referee's order and claimant's filing of her request for review, Dr. Kwasman was deposed and stated that claimant's symptoms were caused by a May 1992 injury rather than the November 1991 event. Dr. Kwasman based the change in his opinion on the recent receipt of a March 17, 1992 report from Dr. Grossenbacher, orthopedic surgeon and claimant's treating physician for the November 1991 injury.

Claimant asserts that the deposition transcript "raises a substantial question whether Dr. Kwasman based his opinion on complete information". In addition, claimant asserts that her attorney was unable to ascertain "the need for a deposition at hearing, as discussions with [claimant] indicated to [claimant's attorney] that Dr. Kwasman did have complete medical reports when he rendered his original opinion."

Under ORS 656.295(5), the Board may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1982). 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).

Claimant has not established a compelling reason warranting remand in this case. In particular, although the deposition transcript itself was not available at the time of hearing, there is no dispute that the March 17, 1992 report by Dr. Grossenbacher was available before hearing. Furthermore, the fact that Dr. Kwasman did not review Dr. Grossenbacher's report when he rendered his opinion was ascertainable at the time of hearing. Therefore, before and at the time of hearing, claimant's attorney was not prevented from supplying the missing report to Dr. Kwasman, learning whether it affected his opinion, and making arrangements to take his deposition. Consequently, lacking a compelling reason, we do not grant claimant's motion for remand.

Compensability

Claimant challenges SAIF's denial of an accidental injury based on a May 1992 event. The Referee upheld the denial, finding that the medical evidence showed only that claimant exacerbated a prior injury.

Claimant is a ballet dancer who has an accepted lumbar strain based on a November 1991 work incident. In March 1992, her treating physician, Dr. Grossenbacher, stated that claimant's strain had resolved, he anticipated no residual disability, and claimant was released to regular work. (Ex. 14).

In May 1992, during a rehearsal, claimant again experienced back pain. She was treated by Dr. Beck, sports medicine specialist, who diagnosed lumbosacral sprain/strain, spondylolisthesis, and congenital scoliosis. (Ex. 20). With regard to causation, in response to SAIF's claims examiner, Dr. Beck first reported that the May 1992 event was a "new injury, separate from that incurred November 22, 1991." (Ex. 27-1). Dr. Beck based his opinion on Dr. Grossenbacher's report that claimant's prior back strain had fully resolved. (Id.)

In a subsequent report, however, again in response to SAIF's claims examiner, Dr. Beck stated that claimant's symptoms were related to the November 1991 injury. (Ex. 30). Dr. Beck based this opinion on his belief that the prior injury had not fully resolved because claimant reported that the symptoms she experienced in May 1992 were the same as those in November 1991 and she did not receive physical therapy for the November 1991 injury. (Id.)

However, Dr. Beck then reported to claimant's attorney that, assuming that claimant was medically stationary without impairment in March 1992, "the 5/05/92 injury was the major contributing cause of the acute lumbar sprain/strain and/or worsening of lumbar spondylolisthesis considered at that time." (Ex. 36-2). Dr. Beck reiterated this opinion during a subsequent deposition, although noting that claimant statistically was predisposed to reinjury following the November 1991 injury. (Ex. 38-25).

Dr. Kwasman began treating claimant in September 1992. Based on an "essentially negative physical examination and normal x-rays," Dr. Kwasman disagreed with the diagnosis of spondylolisthesis, stating that claimant "certainly doesn't have any symptoms at this time of cervical disease. She does have a congenital, anatomical variation in the facet joints of L5-S1. However, this is not related to injury." (Ex. 34-2). Dr. Kwasman further reported that claimant's symptoms in May 1992 were "just a low back strain with an aggravation in May", therefore relating her need for treatment to the November 1991 injury. (Id., Ex. 37).

Finally, Dr. Duff, orthopedist, performed a record review at SAIF's request. Dr. Duff reported that "[a]t some point in time one can expect the spondylolisthesis to become symptomatic, particularly with vigorous physical activity as appears to be the case here." Dr. Duff found that the spondylolisthesis, in conjunction with the scoliosis, were "the major cause of [claimant's] current condition and need for treatment and not her specific employment activities at Oregon Ballet Theatre in May 1992." (Ex. 29-2).

First, we find that Dr. Duff's opinion is not persuasive. In attributing claimant's symptoms to a combination of her spondylolisthesis and scoliosis, it appears that Dr. Duff, at least in part, relied upon Dr. Beck's diagnoses of such conditions. However, subsequent to Dr. Duff's report, Dr. Kwasman found no evidence of spondylolisthesis or scoliosis. Because it appears that Dr. Duff did not review Dr. Kwasman's reports or view an x-ray to verify the existence of spondylolisthesis and scoliosis, we find that Dr. Duff's opinion was based on an incomplete record and, consequently, is not reliable. See Somers v. SAIF, 77 Or App 259 (1986).

Furthermore, we agree with the Referee that Dr. Beck provided inconsistent opinions. Although he was asked during his deposition about the inconsistency, Dr. Beck did not provide an adequate explanation. Therefore, we also give his opinion little or no weight. See id.

Finally, we find no persuasive reason not to defer to the opinion of Dr. Kwasman. See Weiland v. SAIF, 64 Or App 810 (1983). According to Dr. Kwasman, claimant did not sustain a "new injury" in May 1992 but instead experienced an exacerbation of her November 1991 injury. Therefore, we agree with the Referee that claimant did not prove a "new compensable injury." See Peggy Holmes, 45 Van Natta 278, 279 (1993) (applying responsibility determination provisions of ORS 656.308 to determinations as to whether a claim should be processed as a "new compensable injury," as opposed to an aggravation, if a later injury for the same employer occurs). However, we further note that, to the extent that claimant's symptoms were related to her November 1991 compensable injury, her medical treatment is compensable. See ORS 656.245(1).

ORDER

The Referee's order dated February 17, 1993 is affirmed.

November 9, 1993

Cite as 45 Van Natta 2176 (1993)

In the Matter of the Compensation of
LINDA M. SCHEUFFELE, Claimant
WCB Case No. 92-05559
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Scott Terrall & Associates, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of that portion of Referee Tenenbaum's order that set aside its denial of claimant's occupational disease claim for bilateral tendinitis and right carpal tunnel syndrome conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant bears the burden of proving that her employment activities were the major contributing cause of her tendinitis and carpal tunnel diseases or their 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).

It is undisputed that claimant's conditions did not preexist her employment and that her work for the employer involved repetitive activities of a type expected to cause such conditions. In addition, the record establishes that repetitive activities, generally, are the likely major contributing causes of these problems (see Ex. 52-23). See ORS 656.801(c). Thus, the question is whether claimant's repetitive work activities contribute more to the causation of her disease(s) than all other causes combined. See ORS 656.802(2); David K. Boyer, supra.

The medical evidence concerning causation is divided. Dr. Barnhouse, former attending physician, believed that claimant's work was not the major contributing cause of her wrist and forearm problems. (Exs. 41, 44). Dr. Rabie, current attending physician, was unable to say that claimant's work activities were the major contributing cause of her problems, considering off-work causes/contributions and the insufficiency of information necessary to answer the causation question. Dr. Corrigan, consulting orthopedist, opined that claimant's work caused her conditions, based on claimant's history.

The Referee found that claimant was an unreliable witness, based on inconsistencies in the record. Specifically, the Referee noted that claimant was imprecise with dates and "understated" or "minimalized" her off-work activities with her horses. This characterization is not disputed on review. Nonetheless, the Referee concluded that claimant carried her burden, based on Corrigan's opinion, the timing of claimant's worsened symptoms, and consideration of claimant's work and off-work activities. We disagree.

Considering the number of potential causes for claimant's upper extremity problems, the causation issue is a complex medical question which must be resolved by medical evidence. See Madewell v. Salvation Army, 49 Or App 713, 717 (1980). Circumstantial evidence is not sufficient. Compare Barnett v. SAIF, 122 Or App 279 (1993).

As we have stated, claimant's unreliability as a historian is not disputed. Considering that unreliability, we are unable to determine the extent of claimant's off-work activities, particularly horse grooming. Moreover, we find that Dr. Corrigan's opinion lacks persuasive force because it is based largely on claimant's reporting. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). There is no other medical evidence which would support the requisite burden of proof for compensability. Accordingly, in the absence of persuasive medical evidence indicating that claimant's work activities (when compared with her off-work activities) were the major contributing cause of her upper extremity problems, we are unable to conclude that claimant has carried her burden under ORS 656.802(1) and (2).

ORDER

The Referee's order dated March 15, 1993 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's \$2,000 assessed attorney fee award is reversed.

November 9, 1993

Cite as 45 Van Natta 2177 (1993)

In the Matter of the Compensation of
WILLIAM A. TAYLOR, Claimant
WCB Case No. 92-13443
ORDER ON REVIEW
Olson & Rowell, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order that: (1) awarded claimant additional temporary disability benefits; and (2) assessed a penalty and attorney fee for SAIF's untimely payment of temporary disability compensation. On review, the issues are entitlement to temporary disability benefits, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the first sentence in the second paragraph on page two. In addition, we supplement with the following findings.

On September 14, 1992, SAIF paid claimant temporary disability benefits due through September 15, 1992. On September 28, 1992, SAIF paid claimant temporary disability benefits due through September 22, 1992. On October 12, 1992, SAIF paid claimant temporary disability benefits due through October 6, 1992. On October 26, 1992, SAIF paid claimant temporary disability benefits due through October 20, 1992. On November 9, 1992, SAIF paid claimant temporary disability benefits due through November 3, 1992.

SAIF has timely paid all temporary disability due claimant.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The Referee concluded that this case "involves a 'grace period' allegedly authorized by OAR 436-60-150(5)." Finding that no such "grace period" exists under the administrative rule, the Referee ordered SAIF to pay claimant seven days of time loss benefits it had "withheld." On review, SAIF does not contend that it is entitled to a "grace period." Rather, SAIF contends that it has strictly complied with OAR 436-60-150(5) (WCD Admin. Order 1-1992) and timely paid claimant all benefits due. We agree.

OAR 436-60-150(5) provides, in pertinent part, that "[t]emporary disability shall be paid to within seven (7) days of the date of payment at least once each 14 days." Thus, to satisfy the requirements of the administrative rule, an insurer must meet two time criteria. First, the insurer must pay the benefits "at least once each 14 days." Second, each payment must "be paid to within seven (7) days of the date of payment." See Arlene Marshall, 40 Van Natta 1828 (1988) (former OAR 436-60-150(4) (renumbered OAR 436-60-150(5))) requires that all temporary disability payments be paid once each 14 days, and that each payment include benefits payable for a period ending within seven days before the date of payment).

SAIF's payment of temporary disability benefits to claimant complied with both requirements of the rule. SAIF paid claimant temporary disability benefits due through August 28, 1992, on August 27, 1992; due through September 15, 1992, on September 14, 1992; due through September 22, 1992, on September 28, 1992; due through October 6, 1992, on October 12, 1992; due through October 20, 1992, on October 26, 1992; and due through November 3, 1992, on November 9, 1992. Thus, all payments were paid within 14 days of the date of the prior payment. Further, all payments due were paid to within six days of the date of the payment. OAR 436-60-150(5).

Consequently, we find that SAIF has not withheld any time loss benefits from claimant. The Referee's award of temporary disability benefits is reversed.

In light of our finding that claimant is not entitled to additional temporary disability benefits, the Referee's award of an out-of-compensation attorney fee is also reversed.

Penalties and Attorney Fees

The Board has consistently refused to assess a penalty where the insurer has complied with the requirements of this administrative rule. See William L. Bassett, 43 Van Natta 994 (1990); Stanley R. Libel, 42 Van Natta 2576 (1990) (no penalty due because the payment of benefits for a period ending seven days before the date of payment was in accordance with former OAR 436-60-150(4) (renumbered OAR 436-60-150(5))).

As we have found herein, all SAIF's payments were made at least once each 14 days, and included benefits due for a period ending no less than seven days before the date of payment. Thus, all SAIF's payments were timely and complied with the requirements of OAR 436-60-150(5). Accordingly, SAIF has not resisted the payment of compensation, and no ORS 656.262(10)(a) penalty is due. The Referee's award of penalties and related attorney fees for unreasonable claim processing is reversed. See William L. Bassett, *supra*; Stanley R. Libel, *supra*.

ORDER

The Referee's order dated February 8, 1993, as reconsidered March 19, 1993, is reversed. The Referee's award of a penalty and related attorney fee is also reversed.

In the Matter of the Compensation of
RAYMOND B. TERRELL, Claimant
WCB Case No. 92-08260
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Lundeen, et al., Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of Referee Schultz' order that: (1) awarded claimant temporary disability benefits; and (2) directed the insurer to process claimant's claim as a disabling injury to closure. The insurer also moves to strike that portion of claimant's respondent's brief that contends that the insurer's processing and closure of his claim was improper. On review, the issue is claim processing. We deny the motion to strike and reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant did not timely object to the the insurer's classification of his claim as nondisabling. Accordingly, the Referee concluded that claimant must make his claim (that his injury is disabling rather than nondisabling) as a claim for aggravation. Finding that the Hearings Division has jurisdiction over the aggravation claim, the Referee then reviewed the merits of the aggravation claim and found the claim to be compensable.

Motion to Strike

The insurer moves to strike the portion of claimant's respondent's brief that contends that the insurer improperly processed his objection to the nondisabling classification of his claim. The insurer's classification and processing of the claim was raised as an issue at hearing and was specifically addressed by the Referee. The insurer argues, however, that the issue is not properly before the Board because it was not raised in the insurer's appellant's brief, and claimant did not cross-request review of that issue. We disagree. The Board has de novo review and is free to make any disposition of the case it deems appropriate, including reaching issues not raised by a cross-request for review. See ORS 656.295(5); Destael v. Nicolai Co., 80 Or App 596, 600 (1986); Neely v. SAIF, 43 Or App 319, 323, rev den 288 Or 493 (1979). Accordingly, the insurer's motion is denied.

Claim Classification

On review, claimant contends that the Referee erred in finding that he did not timely object to the classification of his claim as nondisabling. We agree.

When a carrier accepts a claim for an industrial injury and classifies the claim as nondisabling, the injured worker has the statutory right to challenge the nondisabling classification. ORS 656.262(6)(c) provides, in pertinent part:

"The notice of acceptance shall:

"(c) inform the claimant * * * 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 supplied.)

ORS 656.268(11) provides, in part:

"Upon receipt of a request made pursuant to ORS 656.262 * * *, the Department of Insurance and Finance shall determine whether the claim is disabling or nondisabling."

As contemplated by ORS 656.262(6)(c) and 656.268(11), the claimant has one year from the date of injury to request the Department's review of a carrier's classification of his claim as nondisabling. See DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993).

Here, claimant filed a claim for chest pain suffered as a result of lifting at work on June 28, 1991. By Notice of Claim Acceptance dated September 23, 1991, the insurer accepted the claim for a "left chest strain" and classified the claim as a nondisabling injury. Claimant was subsequently diagnosed with a cervical spine injury with radiculopathy. On January 21, 1992, the insurer issued a "Notice of Closure" which purported to close claimant's claim with no award of temporary disability or permanent disability benefits. No copy of the closure notice was sent to the Department. On January 31, 1992, the insurer issued a second Notice of Claim Acceptance which accepted a "C5-6 and 7 strain with radiculopathy into the chest and left arm and shoulder." Again, the claim was classified as nondisabling.

On April 20, 1992, claimant filed a request for reconsideration of the Notice of Closure with the Appellate Unit of the Department's Workers' Compensation Division. Using the Department's "Request for Reconsideration" form, claimant checked boxes indicating his objection to the insurer's awards of temporary disability and permanent disability benefits. (Ex. 15).

On April 23, 1992, the Appellate Unit issued an "Order Denying Request for Mandatory Reconsideration." Stating that a notice of closure had not been filed with the Department and that the claim remained in accepted nondisabling status, the Appellate Unit concluded that it lacked jurisdiction. (Ex. 16). Claimant then filed a request for hearing regarding the Notice of Closure.

In finding that claimant did not timely object to the classification of his claim as nondisabling, the Referee reasoned that, although claimant filed the request for reconsideration with the Department within one year after the date of injury, he did not specifically request the Department's Evaluation Section to reclassify the claim as disabling. The Referee further reasoned that the reconsideration request could not be treated as a request for reclassification because it was misdirected to the Appellate Unit. We disagree with the Referee's analysis.

In his request for reconsideration of the Notice of Closure, claimant asserted his entitlement to temporary disability and permanent disability benefits. Inasmuch as the claim had been classified as nondisabling (i.e., without entitlement to disability compensation), claimant's reconsideration request indicated, at a minimum, his disagreement with the classification of the claim. Thus, while claimant did not specifically request claim reclassification, we find that, under the circumstances of this case (where the request is made to the Department within one year from the date of injury and where the claim has been classified as nondisabling, but the carrier has also issued a Notice of Closure), such a request was, in fact, made to the Department.

The rules provide that, upon receipt of a reclassification request, the Department's Evaluation Section shall review the nondisabling classification of the claim. See OAR 436-30-045(2), (4). Claimant's request was made to the Appellate Unit, rather than the Evaluation Section. Nevertheless, upon recognizing the classification dispute, the Appellate Unit should have forwarded claimant's request to the Evaluation Section for processing. Neither the statutes nor the administrative rules prohibit the Appellate Unit from taking such an action. Indeed, there is no mandatory procedure for requesting claim reclassification by the Department. See ORS 656.268(11), OAR 436-30-045. The only requirement is that the reclassification request be submitted to the Department within one year from the date of injury. The "Department" means the Department of Insurance and Finance (now Department of Consumer and Business Services). See ORS 656.005(9). Claimant complied with that requirement in this case. Hence, we conclude that claimant timely requested the Department to reclassify his claim.

We have previously held that a determination by the Department as to the disabling nature of the claim is a condition precedent to a request for hearing on that issue. See Randy G. Fisher, 42 Van Natta 635 (1990). As we stated above, claimant effectively requested claim reclassification by the Department. Although the Department declined to reach the merits of the request on the basis that it lacked jurisdiction, we find that its decision constitutes an order denying a request for reclassification. See Karen S. McKillop, 44 Van Natta 2473, 2475 (1992) (citing Forelaws on Board v. Energy Facility Siting Council, 303 Or 541 (1987)). Because claimant requested a hearing from that order, we conclude that the Referee had jurisdiction of claimant's reclassification request.

Turning to the merits of claimant's reclassification request, we find that claimant has met his burden of proving that his accepted injury claim is disabling. On October 24, 1991, Dr. Brett, the attending physician, reported that claimant had severe left C7 radiculopathy and pain. While noting that claimant had preexisting degenerative changes at C5-6, Dr. Brett opined that the accepted injury is the major contributing cause of his condition and need for treatment. (Ex. 6). Dr. Donahoo, who reviewed the medical records at the insurer's request, also opined that the accepted injury is the major contributing cause of claimant's need for treatment. (Ex. 9A). Based on these reports, we find that claimant's cervical condition and need for treatment were compensably related to the accepted injury. See ORS 656.005(7)(a)(B).

Dr. Brett initially found claimant medically stationary without permanent disability on January 15, 1992. (Ex. 12). However, he later changed his opinion after a follow-up examination on April 17, 1992. At that time, claimant complained of persistent cervical symptoms radiating to his left arm. Dr. Brett opined that claimant is medically stationary with mild permanent disability. He restricted claimant from lifting or carrying more than 35 pounds, performing any repetitive or heavy exertion with the upper extremities and maintaining any awkward or stationary neck positions. (Ex. 15A). Based on Dr. Brett's permanent restrictions, we find that claimant will be entitled to a permanent disability award under the standards for rating permanent disability. Therefore, we conclude that claimant's accepted injury is disabling. See OAR 436-30-045(5)(b).

Finally, we reject the insurer's argument that claimant has withdrawn from the work force and, therefore, is not entitled to temporary disability benefits. Like the Referee, we find that although claimant "retired" from his job with the employer, he did not withdraw from the work force. During an independent medical examination on November 21, 1991, claimant stated his intention to continue working at least part-time, if he can become more comfortable. (Ex. 10-3). In March 1992, claimant did, in fact, return to work for a fruit company. (Ex. 17). Accordingly, we find that claimant remains in the work force. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).

Attorney Fees

Inasmuch as we found that claimant timely objected to the nondisabling classification of his claim, he was not required to make his claim (that his injury is disabling) as a claim for aggravation. It follows, therefore, that there was no aggravation claim for the insurer to deny. Absent an aggravation denial, we conclude that claimant did not prevail against a denial of a claim for compensation so as to be entitled to an assessed attorney fee under ORS 656.386(1). Rather, inasmuch as claimant has obtained additional disability compensation, his counsel's attorney fee must be paid out of his increased compensation, up to a maximum of \$1,050. See ORS 656.386(2), OAR 438-15-045; James R. Jones, Jr., 42 Van Natta 238 (1990). Therefore, we reverse the Referee's assessed fee award and affirm the Referee's approval of an out-of-compensation fee.

Finally, claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the claim classification issue is \$1,200, 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 March 8, 1993 is affirmed in part and reversed in part. That portion of the order that awarded claimant an assessed attorney fee of \$1,500 is reversed. The remainder of the order 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
ALBERT F. PALMER, Claimant
Own Motion No. 93-0531M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable pelvis and low back injury. Claimant's aggravation rights expired on August 31, 1977. Although SAIF agrees that the proposed lumbar surgery is compensable, it opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of disability.

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 an August 5, 1993 letter, Dr. Kitchel, consulting physician, stated that "[a]t this point I believe [claimant] does have severe spinal stenosis and will require lumbar laminectomy for decompression." SAIF concedes that the proposed surgery is compensable. Therefore, we conclude that, as of August 5, 1993, claimant sustained a worsening of his compensable low back condition 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).

Claimant did not respond to SAIF's letter requesting information regarding whether claimant remained in the work force. Claimant has the burden of proof on this issue.

Parenthetically, we note that claimant is receiving permanent total disability benefits on a subsequent injury claim. Claimant is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984).

Accordingly, claimant's request for temporary disability compensation is denied. 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
HEATHER I. SMITH, Claimant
WCB Case No. 91-05062
ORDER OF ABATEMENT
Francesconi & Busch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

On October 28, 1993, we issued an Order on Remand which reduced claimant's unscheduled permanent disability award from 13 percent (41.6 degrees), as granted by a Referee's order, to 8 percent (25.6 degrees). Claimant moves for reconsideration, contending that she is entitled to an attorney fee award for "finally prevailing" before the Board and the Court of Appeals.

In order to further consider claimant's request, we withdraw our October 28, 1993 order. In addition, we grant each party an opportunity to submit their respective positions. Specifically, the self-insured employer's supplemental response shall be due 14 days from the date of this order. Claimant's supplemental reply shall be due 14 days from the date of mailing of the employer's response. Thereafter, we shall take this matter under advisement. In submitting their respective positions, the parties are requested to discuss the effect, if any, the Board's holding in Cleo I. Beswick, 43 Van Natta 876 (1991), on recon 43 Van Natta 1314 (1991), has on this dispute.

IT IS SO ORDERED.

November 16, 1993

Cite as 45 Van Natta 2183 (1993)

In the Matter of the Compensation of
MITCHELL C. BEEM, Claimant
WCB Case No. 92-04596
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Mills' order which: (1) affirmed that portion of a Determination Order which awarded no unscheduled permanent disability for claimant's back condition; (2) modified the Determination Order by setting aside the temporary disability benefits awarded after August 1989; and (3) authorized an offset for overpayment of temporary disability benefits in the amount of \$3,410.14. On review, the issues are extent of unscheduled permanent disability, temporary disability benefits, and offset. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

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

We correct the second paragraph of the Referee's findings of fact, on page 1 of his order, to indicate that Dr. McCrory's report was in early 1989, not 1988. (Ex. 6). We correct the first paragraph on page 2 of the order to reflect that claimant returned to work in August 1989, not 1988.

Dr. Feinberg, chiropractor, became claimant's attending physician in October 1989. (Ex. 7).

Claimant was declared medically stationary on June 26, 1990 with respect to his October 1988 back condition. (Ex. 17).

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

Claimant contends that he is entitled to 5 percent impairment due to a chronic condition which limits repetitive use of his back. Former OAR 436-35-320(4) (WCD Admin. Order 7-1988, effective January 1, 1989). The Referee found that the medical evidence fails to establish that claimant has a chronic condition resulting from his 1988 injury which limits repetitive use of his back. See William K. Nesvold, 43 Van Natta 2767 (1991). We agree.

We agree with the Referee's finding that, although Dr. Feinberg opined that the supportive ligaments in claimant's back have been permanently weakened as a result of the 1988 injury, it is unclear whether Dr. Feinberg attributed any resulting limitation on repetitive use of the back to the 1988 injury, as distinguished from a 1990 back injury. (See Ex. 12A-45 to -46; 12A-51 to -52; Exs. 24, 24A). Therefore, even if Dr. Feinberg's findings concerning impairment could be considered, those findings do not support a permanent disability award as a result of claimant's compensable 1988 back injury.¹

Moreover, we note that independent medical examiners Dr. Dinneen, orthopedist, and Dr. Simpson, chiropractor, found in a September 1991 examination that claimant had no permanent impairment as a result of the 1988 injury. (Ex. 13-3). In addition, orthopedist Dr. Fuller found, in a March 6, 1992 examination, no objective evidence of impairment and no chronic medical condition which limits repetitive use of claimant's back. (Ex. 21-4). Therefore, in light of the ambiguity of Dr. Feinberg's opinion and the opinions of independent medical examiners who found no permanent impairment, we find that claimant failed to establish by a preponderance of the medical evidence that he has impairment due to a chronic condition limiting repetitive use, attributable to his 1988 injury.

Since claimant has no measurable impairment under the standards, he is not entitled to an unscheduled permanent disability award. See former OAR 436-35-320(1). Accordingly, we affirm the Determination Order insofar as it awarded no unscheduled permanent disability.

Temporary Disability Benefits

The Referee held that claimant was not entitled to any temporary disability benefits after August 1989, based on the following findings: (1) claimant was released to regular duty by his attending physician; (2) claimant returned to regular duty in August 1989, albeit not to the same job he had prior to his injury; (3) he voluntarily left work after two days, without a medical release; and (4) there is no subsequent medical release from work prior to claimant's becoming medically stationary on June 26, 1990.

The October 1991 Determination Order awarded claimant temporary total disability from the date of injury until January 12, 1989 and temporary partial disability benefits from January 13, 1989 until June 26, 1990, the medically stationary date. (Ex. 17). Claimant contends that the temporary disability benefits awarded by the Determination Order should be affirmed, because he was released only to modified work, and because he left work in August 1989 due to his compensable injury. We agree.

A claimant's substantive entitlement to temporary disability benefits is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Thus, if a claimant leaves work as a result of his compensable injury, he is entitled to temporary disability benefits. See Tom D. Husted, 44 Van Natta 510 (1992). Unlike a claimant's procedural entitlement to temporary disability benefits during an open claim, substantive entitlement to such benefits is not contingent upon authorization of time loss by the attending physician. Esther C. Albertson, 44 Van Natta 2058 (1992).

Here, claimant's then treating chiropractor, Dr. McCrory, released him for "full duty" work effective January 13, 1989, with occasional lifting limited to no more than 75 pounds. (Ex. 6). Two weeks later, however, Dr. McCrory wrote to the insurer that claimant had been released for modified work effective January 13, 1989, with a lifting restriction of 75 pounds occasionally. (Ex. 6B). Dr. McCrory explained his concern that claimant's at-injury job, which required lifting 40-pound cases and twisting to place them on a conveyor in a quick, repetitive manner about 600 times each work shift, would place claimant at a higher risk for re-injury. (Id).

¹ Effective July 1, 1990, only the attending physician at the time of claim closure can make impairment findings. ORS 656.005(12)(b)(B); ORS 656.245(3)(b)(B); see Dennis Connor, 43 Van Natta 2799 (1991). Dr. Feinberg became claimant's attending physician in October 1989 and continued treating him until February 1991. Dr. Feinberg, a chiropractor, treated claimant at a frequency of four times per month from July 20, 1990 until February 7, 1991. (Ex. 12A-4, 12A-10). Under such circumstances, Dr. Feinberg likely did not qualify as an attending physician under ORS 656.005(5)(12)(b)(B) by the time of claim closure in October 1991, since his treatment exceeded 30 days or 12 visits from the date of the first visit on the claim.

Dr. Fechtel, in an independent chiropractic examination on May 20, 1989, found that claimant was not medically stationary, that his dorsolumbar sprain had "faded into a myofascial pain syndrome," and that his subjective complaints were consistent with objective findings. (Ex. 6A-4 to -5). He recommended work hardening and an exercise program to complete claimant's rehabilitation. (Ex. 6A-4). In August 1989, Dr. McCrory agreed that work hardening may benefit claimant. (Ex. 6C-1).

Claimant returned to work in August 1989, but not to his previous job. Claimant testified that his at-injury job involved too much strain on his back. (Tr. 14). Instead, he returned to a job checking seals on lids, which required repetitively reaching out with both arms to check the seals on approximately 8,000 cans per shift. He performed the job seated. (Tr. 12-13). Claimant testified that he experienced burning in his back from the repetitive movements. (Tr. 13). He left the job after two days because he could not physically continue the work. (Tr. 14). Claimant contacted Dr. McCrory, who advised him to "try to hang in there," but claimant continued working only one more hour. (Tr. 20). After unsuccessfully trying to contact Dr. McCrory again, claimant left work. (Id.)

Dr. McCrory saw claimant the day he left work in mid-August 1989, as well as the two previous days. (Ex. 6D). He noted that claimant experienced increased burning-type spinal pain working on the conveyor line. He provided chiropractic treatment and ordered a TENS unit; however, he did not specifically release claimant from work. (See id.)

In a report to the insurer dated August 15, 1989, Dr. McCrory advised that claimant had "significant increased spinal pain while working" for the employer, where he had returned to work on August 14, 1989. (Ex. 6C-1). He noted that claimant would be seen again on August 15, 1989 due to his complaints of "rather significant discomfort." (Id.) Dr. McCrory also noted that claimant should be able to perform "medium heavy work," but agreed with Dr. Fechtel that work hardening may be beneficial. (Id.)

After claimant left work in August 1989, he moved to another city and began treating with chiropractor Dr. Feinberg in October 1989. (Tr. 14-15). He did not return to work with the at-injury employer, but he worked odd jobs for a temporary agency prior to being declared medically stationary in June 1990. (Tr. 15).

In an independent medical examination in January 1990, Drs. Gritzka and Burke found that claimant was not medically stationary and should be released to only sedentary or light work. (Ex. 7A-5). They further found that claimant's subjective complaints were generally consistent with objective findings, with a "mild functional component." (Id.) Dr. Feinberg concurred with this report. (Ex. 7B).

Dr. Feinberg declared claimant to be medically stationary on June 26, 1990.

In September 1990, Dr. McCrory concurred with the insurer's letter, which stated that claimant had been released to his regular job effective January 13, 1989. (Ex. 11). The letter explains that, although Dr. McCrory initially released claimant to modified work, he changed the release to regular work on May 15, 1989 (effective retroactive to January 13, 1989) after claimant advised him that "his regular work was less problematical for him." (Id.)

The insurer urges us to rely on Dr. McCrory's September 1990 statement in support of its contention that claimant was released to regular work in 1989. We do not find this statement persuasive. Dr. McCrory's explanation that claimant's regular work was "less problematical" for him is not consistent with his report of May 26, 1989, when he was concerned that claimant's regular job may place him at a greater risk of re-injury. (See Ex. 6B.) The September 1990 statement does not take into account Dr. McCrory's May 26, 1989 report where he released claimant for modified work, nor is the statement consistent with claimant's testimony that his at-injury job involved too much strain on his back. (See Tr. 14.) Moreover, the September 1990 report came over a year after Dr. McCrory last treated claimant. For these reasons, we give little weight to Dr. McCrory's September 1990 statement regarding the nature of claimant's work release.

After our review of the record, we find that the preponderance of evidence establishes that claimant was released by Dr. McCrory to modified work, that he returned to modified work in August 1989, and that he left that job due to his compensable injury. In addition, we find that claimant remained at least partially disabled from working until he became medically stationary in June 1990.

Claimant concedes he was only partially disabled after August 1989, since he does not contest the temporary disability award made by the October 1991 Determination Order, which included temporary partial disability benefits after January 12, 1989. The insurer, on the other hand, contends that claimant voluntarily left work in August 1989 without medical authorization and that he remained capable of performing his regular work.

However, we have found that claimant left work due to his compensable injury. In addition, we have found that claimant returned to modified work, not to his regular job. Furthermore, during the period between August 1989 and June 26, 1990, the only medical evidence concerning claimant's ability to work is the independent medical examination of Drs. Gritzka and Burke, who found that claimant should be performing only sedentary to light work. Dr. Feinberg, the physician who had most recently been treating claimant, concurred in this report. We find no persuasive contrary medical evidence concerning claimant's ability to work during this period. Accordingly, we find that claimant remained partially disabled from working after August 1989, until he was declared medically stationary in June 1990. Therefore, we affirm the Determination Order with respect to the award of temporary disability benefits.

Offset

The Referee authorized an offset for overpayment of temporary disability benefits in the amount of \$3,410.14, based on his finding that claimant was not entitled to temporary disability benefits after August 1989. Because we have reinstated and affirmed the award of temporary disability benefits made by the Determination Order, we modify the offset authorization.

Claimant concedes that he is not entitled to temporary disability benefits after June 26, 1990, the date he became medically stationary. See Lebanon Plywood v. Seiber, *supra*. Accordingly, we authorize an offset for temporary disability benefits paid for any period after June 26, 1990, to be offset against future awards of permanent disability on this claim. ORS 656.268(13).

Attorney Fee

As discussed above, we have reversed that portion of the Referee's order which found claimant not entitled to temporary disability benefits after August 1989 and reinstated the temporary disability award made in the Determination Order. Therefore, as a result of this order, claimant's temporary disability compensation has been effectively increased, in that he has been found to be substantively entitled to temporary disability benefits from August 11, 1989 until June 26, 1990, less time worked.

Claimant's attorney is entitled to receive an attorney fee for his efforts in securing claimant's substantive entitlement to such benefits. See ORS 656.386(2); Stokes R. Crotts, Jr., 42 Van Natta 1666 (1990). Furthermore, the attorney fee is not subject to any offset based on prior overpayment of compensation to claimant. OAR 438-15-085(2); Judy A. Jacobson, 44 Van Natta 2393, on recon 44 Van Natta 2450, 2451 (1992). Accordingly, claimant's attorney is awarded an approved fee of 25 percent of the temporary disability benefits paid between August 11, 1989 and June 26, 1990, not to exceed \$3,800. OAR 438-15-055(1). This fee should be paid by the insurer directly to claimant's attorney.

To the extent claimant has already been paid the benefits awarded by this order, claimant is not entitled to receive additional payment. Therefore, our order may create an overpayment of compensation, equal to the attorney fee awarded by this order. Should that circumstance exist, the insurer is further authorized to recover the overpayment created by this order against claimant's future awards of permanent disability. See Judy A. Jacobson, *supra*, 44 Van Natta at 2451.

ORDER

The Referee's order dated October 16, 1992 is affirmed in part, reversed in part, and modified in part. That portion of the Referee's order which modified the Determination Order by setting aside the award of temporary disability benefits after August 1989 is reversed. The October 1991 Determination Order, which awarded temporary disability benefits from the date of injury until June 26, 1990, is reinstated and affirmed. That portion of the Referee's order which authorized an offset in the amount of \$3,410.14 is modified. Instead, the insurer is authorized to offset any temporary disability benefits paid for the period after June 26, 1990, to be offset against future awards of permanent disability on this claim. Claimant's attorney is awarded an approved fee of 25 percent of the temporary disability benefits paid between August 11, 1989 and June 26, 1990, not to exceed \$3,800. The insurer is authorized to recover the overpayment created by this order, if any, against future awards of permanent disability on this claim. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
PETER BRITZ, Claimant
WCB Case No. 92-09803
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Barber's order that affirmed the Director's Proposed and Final Order Concerning a Bona Fide Medical Services Dispute. On review, the issue is jurisdiction under ORS 656.327. We remand.

Claimant has an accepted claim for a back condition. Dr. Grewe, claimant's treating neurosurgeon, requested authorization to perform a laminectomy and removal of discs at T6-7, T7-8 and T8-9. Pursuant to ORS 656.327(1), the insurer requested Director review of the proposed surgery. Diana Mangels, R.N., on behalf of the Director, ordered that the insurer was not required to pay for the proposed surgery, if rendered to claimant.

Claimant requested a hearing. See ORS 656.327(2). The Referee, after reviewing the record, found that substantial evidence supported the Director's order and affirmed. On review, claimant asserts that the Director's order is procedurally invalid because review was conducted by a registered nurse and not supported by substantial evidence. We conclude that we need not address claimant's arguments inasmuch as we hold that the Director did not have jurisdiction to review the medical services dispute pursuant to ORS 656.327.

ORS 656.327(1) provides for review by the Director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services[.]" In Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time Director review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment. Moreover, the court determined that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 466-67.

Here, the dispute pertains to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, supra, the insurer was not entitled to Director review of the proposed surgery under ORS 656.327. Rather, the Hearings Division has jurisdiction to resolve the dispute concerning the proposed surgery. Furthermore, the proceeding before the Referee consisted only of reviewing the Director's findings for substantial evidence. See ORS 656.327(2). Consequently, it is apparent that the parties were presenting their respective positions under an inappropriate standard of review. Considering such a review standard, it is likewise apparent that the evidence was limited to that developed before the Director (since no testimony was offered nor any additional evidence allowed into the record other than that developed before the Director).

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). Given the posture of this case, we find a compelling reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Consequently, we conclude that the record is incompletely and insufficiently developed. See ORS 656.295(5). Therefore, we remand this case to the Hearings Division for further proceedings.

Accordingly, the Referee's order dated January 14, 1993 is vacated. We remand to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall conduct further proceedings in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective position regarding this dispute. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HUGH D. BROWN, Claimant
WCB Case No. 92-13938
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of that portion of Referee Schultz's order which affirmed an Order on Reconsideration that awarded claimant temporary disability for the period from February 18, 1992 through March 24, 1992. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for scalp laceration and multiple lacerations. A Notice of Closure awarded temporary disability for the period from February 18, 1992 through March 21, 1992 and no permanent disability. Claimant requested reconsideration. The Order on Reconsideration awarded additional temporary disability for the period of March 22, 1992 through March 24, 1992. The insurer then denied claimant's headache condition.

At hearing, claimant contended that his headache condition was compensable. He further contended that his claim was prematurely closed and, alternatively, that he was entitled to permanent disability. The Referee rejected all three contentions.

Although the insurer did not challenge the award of temporary disability on reconsideration, at hearing it asserted that claimant was not substantively entitled to the temporary disability awarded by the Notice of Closure. The Referee, on reconsideration, first found that he had jurisdiction to address the temporary disability issue. He further concluded, however, that the insurer was equitably estopped from challenging the temporary disability awarded by the Notice of Closure because the insurer did not disagree with the award during the reconsideration proceeding before the Director. With regard to the additional temporary disability awarded by the Order on Reconsideration, the Referee found that claimant was procedurally entitled to such benefits.

Although he referred to equitable estoppel, the basis for the Referee's conclusion that the insurer was precluded from challenging the temporary disability awarded by the Notice of Closure is more similar to judicial estoppel. That doctrine bars a party from asserting a position that is in conflict with a position asserted in an earlier proceeding when the defending party relies on that position to his detriment. Marshall v. Korpa, 118 Or App 144, 148 (1993). In particular, the Referee found that, "[b]y telling the Appellate Unit that it did not disagree with the Notice of Closure, employer/insurer put claimant in the position of not having to provide the Appellate Unit with any additional medical evidence from the attending physician on the issue of time loss."

We conclude that the doctrine of judicial estoppel is not applicable to this case. First, it is arguable that the insurer took a position at hearing that conflicted with its stance on reconsideration. The insurer did not explicitly assert on reconsideration that the award of temporary disability was correct, instead merely stating that "the Notice of Closure * * * was correctly issued for [claimant's] compensable conditions with no permanent partial disability." (Ex. 25-2).

More importantly, even assuming that the insurer took conflicting positions, there is no proof of detrimental reliance by claimant. For instance, there is no proof, or even assertion, that claimant did not introduce otherwise available evidence regarding his entitlement to temporary disability in reliance on any concession by the insurer regarding that issue. On the contrary, claimant submitted documents from his treating physician showing that he had not been released from work from February 18, 1992, through March 24, 1992. Consequently, having found that judicial estoppel is not applicable, we proceed to the merits. See also Darlene K. Bentley, 45 Van Natta 1719 (1993) (Claimant's failure to contest age, education, and adaptability factors during reconsideration proceeding did not preclude claimant from contesting those factors at subsequent hearing).

A claimant's substantive entitlement to temporary disability is proved by a preponderance of evidence in the entire record showing that the claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Here, only Dr. Jarvis, claimant's treating physician for a period of time, released claimant from work, thus indicating that he was disabled. (Ex. 13). Dr. Jarvis subsequently indicated, however, that claimant's disability was more probably due to his noncompensable mental condition rather than his accidental injury. (Exs. 33, 35). Consequently, we find that claimant failed to prove that any disability was due to his compensable condition and, therefore, he is not entitled to temporary disability for any period of time.

Finally, we note that the Referee concluded that claimant was procedurally entitled to temporary disability for the period from March 21, 1992 through March 24, 1992. Even assuming that claimant was procedurally entitled to such benefits, we have no authority to order such time loss since, having found that claimant had no substantive entitlement, it would create an overpayment. Lebanon Plywood v. Seiber, *supra*.

ORDER

The Referee's order dated March 8, 1993, as reconsidered March 29, 1993, is reversed in part and affirmed in part. Those portions of the April 16, 1992 Notice of Closure and October 19, 1992 Order on Reconsideration awarding temporary disability are reversed. The Referee's attorney fee award is reversed. The remainder of the order is affirmed.

November 16, 1993

Cite as 45 Van Natta 2189 (1993)

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 92-06386
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee Crumme's order that set aside its partial denial of claimant's degenerative lumbar spine condition. Claimant cross-requests review of that portion of the order that declined to award temporary disability benefits from February 20, 1992 through July 21, 1992. On review, the issues are compensability and temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the third sentence in Fact number 10, with the following supplementation.

On April 25, 1989, claimant filed an 801 form, indicating that she had been experiencing low back and abdominal pain since October 11, 1988 as a result of wearing a gunbelt. On May 25, 1989, the employer accepted claimant's condition as a disabling injury on the 801 form.

Dr. Bell, neurologist, began treating claimant on September 15, 1989. He noted a one-year history of low back pain, and suspected lumbar disc disease. Dr. Bell ordered an MRI which confirmed degenerative facet joint disease. Subsequent studies have indicated progression of claimant's degenerative lumbar spine condition.

On April 17, 1992, the employer issued a partial denial of claimant's lumbar spine condition. In its denial letter, the employer stated that "the degenerative changes which were seen at L3-4 and L4-5 diagnosed as lumbar spondylosis with early degenerative changes, were preexisting and not relat[ed] to your injury [of October 11, 1988]."

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on ORS 656.802(1)(c), the Referee found that claimant's work activities were the major contributing cause of a worsening of claimant's underlying degenerative lumbar condition. The Referee, therefore, set aside the employer's partial denial of that condition. We disagree that ORS 656.802(1)(c) is applicable to this case. Instead, we find that the employer's denial constituted an improper "back-up" denial of claimant's current low back condition.

ORS 656.262(6) allows a carrier two years from its good faith acceptance of a claim in which to deny the claim if evidence is obtained which indicates that the claim is not compensable. We have previously recognized that the statute expresses a clear legislative intent to allow "back-up" denials, subject only to four limitations: (1) the insurer accepts the claim in "good faith"; (2) the insurer subsequently obtains evidence that the claim is not compensable after its acceptance; (3) a "back-up" denial issued within two years from the acceptance; and (4) if the denial is contested at hearing, the insurer proves by clear and convincing evidence that the claim is not compensable. See Susie A. Fimbres, 44 Van Natta 1730, 1732 (1992), rev'd on other grounds, Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993).

We find that the employer accepted claimant's degenerative back condition. Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9). However, where an insurer accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988).

Here, on the 801 form, claimant complained of lower back pain attributable to the weight of a gun belt worn during work. She listed the injured body part as lower back (right). The employer "accepted" the claim by checking a box on the 801 form. Following the employer's acceptance, Dr. Bell related claimant's ongoing low back problems to her degenerative condition. Based on this record, we conclude that claimant's current degenerative joint condition is the same condition she had at the time of the employer's May 25, 1989 acceptance. By accepting claimant's low back pain without limitation in 1989, the employer accepted claimant's low back condition, however it is diagnosed.

The employer may, nevertheless, issue a "back-up" denial of the accepted condition, if it does so within two years of its acceptance. ORS 656.262(6). Susie A. Fimbres, supra. In the instant case, however, the employer did not issue its "back-up" denial until April 17, 1992, almost three years after its May 25, 1989 acceptance. Therefore, inasmuch as the employer's denial of claimant's degenerative condition was not issued within the two-year period permitted by statute, the employer is precluded from denying claimant's degenerative condition on the basis that it is due to a preexisting condition. The employer's denial must be set aside.

Temporary Disability

We affirm and adopt the Referee's reasoning and conclusion, with the following comment. Claimant's hearing request, as it concerns this issue, is reinstated. The relief sought is denied.

Attorney Fees

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

ORDER

The Referee's order dated November 25, 1992 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
LYNDA M. ENGLAND, Claimant
WCB Case No. 92-08135
ORDER ON REVIEW (REMANDING)
Schneider, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Neal's order which found that the Director had jurisdiction over the issue of proposed surgery. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant never underwent the surgery proposed by her treating doctor, the self-insured employer's request for Director review was timely pursuant to former OAR 436-10-046(2). Alternatively, the Referee concluded that claimant waived any right to object to a delay in the employer's request when she entered into an agreement with the employer to withdraw the hearing request in order to seek review by the Director.

On review, claimant contends that the Referee misconstrued the Department's rule providing for Director review. Claimant argues that the employer's request for Director review was untimely and, therefore, the Director did not have jurisdiction over this matter.

We need not resolve the issue of whether the employer timely requested Director review, because we conclude that the Director lacks authority to resolve this proposed surgery dispute. We base our conclusion on the following reasoning.

The court has recently concluded that if any party initiates the Director's review of a medical services dispute pursuant to ORS 656.327, then that process is the exclusive means of review. Meyers v. Darigold, Inc., 123 Or App 217 (1993). However, in the subsequent case of Jefferson v. SAIF, 123 Or App 464 (1993), the court specifically addressed whether ORS 656.327 applied in the context of proposed medical treatment.

In Jefferson, the court concluded that the language of ORS 656.327 was clear, and that the statute expressly applied only to treatment that the claimant "is receiving" at the time the Director is asked to review the dispute. The court held that the process of review by the Director did not apply to requests for future medical treatment, and that the Hearings Division and the Board have jurisdiction to resolve disputes concerning proposed medical treatment. Jefferson, supra.

Here, the present case was before the Referee on claimant's appeal from a Proposed and Final Order issued by the Director, whereas in Jefferson, the parties proceeded to a hearing before a referee prior to any order being issued by the Director. Nonetheless, we do not find the procedural posture of this case to be dispositive. In Jefferson, the court held that the claimant was entitled to a hearing on the insurer's "de facto" denial of medical treatment, and the insurer was not entitled to have the dispute reviewed by the Director.

Consequently, we conclude that the Director did not have jurisdiction over this matter. See Jefferson, supra. Moreover, we hold that the Referee had jurisdiction over the employer's "de facto" denial and the issue concerning the propriety of claimant's proposed surgery.

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

The Referee did not reach the merits of the proposed surgery and no testimony was taken from claimant. Furthermore, the proceeding before the Referee consisted only of reviewing the Director's findings for substantial evidence. See ORS 656.327(2). Consequently, it is apparent that the parties were presenting their respective positions under an inappropriate standard of review. Considering such a review standard, it is likewise apparent that the evidence was limited to that developed before the Director (since no testimony was offered nor any additional evidence allowed into the record other than that developed by the Director).

Under the circumstances, we find that the record has been incompletely developed. ORS 656.295(5). Given the posture of this case, we find a compelling reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Therefore, we remand this matter to Referee Neal for further proceedings consistent with this order in any manner that will achieve substantial justice.

ORDER

The Referee's order dated October 30, 1992 is vacated. This matter is remanded to Referee Neal for further proceedings consistent with this order.

November 16, 1993

Cite as 45 Van Natta 2192 (1993)

In the Matter of the Compensation of
ROBERT P. HOLLOWAY, SR., Claimant
 WCB Case No. 92-05993
ORDER OF ABATEMENT
 Tooze, Shenker, et al., Claimant Attorneys
 William E. Brickey (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 18, 1993 order that: (1) set aside SAIF's "de facto" denial of claimant's claim for home health care; (2) awarded an assessed attorney fee of \$3,250 for services at hearing and on review under ORS 656.386(1); and (3) awarded an assessed attorney fee of \$750 for SAIF's unreasonable resistance to the payment of compensation under ORS 656.382(1). On reconsideration, SAIF specifically requests that the Board find that there was no "de facto" denial of home health care, that the issue of home health care services was moot at the time of hearing, and that claimant's attorney is not entitled to attorney fees under either ORS 656.386(1) or 656.382(1).

In order to further consider this matter, we withdraw our October 18, 1993 order. Claimant is granted an opportunity to respond. To be considered, his response must be filed within 14 days from the date of this order. Thereafter, we shall take SAIF's motion under advisement.

IT IS SO ORDERED.

November 16, 1993

Cite as 45 Van Natta 2192 (1993)

In the Matter of the Compensation of
TAMRA M. LEE, Claimant
 WCB Case No. 92-10344
ORDER ON REVIEW
 Royce, et al., Claimant Attorneys
 Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denials of her left knee strain and disability and need for treatment; and (2) declined to assess a penalty or attorney fee for SAIF's allegedly unreasonable failure to provide discovery. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order with the exception of the last two sentences of the sixth paragraph under "Conclusions of Law and Opinion," and with the following comment. After review of the medical evidence, we are persuaded that claimant's torn anterior cruciate ligament (ACL) condition is properly considered a preexisting condition, rather than a predisposition or propensity to injury. Liberty Northwest Insurance Corporation v. Spurgeon, 109 Or App 566 (1991); Tony L. Rivord, 44 Van Natta 1036 (1992).

ORDER

The Referee's order dated March 19, 1993 is affirmed.

November 16, 1993

Cite as 45 Van Natta 2193 (1993)

In the Matter of the Compensation of
DYANE L. LLOYD, Claimant
WCB Case No. 92-12806
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Referee Michael V. Johnson's order that set aside its "de facto" denial of claimant's aggravation claim for her current low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, the employer contends that there has been no claim for an aggravation made in this case. Alternatively, the employer argues that claimant has not established a compensable aggravation. Because we agree with the employer that claimant has failed to prove an aggravation, we do not discuss whether a "claim" for aggravation was made.

To establish a compensable worsening of her unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Following claimant's compensable low back injury in 1987, she was prescribed painkillers and was taken off work for four days. Claimant eventually left her CNA job for reasons unrelated to her injury.

In December 1990 and January 1991, claimant was treated for non-related wrist injury with a subsequent employer. At that time, claimant was primarily treated for arm and neck pain, although claimant's treating doctor, Dr. Bernstein, also noted claimant's complaints of cervical and lumbar pain. Dr. Bernstein diagnosed diffuse cervical, lumbar and occipital spasm.

In May 1992, claimant had complaints of low back pain and was referred for an MRI by Dr. Bernstein. The MRI showed disc bulges at L4-5 and L5-S1.

In September 1992, claimant was examined by Dr. Rabin, D.C. Dr. Rabin found claimant's range of motion findings to be normal, except for rotation and lateral flexion, which were both "within 85 percent of normal." Dr. Rabin diagnosed an "on the job injury of 7-19-87 with persisting" disc injury, radicular involvement, lower back pain and left hip fibromyalgia.

On November 25, 1992, claimant's treating doctor, Dr. Bernstein, reported that he had referred claimant to Dr. Rabin for palliative care, claimant's condition remained medically stationary, and he had requested the MRI because of claimant's subjective complaints. Finally, Dr. Bernstein reported that he "did not believe that she has had any objective worsening" and he did not authorize temporary total disability.

On December 15, 1992, claimant's counsel wrote to Dr. Bernstein and reported that claimant had experienced chronic low back problems which had continued since 1987 which had limited her ability to lift, bend, and perform repetitive work. On December 16, 1992, Dr. Bernstein agreed that claimant had permanent limitations.

We do not find that Dr. Bernstein's last letter establishes that claimant's condition has worsened. The correspondence he was responding to indicated that claimant's problems and restrictions had limited her since the injury. Dr. Bernstein's agreement with that assessment does not establish that claimant's low back condition has worsened.

Finally, Dr. Bernstein had the opportunity to treat claimant and review her MRI and medical records. Because Dr. Bernstein specifically stated that claimant's condition had not worsened, we conclude that claimant has failed to establish a compensable worsening. Furthermore, even if claimant had proven a worsening, there is no evidence that a worsening of the compensable low back condition resulted in a diminished earning capacity.

Following the compensable 1987 injury, claimant sustained injuries with subsequent employers, including injuries to her upper back and neck and to her wrist, arm, shoulder and chest. Claimant left work with her employers for various reasons, but there is no indication that she was taken off work solely for her low back condition. Moreover, Dr. Bernstein's report stated that he had not authorized temporary disability for her low back condition in 1992.

Under the circumstances, we conclude that claimant has failed to establish a worsened low back condition which resulted in a diminished earning capacity. Therefore, claimant has failed to prove a compensable aggravation.

ORDER

The Referee's order dated February 8, 1993 is reversed. The self-insured employer's aggravation denial is reinstated and upheld. The Referee's attorney fee award of \$1,900 is also reversed.

November 16, 1993

Cite as 45 Van Natta 2194 (1993)

In the Matter of the Compensation of
GEORGE A. McCLELLAN, Claimant
 WCB Case No. 92-05014
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Barber's order that found that his right knee claim remains in nondisabling status. On review, the issue is claim reclassification. We affirm.

FINDINGS OF FACT

On June 6, 1989, claimant injured his right knee while operating a pallet stacker. He reported the incident to the employer but did not file a workers' compensation claim at that time.

On May 16, 1990, after seeking treatment from Drs. Hazel and Ho for both knees, claimant filed a claim for ongoing bilateral knee conditions and for the June 6, 1989 right knee injury. (Exs. 24, 25, 27, 28 and 47-2).

On June 8, 1990, the employer denied the compensability of the right knee condition. On February 22, 1991, during the course of a prior hearing, the employer accepted the June 6, 1989 right knee injury claim as nondisabling. (Ex. 47-2). The prior referee concluded that claimant's preexisting bilateral knee condition, diagnosed as patellar malalignment syndrome or subluxed patella, was not compensable as either an injury or occupational disease. (Ex. 47-4). The referee amended his order, declining to reclassify the claim as disabling on the ground that such a challenge is initially processed by the Department, not through the hearings process, and declined to make a finding regarding whether claimant missed time from work because of the compensable right knee injury. (Ex. 48-1).

In a June 25, 1992 Order on Review, we concluded that claimant was barred from raising the issue of reclassification for the first time in his request for reconsideration of the prior referee's order, and, even if the issue had been properly raised at hearing, the Hearings Division and the Board were without jurisdiction to address the issue of reclassification. (Ex. 52). This order was not appealed and became final by operation of law.

Meanwhile, by a December 26, 1991 Determination Order, the Department ordered that claimant's injury remain classified as nondisabling. (Ex. 49). Claimant requested reconsideration of the Determination Order and an arbiter panel was appointed. (Exs. 49A and B). The panel, which consisted of Drs. Bald, orthopedic surgeon; Gritzka, orthopedist; and Watson, neurologist, diagnosed bilateral patellofemoral tracking disorder, which would limit the repetitive use of his right knee. (Ex. 50-3). In a March 30, 1992 Order on Reconsideration, the Department concluded that the injury was disabling. (Ex. 51). The employer requested a hearing on the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the claim remained nondisabling on the basis that, although claimant has a permanent impairment, it is attributable to his preexisting noncompensable patellar condition and not the compensable injury, and that claimant missed no more than three days of work due to the injury.

Claimant contends that he has a permanent disability which is attributable to the compensable injury and which is demonstrated by reduced range of motion in the right knee. The employer contends that the reduced range of motion in the right knee is due to his noncompensable, preexisting patellar condition, the compensability of which was determined against claimant in the prior litigation. We agree with the employer and affirm and adopt the Referee's opinion on the merits, with the following supplementation.

Claimant was injured on June 6, 1989. It was not until February 22, 1991, more than one year after the injury, that the employer accepted the claim and classified it as nondisabling.

A claimant has one year from the date of injury in which to seek reconsideration by the Department of an insurer's decision to reclassify his or her claim from disabling to nondisabling. ORS 656.262(6)(c); Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993). Upon receipt of a request pursuant to ORS 656.262, the Department shall determine whether the claim is disabling or nondisabling. ORS 656.268(11).

Here, the employer initially classified the claim as nondisabling more than one year after the injury. Because claimant did not object to the nondisabling classification within one year from the date of injury, the Director had no authority to address claimant's reclassification request. See Donald R. Dodgin, 45 Van Natta 1642 (1993). As a result, we conclude that the Determination Order and Order on Reconsideration were improperly issued and were, therefore, invalid. Nevertheless, the invalidity of the Order on Reconsideration does not remove the issue from the Hearings Division and the Board. See Pacheco-Gonzalez v. SAIF, 123 Or App 312, 315 (1993).

In Dodgin, we concluded that, where a claimant is precluded, through no fault of his own, from seeking reclassification by the Department because the claim was initially classified as nondisabling more than one year after the date of injury, the claimant may request a hearing on the matter pursuant to ORS 656.283(1).

Here, the employer requested a hearing concerning the classification issue. Inasmuch as any party, including the employer, has the right to request a hearing on any question concerning a claim, See ORS 656.283(1), the classification issue was properly raised before the Referee. See Donald R. Dodgin, supra.

ORDER

The Referee's order dated February 22, 1993 is affirmed. The claim shall be processed as nondisabling.

November 16, 1993

Cite as 45 Van Natta 2196 (1993)

In the Matter of the Compensation of
DALE A. SJOBERG, Claimant
WCB Case Nos. 92-03449, 92-03856 & 92-05346
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Hazelett's order that: (1) upheld Aetna Casualty Company's partial denial (on behalf of Commercial Sprinklers) of claimant's claim for his current low back condition; (2) upheld the self-insured employer's partial denial of claimant's claim for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's partial denial (on behalf of Master Fire Control) of claimant's claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's disability and need for treatment was attributable to alcoholism and socioeconomic factors. The Referee further found that there was no evidence to establish causation between any of claimant's prior compensable injuries and his disability or need for treatment after March 27, 1992. The Referee, therefore, upheld the current condition denials of Liberty, Aetna, and the self-insured employer.

On review, claimant contends that the Referee should not have considered alcoholism and socioeconomic factors to be preexisting conditions pursuant to ORS 656.005(7)(a)(B). We conclude that it is not necessary to reach the issue of whether claimant's alcoholism and socioeconomic factors constitute preexisting conditions, as the medical evidence does not establish that claimant's injuries are even a material contributing cause of his current condition.

We conclude that the Referee correctly relied upon the opinion of Dr. Utterback, M.D., who was claimant's former treating physician and performed claimant's low back surgery in 1990. Dr. Utterback reported that claimant's July 1990 injury was a temporary flare-up and did not contribute to his current condition in any way. He also testified that claimant's injury of 1991 had resolved. Dr. Utterback stated that he did not wish to operate on claimant, and when he last saw claimant in March 1992, claimant did not require any curative treatment.

Finally, although claimant argues that Dr. Berkeley, his current treating physician, has opined that his current condition is related to his prior work injuries, we are not persuaded by Dr. Berkeley's opinion. Dr. Berkeley did not begin treating claimant until April 1992, and his opinion consists of a "yes" response to a "check-the-box" letter authored by claimant's attorney. Under the circumstances, we do not find such an opinion to be persuasive, and we decline to rely upon Dr. Berkeley's opinion.

We conclude that claimant has failed to establish that his prior industrial injuries are materially related to his current low back condition. We, therefore, affirm the Referee's order.

ORDER

The Referee's order dated January 7, 1993 is affirmed.

In the Matter of the Compensation of
TERRY L. CLELAND, Claimant
Own Motion No. 92-0442M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On October 28, 1993, the Board received the SAIF Corporation's request for reconsideration of our August 28, 1992 Own Motion Order. In that order we concluded that claimant was entitled to own motion relief because his compensable right shoulder condition had worsened requiring surgery. We authorized the reopening of claimant's claim to provide temporary disability benefits beginning the date he was hospitalized for the proposed surgery. SAIF contends that the claim should not be reopened because claimant's compensable injury has not required the proposed surgery.

Pursuant to OAR 438-12-065(2), SAIF had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if SAIF could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. OAR 438-12-065(2). Under the particular circumstances of this case, we conclude that an exception to the deadline is appropriate. We withdraw our prior order for purposes of reconsideration and issue the following order in its place.

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 June 15, 1992, Dr. Straub, claimant's treating orthopedist, requested authorization to perform an arthroscopy and possible decompression with possible rotator cuff repair on claimant's right shoulder. On July 22, 1992, SAIF authorized the surgery and waived the right to a second opinion. However, claimant did not undergo the proposed surgery.

On September 15, 1993, the board received a response from SAIF to our September 3, 1993 letter in which we requested information as to whether claimant was receiving temporary disability benefits. A note on the response letter from SAIF indicated that the "worker withdrew surgery request." On October 8, 1993, the Board wrote to SAIF and requested that SAIF provide further information regarding the withdrawal of the surgery request. A copy of this October 8, 1993 letter was also sent to claimant.

In response, on October 29, 1993, the Board received a letter from SAIF with an attached letter from claimant in which he stated, "Regarding my surgery cancellation. The reason I cancelled it was for personal family reasons."

Surgery was recommended and authorized more than one year ago and claimant has not pursued that option. Furthermore, claimant has apparently decided not to go through with the proposed surgery at this time. Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, the request for own motion relief is denied. If claimant's compensable condition should require surgery or other treatment requiring hospitalization in the future, he may request own motion relief at that time. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HOE S. KIM, Claimant
Own Motion No. 93-0733M
OWN MOTION ORDER
Doblie, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable back, cervical and right clavicular injuries. Claimant's aggravation rights expired on May 1, 1989. SAIF recommends against reopening claimant's claim on the following grounds: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) surgery or hospitalization is not reasonable and necessary for the compensable injury; (3) claimant has not sustained a worsening of the compensable injury; and (4) claimant has withdrawn from the work force. On November 2, 1993, SAIF issued a denial of the compensability of claimant's current L5-S1 disc condition.

With its recommendation that claimant's claim not be reopened for the payment of temporary disability benefits, SAIF submitted a Claim Disposition Agreement (CDA) dated January 16, 1992. This CDA related to the same injury claim that is at issue in the current own motion matter. (Claim number 4674514L, date of injury March 12, 1984). This settlement document stated that SAIF accepted the following conditions: (1) right sterno-clavicular separation; (2) right epicondylitis; (3) cervical strain; and (4) L4-5 herniation. However, by this settlement, claimant agreed to full release of all "past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services."

Here, claimant has permanently relinquished her rights to all past, present and future temporary disability compensation. In other words, as a result of the January 16, 1992 CDA, claimant is no longer entitled to any temporary disability compensation related to her March 12, 1984 work injury. Although claimant retains her lifetime entitlement to medical services related to the 1984 compensable injury pursuant to ORS 656.245, those benefits are not within the Board's own motion jurisdiction.

On November 2, 1993, SAIF denied the compensability of claimant's current "level of treatment as it appears unrelated to the incident of March 12, 1984." However, it is not necessary to wait to determine if claimant will appeal that denial and, if so, the results of such an appeal. Due to the CDA, even if claimant prevails in any eventual compensability decision regarding the November 2, 1993 denial, the extent of benefits flowing from such a decision is limited to claimant's entitlement to medical services regarding that partial denial. See ORS 656.236(1); Jon A. Rogers, 45 Van Natta 1013 (1993). In other words, pursuant to the CDA, no matter how many conditions claimant's 1984 injury claim encompasses, her benefits are limited to medical services related to that 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
ILINE M. KOEHLER, Claimant
WCB Case No. 92-05715
ORDER ON REVIEW
William Mansfield, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brown's order that upheld the self-insured employers' denial of compensability for claimant's right carpal tunnel condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant first started working for the employer in 1987 as a typist.

She first began to experience carpal tunnel syndrome symptoms in early 1990. (Tr. 8). On July 6, 1990 she sought treatment from Dr. Bonazzola. He diagnosed probable carpal tunnel syndrome on the right. (Ex. 3).

In July 1991, claimant changed jobs to file clerk. Claimant worked full time. Her duties included filing, sorting mail, and on occasion typing. (Ex. 8, Tr. 18). These work activities were hand intensive and repetitive. (Ex. 8).

On December 23, 1991, claimant sought medical treatment for her condition from Dr. Brummer. On January 7, 1992, claimant was referred to Dr. Saviers. Based on clinical examination and nerve conduction studies, he diagnosed right carpal tunnel syndrome of moderate severity. (Ex. 8).

An independent medical examination was conducted by Dr. Button on March 20, 1992, and a file review on behalf of the employer was accomplished by Dr. Jewell on January 22, 1993.

Claimant's off-work activities include yard work, walking, exercising using an "exercise stepper," and reading. (Tr. 19).

FINDINGS OF ULTIMATE FACT

The existence of claimant's right carpal tunnel syndrome is established by medical evidence supported by objective findings.

Claimant's repetitive work activities were the major contributing cause of her right carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

In order to establish compensability of her occupational disease claim, claimant must show that work activities or exposures were the major contributing cause of her right carpal tunnel syndrome. ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster, Co., 295 Or 298 (1983). Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2). An "occupational disease" includes any series of traumatic events or occurrences which requires medical services or results in disability. ORS 656.802(1)(c).

The Referee found that claimant failed to prove that her work activities were the major contributing cause of her right carpal tunnel syndrome. In reaching this result, the Referee found the opinion of Dr. Button, the independent medical examiner, more persuasive than the opinion of Dr. Brummer. We disagree.

We generally defer to the opinion of an injured worker's attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons.

It is undisputed that claimant has right carpal tunnel syndrome supported by objective medical findings. (Ex. 8-3). The medical record is also persuasive that this condition was insidious in its development. (Ex. 7).

It was the opinion of Dr. Brummer, claimant's attending physician, that the major contributing cause of this condition was work activities. (Exs. 10, 17, 19). This conclusion was based on the extensive knowledge he had of claimant's work activities. (See Exs. 10, 12, 16). We are also convinced that in forming his opinion Dr. Brummer was aware of claimant's off-work leisure activities. (Ex. 10). It was also the opinion of the consulting physician, Dr. Saviers, that the major contributing factor of claimant's right carpal tunnel condition was the repetitive nature of her work. (Ex. 8).

In contrast, it was Dr. Button's opinion that claimant's right carpal tunnel syndrome was more likely than not due to factors intrinsic to claimant. He found that claimant's carpal tunnel syndrome was a combination of factors which included the fact that claimant was middle-aged and female. He also found significant claimant's "general body habitus" with corresponding weight gain, fluid retention and edema. Button dismissed the relative contribution of work activities because he believed that claimant's symptoms had increased despite the fact that current work duties were less hand intensive. (Ex. 13). Dr. Jewell, although he wrote a separate report, essentially concurred with Dr. Button. (Ex. 21).

Even assuming the aforementioned factors contributed to the onset of claimant's condition, we note that Drs. Brummer and Saviers were aware of and considered these factors in forming their opinions on causation. (Exs. 7, 8, 17). In his June 30, 1992 report, Dr. Brummer compared the relative contributions of claimant's weight gain, fluid retention, and edematous state with work activities, and concluded that the "overwhelming problem" was repetitive work activities. (Ex. 17). Similarly, Dr. Saviers, in comparing the contributions of claimant's dependent edema and work activities, opined that although the edema was contributing to "some degree" repetitive work activities were the major contributing cause of the carpal tunnel syndrome. (Ex. 8).

With respect to the relationship between claimant's work and symptoms, we find her testimony persuasive that there was a direct correlation to symptoms and work activities. (Tr. 8, 12, 13, 18). The fact she may have experienced less symptoms filing than when she was typing does not prove that work activities were not the major contributing cause of her present condition. We find the evidence sufficient to conclude that the repetitive filing was the major contributing cause of the resultant carpal tunnel syndrome.

In summary, we find no reason to discount the opinion of Drs. Brummer and Saviers. Their opinions are based on an accurate history, clinical examination of claimant, and consideration of all relevant factors. On this evidence we find that claimant has proven that her work activities for the employer were the major contributing cause of her right carpal tunnel syndrome. Accordingly, the claim is compensable. See also Susan M. Myers, 45 Van Natta 84 (1993); Darlene L. Bartz, 45 Van Natta 32 (1993).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the claim is \$3,250, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 8, 1993 is reversed. The employer's denial is set aside and the claim remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of \$3,250, payable by the employer.

In the Matter of the Compensation of
KENNETH MURRELL, Claimant
Own Motion No. 66-0372M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On August 3, 1993, the SAIF Corporation recommended reopening of claimant's claim under the Board's own motion authority to provide an IME and testing for diagnostic purposes in order to determine whether claimant's 1955 industrial injury was the major cause of his current low back condition. The Board found that the requested medical services were reasonable and necessary for the compensable injury, and reopened claimant's claim on August 12, 1993, for diagnostic evaluation. By the same order, the Board closed the claim.

On October 21, 1993, SAIF submitted claimant's request for medical benefits relating to his compensable back injury. SAIF recommended that claimant's claim not be reopened for further medical services, contending that claimant's industrial injury is not causally related to his current low back condition.

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 and, if qualified, temporary total disability compensation. ORS 656.278(1)(b).

The question presented here is whether claimant's need for treatment is causally related to the 1955 compensable injury. Claimant bears the burden of proving the necessary causal relationship between his current problems and the compensable injury.

On August 27, 1993, Dr. Hacker, consulting physician, stated that claimant had a history of low back problems extending back to an injury in 1955. He stated that "[f]luctuating pains thereafter and occasional symptoms affecting the left leg were noted." Dr. Hacker also stated that "in June of this year, severe pain developed and radiated to the right calf, thigh and lateral border of the foot." He noted that claimant's left leg "is unaffected at this time."

On September 16, 1993, Dr. Hacker performed a lumbar myelogram which indicated severe spinal canal stenosis at L4-5. On the same date, claimant underwent a CT scan of the lumbar spine which indicated large right posterolateral disc herniation at L4-5 with probable nerve root entrapment.

On September 23, 1993, Dr. Freeman, M.D., examined claimant in an independent medical examination. In an October 1, 1993 report, Dr. Freeman opined that claimant's spinal stenosis at L4-5 was caused by the natural aging process. In addition, Dr. Freeman stated that:

"[t]he apparent disc herniation at L4-5 on the right such as to cause his current level of symptoms would, in my opinion, have to have been a relatively recent event. It does not appear likely that a disc herniation of that magnitude would have remained clinically silent, in terms of right leg symptoms, for almost 40 years. I, therefore, believe that the industrial injury of 1955 was not a major contributing cause of his current condition."

We note that there is no "causation" opinion from Dr. Hacker in the record, nor is an opinion as to the cause of claimant's current condition provided by claimant's treating physician, Dr. Scott. Therefore, Dr. Freeman's opinion remains unrebutted. Thus, there is no persuasive medical opinion relating the diagnosed conditions to the compensable injury. Consequently, we cannot reopen claimant's claim for medical services under ORS 656.278.

Accordingly, claimant's request for medical services is denied. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT D. PECK, Claimant
Own Motion No. 92-0587M
OWN MOTION ORDER ON RECONSIDERATION
Myrick, et al., Claimant Attorneys
D. Schoen, Defense Attorney

Claimant requests reconsideration of our August 10, 1993 Own Motion Order in which we declined to reopen claimant's claim for the payment of temporary disability compensation on the ground that he had not proven he was in the work force at the time of disability. On reconsideration, claimant argues that, given the facts of his case, it is unreasonable to require him to show evidence of work effort.

In order to consider claimant's motion, we abated our August 10, 1993 order and granted the insurer an opportunity to respond to the motion. The insurer's response has been received, and we proceed with our reconsideration.

It is claimant's burden to prove that he was in the work force at the time of disability. The insurer closed claimant's claim on August 5, 1992, awarding temporary disability compensation from January 1, 1988 through July 27, 1992. The insurer declared claimant medically stationary as of July 27, 1992. By a separate order dated August 10, 1993, we affirmed the insurer's Notice of Closure. As of September 10, 1992, claimant's condition worsened requiring surgery. Thus, claimant must prove he was in the work force on September 10, 1992, the time of his disability.

As we discussed in our August 10, 1993 order, claimant presented no evidence as to his work search efforts, his ability to work, or his willingness to work at the time of his disability. On reconsideration, claimant continues to fail to submit any evidence on the work force issue. Instead, he states that it is unreasonable to require him to show evidence of work effort in the short time from the closure of his claim until the worsening of his condition.

Approximately seven weeks passed from claimant's medically stationary date to the date of worsening and approximately five weeks passed from the date of closure to the date of worsening. We agree that these are relatively short time periods. However, claimant provides no evidence of any work search, inability to work or willingness to return to work. Although the length of the time period within which to look for work may go to the reasonableness of a work search, the time periods here are not so brief as to relieve claimant of his burden of proving that he remained in the work force.

Claimant also states that "time loss is to be paid when the worker is unable to be gainfully employed due to the industrial injury." We do not dispute that statement. However, claimant offers no proof that he was unable to work due to the injury at the time of disability. We would gladly award claimant wage loss benefits, provided he submits evidence that he suffered a wage loss as a result of the surgery.

Finally, claimant notes that ORS 656.278(1)(a), which gives the Board the authority to authorize temporary disability compensation on its own motion under certain conditions, does not include the restrictions on entitlement to temporary disability benefits provided by the Supreme Court in Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989) and Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). However, we note that neither are those restrictions explicitly provided in ORS 656.210(1), the temporary disability statute interpreted by Cutright v. Weyerhaeuser Co., *supra.*, which was in turn refined by Dawkins v. Pacific Motor Trucking, *supra.* The legislature has not altered the Court's interpretation of the requirements for entitlement to temporary disability compensation and that interpretation applies to own motion claims.

On this record, we continue to adhere to our prior conclusions. Accordingly, we 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.

Board Member Gunn dissenting.

On the facts of this case, I would find that claimant remained in the work force. On that basis, claimant is entitled to temporary disability compensation beginning September 21, 1992, the date he underwent an arthroscopy on his left knee. Therefore, I respectfully dissent.

Here, on January 1, 1988, the insurer voluntarily reopened claimant's claim. On May 17, 1989, the Board issued an Own Motion Order which formally reopened the claim. On August 5, 1992, the insurer closed claimant's claim, awarding temporary disability compensation from January 1, 1988 through July 27, 1992. The insurer declared claimant medically stationary as of July 27, 1992. By a separate order dated August 10, 1993, we affirmed the insurer's Notice of Closure.

At the time claimant's claim was closed, he had been receiving temporary disability benefits for more than four and a half years. By definition, claimant remained in the work force during the period he was entitled to temporary disability benefits, although he was unable to work due to the compensable injury. Dawkins v. Pacific Motor Trucking, supra. As of September 10, 1992, claimant's condition worsened requiring the surgery which was ultimately performed on September 21, 1992. Therefore, only about seven weeks passed from claimant's medically stationary date to the date of worsening and only about five weeks passed from the date of closure to the date of worsening.

The majority acknowledges that these are "relatively short time periods." However, they find that "the time periods here are not so brief as to relieve claimant of his burden of proving that he remained in the work force." I disagree with this analysis. Although I agree that claimant is not relieved of his burden of proving that he remained in the work force, I find that the brevity of this period in itself establishes that claimant remained in the work force at the time of his worsening.

I do not dispute that the Cutright, supra, and Dawkins, supra, standards apply to own motion claims. However, applying those standards, I would find that claimant has established that he remained in the work force at the time of disability. As noted above, claimant has established that he remained in the work force as of July 27, 1992. By virtue of the fact that claimant was unable to work for four and a half years due to the compensable injury, it is reasonable to conclude that he remained in the work force during the brief period of five to seven weeks before his condition again worsened requiring surgery.

The work force issue is determined on a case by case basis looking at all of the facts before us. Here, the question before us comes down to a matter of equity and reasonableness. It would be both inequitable and unreasonable to conclude that claimant had withdrawn from the work force in the short period between the time he became medically stationary and his claim was closed and the time his condition again worsened. Therefore, for the above reasons, I respectfully dissent and would find that claimant remained in the work force at the time of his disability.

November 19, 1993

Cite as 45 Van Natta 2203 (1993)

In the Matter of the Compensation of
LYNN A. HORTON, Claimant
WCB Case No. 91-15648
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Barber's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a stress-related mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. However, in lieu of the Referee's ultimate findings of fact, we make the following findings.

Claimant suffers from a generally recognized mental disorder. The employment conditions which allegedly caused the mental disorder either did not exist in a real and objective sense, or were generally inherent in every working situation, or were reasonable disciplinary, corrective or performance evaluation actions of the employer, or cessation of employment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to establish a compensable stress claim pursuant to ORS 656.802(1)(b). We agree and offer the following analysis.

Compensability Standard

In order to establish compensability of a stress-related mental disorder, the worker must prove that employment conditions were the major contributing cause of the mental disorder and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). The diagnosed mental disorder must be one that is recognized in the medical or psychological community. ORS 656.802(3)(c).

In addition, the employment conditions producing the mental disorder must exist in a real and objective sense. ORS 656.802(3)(a). They must be conditions other than those generally inherent in every working situation, or reasonable disciplinary, corrective or job performance actions by the employer, or cessation of employment. ORS 656.802(3)(b).

Finally, there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(d). If claimant fails to establish any one of these elements, her occupational disease claim for a stress-related mental disorder fails. See Dana Lauzon, 43 Van Natta 841 (1991).

Mental Disorder

We agree with the Referee's finding that claimant suffers from Major Depression, based on the diagnosis of her treating psychiatrist, Dr. Gwinnell. (See Ex. 35). We further find that this mental disorder is generally recognized in the medical or psychological community. In addition, based on Dr. Gwinnell's chart notes and report, we find that the existence of claimant's condition is established by medical evidence supported by objective findings. (See Exs. 34, 35).

Employment Conditions

Next, we determine whether the employment conditions which allegedly caused claimant's mental disorder: (1) exist in a real and objective sense; (2) are other than conditions generally inherent in every working situation; and (3) are not reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Stressful employment conditions may exist in a real and objective sense, even if a claimant's perception of those conditions is inaccurate. See Duran v. SAIF, 87 Or App 509 (1987); Katherine F. Taylor, 44 Van Natta 920 (1992). Employment conditions which are excluded under ORS 656.802(3) may not be considered in the analysis of the major contributing cause of claimant's mental disorder. Katherine F. Taylor, *supra*.

Claimant contends that one of the stressful employment conditions which caused her mental disorder was an increasing workload in the fall and winter of 1990, which resulted in claimant working nights and weekends in addition to performing her regular job duties. Claimant, who was director of the employer's residential program for mentally retarded and developmentally disabled (MRDD) clients, asserts that her workload increased due to the opening of two new residential homes, the failure of claimant's assistant, Ed Chase, to fulfill his duties, and difficulty in filling the position of home coordinator at Beach House, one of the employer's residential homes. In addition, claimant contends that in-fighting among staff, stemming from conflict between claimant and Chase, was another stressful employment condition.

After our review of the record, we are unable to conclude that claimant's increased workload either (1) existed in a real and objective sense, or (2) was other than a condition generally inherent in every working situation.

Claimant testified that during the Beach House "crisis," which developed following the employer's acquisition of a new home in Seaside, she worked seven days per week and stayed at the facility ten nights in a row, because Chase refused to help and because she had to cover for a terminated home coordinator. (Tr. Day 2 at 19-23). We find that the testimony of claimant's former co-workers confirms that she worked evenings and weekends at Beach House for about one week in November 1990 while there was no home coordinator in place. (See Tr. Day 1 at 30, 139, 177-78). We also find that claimant closely supervised a Beach House coordinator for about 3 weeks in October-November 1990, and again performed the coordinator's duties in late January 1991. (See Tr. Day 1 at 180-81, 185-88; Day 2 at 27-28). In addition, claimant testified that she assisted in opening a new home in late December 1990, while supervising and training a new home coordinator at Beach House. (Tr. Day 2 at 25-27)

We are unable to conclude, however, that claimant's workload actually increased in late 1990. Alma Leach, the employer's comptroller, could not confirm that the hours claimant worked at Beach House were in addition to her full time work duties as a salaried manager. (Tr. Day 1 at 32). Indeed, Leach testified that she was impressed with how much time claimant generally devoted to her work. (Id. at 33). Mark Terranova, the employer's Executive Director and claimant's supervisor, stated that claimant was not required to work longer hours in the seven months preceding her termination. (Tr. Day 3 at 132). He also testified that claimant always worked evenings, but that she had flexible daytime hours; she worked whatever hours were required to get the job done. (Tr. Day 3 at 159).

Moreover, we find that claimant's duties in late 1990 were consistent with her Residential Director job description and comparable to her workload as interim director when she brought all the employer's homes into compliance between June and October of 1988. (Ex. 2-1 to -2, 2-6, 2-11; Tr. Day 2 at 106, 110-111). Therefore, on this record, we cannot conclude that claimant's workload increased in a real and objective sense in the fall and winter of 1990. In addition, we find that claimant's responsibilities to closely supervise home coordinators and to provide coverage when positions are unstaffed are employment conditions that are generally inherent in every managerial working situation.

Claimant also asserts that her workload increased because her assistant failed to perform his duties and claimant had to fill in for him. The record confirms that Chase did not perform his scheduling duties; instead, either claimant or the home coordinator did the scheduling. (Tr. Day 1 at 139, 152-53, Day 3 at 6). Claimant also complained that Chase "just stopped working" when he did not get the salary increase he wanted in the summer of 1990, that he failed to perform his work duties generally, and that he was frequently unavailable. (See Tr. Day 2 at 47-50; Ex. 34-1). However, claimant also testified that she never discussed with Terranova the revised division of job duties between herself and Chase, and that she verbally informed Terranova of Chase's failure to perform his duties only in late December 1990. Claimant did not document Chase's nonperformance in writing until February 3, 1991. (Ex. 10; see also Tr. Day 3 at 136-46).

On this record, we are unable to find that Chase failed to perform his job duties in the fall and winter of 1990 in a real and objective sense, other than failing to perform his scheduling duties. Furthermore, to the extent there is real and objective evidence of Chase's failure to perform his duties (scheduling), resulting in an increased workload for claimant, we find that this is an employment condition that is generally inherent in every managerial working situation.

Claimant also asserts that staff in-fighting, stemming from conflict between herself and Chase, was a stress-producing employment condition. The record reflects the existence of conflict between claimant and her assistant. However, we find that interpersonal conflict is a common stressor that is generally inherent in every working situation. See Gregory L. Brodell, 45 Van Natta 924 (1993). The record is less clear regarding the extent to which staff in-fighting in general existed. We find that the record establishes only that some staff supported claimant, while others disliked her. We find that this circumstance also is generally inherent in every working situation.

Accordingly, we conclude that the allegedly stressful employment conditions identified by claimant--increasing workload, nonperformance of work duties by her assistant, and interpersonal conflict among staff in general and between claimant and Chase specifically--are excluded under ORS 656.802(3)(a) or (b).

Dr. Gwinnell identified additional stressors: (1) excessive working hours with inadequate authority to make decisions about whether or not to work those hours; and (2) the behavior of

claimant's supervisor, Terranova, including publicly berating claimant, giving contradictory reprimands, and giving claimant a poor performance evaluation immediately after giving her a raise. (See Ex. 35-2).

We find no evidence in the record that claimant lacked authority, as the Residential Director, to decide whether to work increased hours. Accordingly, we cannot find that this employment condition existed in a real and objective sense. Regarding Terranova's behavior, we cannot conclude on the record before us that his conduct constituted other than reasonable disciplinary or corrective actions. We also specifically find that claimant's July 1990 performance evaluation, which both praised certain areas of claimant's job performance and provided specific criticism in other areas, was a reasonable evaluation. (See Ex. 2-13 to -17; Tr. Day 3 at 120-27). Accordingly, we conclude that the stressors identified by Dr. Gwinnell also are excluded under ORS 656.802(3)(b).

The Referee found that claimant's mental disorder was caused by her termination. Mental illness resulting from stress due to reasonable cessation of employment is excluded under ORS 656.802(3)(b) and is not compensable. See Kip S. Helm, 45 Van Natta 1539 (1993). Here, we find that the primary reason for claimant's termination--claimant's and Chase's inability to work together, which affected the entire agency--is reasonable under the circumstances of this case. (See Tr. Day 3 at 82, 146). Accordingly, to the extent claimant's mental disorder was caused by the cessation of employment, it is not compensable.

In summary, we find that all the employment conditions identified as causing claimant's mental disorder are excluded under ORS 656.802(3)(a) or (b). Because we find no employment conditions which may be considered in analyzing the cause of claimant's mental disorder, we do not address whether there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. For the same reason, we do not determine whether employment conditions were the major contributing cause of claimant's mental disorder. Accordingly, we conclude that claimant's occupational disease claim for a stress-related mental disorder is not compensable.

ORDER

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

November 19, 1993

Cite as 45 Van Natta 2206 (1993)

In the Matter of the Compensation of
DENNIS L. KELLER, Claimant
Own Motion No. 93-0768M

OWN MOTION ORDER DENYING CONSENT TO DESIGNATION OF PAYING AGENT
(ORS 656.307)

Scheminske & Lyons, Attorneys
Saif Legal Department, Defense Attorney

The Benefits 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 February 23, 1986. Thus, that claim is subject to ORS 656.278.

Under OAR 438-12-032(3), the Board shall notify the Benefits 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 May 26, 1993, Dr. Bower, treating physician, opined in a letter that "ongoing chiropractic therapy that [claimant] has responded to in the past is indicated." The record contains no information regarding any other type of treatment. Thus, 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.

November 19, 1993

Cite as 45 Van Natta 2207 (1993)

In the Matter of the Compensation of
GENE G. MARTIN, Claimant
 WCB Case Nos. 92-06438 & 92-05056
 ORDER OF ABATEMENT
 Karen M. Werner, Claimant Attorney
 Employers Defense Counsel, Defense Attorneys

On October 28, 1993, we issued an Order on Review that: (1) reversed the Referee's order, which directed the insurer to pay permanent disability benefits awarded by an Order on Reconsideration, even though that order had been set aside; and (2) assessed a penalty and related attorney fee for the insurer's unreasonable refusal to pay those benefits. Contending that it is entitled to offset overpaid temporary disability benefits against the permanent disability awarded by the Order on Reconsideration before calculation of the assessed penalty, the insurer seeks reconsideration of what amounts are "then due" upon which to assess a penalty.

In order to further consider the insurer's request, we withdraw our October 28, 1993 order. Claimant is granted an opportunity to respond to the insurer's motion. To be considered, claimant's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

November 19, 1993

Cite as 45 Van Natta 2207 (1993)

In the Matter of the Compensation of
MARTIN O. TADLOCK, Claimant
 WCB Case No. 92-10524
 ORDER ON REVIEW
 Rasmussen & Henry, Claimant Attorneys
 Brian L. Pocock, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Referee McWilliams' order that upheld the self-insured employer's denial of claimant's head and upper body injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant is employed as a deputy sheriff assigned to the Lane County Jail. He is a certified peace officer, with authority to arrest 24 hours a day, seven days a week. He is expected to be physically and mentally prepared to respond to a call to duty at all times.

It is the employer's policy that employees not become involved in neighborhood incidents when off duty. However, if a deputy observes a crime being committed within the jurisdiction of the sheriff's office, an off-duty deputy is expected to take action to prevent the crime and/or assist in apprehending the perpetrator.

After completing his work shift on June 28, 1992, claimant left for work in his own car, dressed in civilian clothes. He stopped at a gas station to buy gas then entered a grocery store parking lot and parked. He exited his car, intending to buy groceries for his wife.

Several individuals shouted profanities at claimant from one or two vehicles as he proceeded toward the grocery store. Claimant said, "Excuse me." Three males exited the vehicles and surrounded claimant, one in front of him and two behind him, threatening him verbally and with their presence. Claimant repeatedly advised them to return to their vehicles, stating that he was only trying to go to the grocery store.

When the persons threatening claimant did not desist, he displayed his badge and identified himself as a deputy sheriff. This triggered increased activity by the aggressor facing claimant, who announced that he had taken an Explorer Scout down and would take claimant down as well. The aggressor began shoving claimant and continued ranting at him.

Claimant turned to the left as he saw movement in that direction. He was suddenly knocked to the ground by a blow to the head which rendered him unconscious.

Thereafter, claimant sought medical treatment for injuries to his head and upper body resulting from the blow. He filed a claim on July 10, 1992, which was denied on the grounds that the injury did not arise out of or in the course and scope of claimant's employment.

Claimant was a credible witness at hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found the connection between claimant's injury and his employment too tenuous to support a compensable claim. In reaching this result, the Referee relied on evidence indicating that claimant was not paid for his activity at the time of injury; claimant was in a grocery store parking lot to do a personal errand for his wife which did not benefit the employer; the employer did not contemplate that claimant would intervene in a neighborhood incident while off duty; aggression against claimant had already commenced by the time claimant identified himself as a deputy sheriff; and the employer did not expect that claimant would be involved in combat outside the corrections facility where he worked, "especially where no criminal activity had yet occurred requiring his intervention while off duty." (O&O p. 5).

The parties apparently agree that a pivotal question is whether claimant's identity as a sheriff's deputy, once revealed to his assailant, was a significant cause of the subsequent attack which resulted in the injuries claimed. We conclude that a preponderance of the evidence, including the circumstances of claimant's self-identification, indicates that claimant's injuries arose out of and in the course and scope of his employment.

To begin, we discuss facts which we view differently from the Referee. First, we do not believe that claimant's conduct in the grocery store parking lot amounted to intervening in a neighborhood incident. Second, we do not find that claimant was involved in "combat" when he incurred the injuries claimed. (See O&O pp. 5-6).

The problem came to claimant; he did not "intervene" in this neighborhood incident. In addition, we find that claimant reasonably believed that his assailant was about to commit a crime when he displayed his badge and identified himself as a sheriff's deputy. Further, we do not find that claimant was involved in combat. Rather, we are persuaded that claimant attempted to defuse the aggression directed against him by identifying himself as a peace officer. Although his attempt failed (to his detriment), we believe that claimant's conduct under the circumstances conformed with that required of an off-duty sheriff's deputy. Moreover, because claimant used no physical force whatsoever, he was merely the victim, not a participant in the ensuing "combat."

In order to prove the compensability of his claim, claimant must establish that his injury arose out of and in the course of his employment. ORS 656.005(7)(a). He may do so by proving that his injury was "sufficiently" work related. Rogers v. SAIF, 289 Or 633, 642 (1985). Oregon follows the "going and coming rule" or limitation, which provides that injuries sustained while going to and from work are not compensable. See Cope v. West American Ins. Co., 309 Or 232, 237 (1990).

Here, it is undisputed that claimant was going home from work when he stopped in the parking lot where he was injured. However, considering the nature of claimant's work, particularly the off-duty conduct required and the work connection claimed, we do not find that the "going and coming rule" applies. Instead, we apply the law concerning the sufficiency of the work relationship generally.

In Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985), the court discussed seven factors for determining whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his or her own. Whether an injury is work-related is a matter to be decided on a case-by-case basis; not all of the seven factors need be satisfied, and no single factor is dispositive. Preston v. SAIF, 88 Or App 327, 331 (1987); Haugen v. SAIF, 37 Or App 601, 604 (1978).

Whether the activity was for the benefit of the employer

The Lane County Department of Public Safety manual sets out the Department's policy so that employees will have a clear understanding of the organization and guidance in decision making. (Ex. 4-1). Section E, entitled "Status of Employees while Off Duty," provides that a commissioned Reserve Deputy (such as claimant) has police officer authority 24 hours a day, seven days a week. (Ex. 4-3). Further:

"Any time that a police certified employee of this department and/or commissioned Reserve Deputy observes a crime being committed. . .that employee/Reserve Deputy shall be expected to take some initiative to prevent the crime from being committed. . . It is not expected that any off-duty employee/Reserve Deputy would take unnecessary risk[.] It is the policy of this department that off-duty employees/Reserve Deputies should avoid becoming involved in family and/or neighborhood incidents." (Ex. 4-3-4).

As we have stated, we find that claimant's specific conduct, identifying himself as a sheriff's deputy when he was threatened with bodily harm, was a proper attempt to prevent a physical assault. Moreover, as we have stated, we believe that claimant's conduct conformed with that required of an off-duty sheriff's deputy. Under these circumstances, we conclude that claimant's conduct before his injury also benefited his employer.

Whether the activity was contemplated by the employer and the employee

Because we view claimant's conduct as an attempt to prevent a physical assault and claimant was subject to the above quoted manual, we conclude that claimant's activity was contemplated by employer and employee. See Youngren v. Weyerhaeuser, 41 Or App 333, 336-37 (1979) (Where the worker did not have an opportunity to coolly deliberate his course of action, his conduct did not "so far depart from reasonably expected behavior[.]" that the resulting injury was declared noncompensable) (citations omitted).

Whether the activity was an ordinary risk of, and incidental to, the employment

The Referee found that the aggression directed toward claimant escalated when claimant identified himself as a deputy sheriff and that the exacerbation was attributable to claimant's status as a law enforcement officer. (O&O p. 5).

The employer argues that claimant failed to prove that his status was a cause of his injury. In support, the employer relies on claimant's statement that one of the assailants responded to claimant's badge by screaming that "it flat did not matter to him as he had already 'f*** up an explorer who tried that s*** and he was going to f*** me up to!" (Ex. 1C-2). Apparently, the employer takes the assailant's assertion that claimant's status as a deputy "flat did not matter" at face value. We do not agree. Instead, we find that the assailant's actions spoke louder than his words. Specifically, after claimant displayed his badge, the above-quoted individual shoved claimant and swung at him, striking him in the head and knocking him unconscious. (Id).

Considering the clear threats aimed at claimant and the subsequent sequence of events, we find that the act of identifying himself as a police officer caused the verbal assault to escalate into a physical assault, which in turn resulted in the injury claimed. Under these circumstances, we find that the risk of injury here was directly related to claimant's employment as a police officer. In other words, claimant's identity as a law officer itself exposed him to this particular hazard.

Consequently, we conclude that claimant's risk of injury was a risk of his employment. Moreover, because claimant had a work-related duty to try to prevent the crime threatened, which he did, we also conclude that the risk was incidental to claimant's employment. Thus, the very nature of claimant's job enhanced the risk of assault against him. Compare Carr v. U.S. West Direct Co., 98 Or App 30, 35 (1989).

Whether the employer directed or acquiesced in the activity

As we have stated, we believe that claimant had a work-related duty to try to prevent the crime threatened, based on the employer's policy as outlined in the Public Safety manual. Moreover, because we find that claimant's self-identification was conduct within that policy, we conclude that the employer effectively directed claimant to respond to the threatened crime just as claimant responded.

Whether the employee was on a personal mission of his own

We acknowledge that claimant's presence in the grocery store parking lot had nothing to do with his employment. Claimant's intent to purchase groceries clearly establishes that his initial mission was purely personal. However, when threatened by three assailants, the character of claimant's mission changed drastically. More specifically, when claimant displayed his badge and identified himself as a law officer, he was no longer on a personal mission. His subsequent activity, prior to becoming unconscious, was work-related.

Conclusion

In summary, we conclude that claimant was not paid for his activity at the time of his injury and his activity was not on the employer's premises. In addition, we conclude that claimant's activity was for the benefit of the employer; it was contemplated by the employer and the employee at the time of hiring or later; it was an ordinary risk of, and incidental to, the employment; and it was directed by or acquiesced in by the employer. Finally, claimant was not on a personal mission of his own when he was injured. Under these circumstances, and keeping in mind that no one factor is dispositive, we hold that claimant's injury arose out of and in the course of claimant's employment.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$4,000, to be paid by the 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 1, 1992 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded a \$4,000 attorney fee, payable by the employer.

In the Matter of the Compensation of
DARRELL R. EVANS, Claimant
WCB Case No. 91-10991
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Claimant has requested reconsideration of our May 4, 1993 Order on Review that affirmed a Referee's order which: (1) found the claim to be prematurely closed; and (2) awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by the Referee's order, not to exceed \$1,050. Specifically, claimant contends that we erred in declining to grant his counsel an extraordinary approved attorney fee. In order to consider this matter fully, we abated our order. After further considering this issue, we issue the following Order on Reconsideration.

At hearing, claimant's primary contention was that his claim was prematurely closed. (Tr. 5). If claim closure was correct, claimant contended alternatively that he should be awarded further permanent disability. (Tr. 5). Claimant did not request approval of an extraordinary attorney fee in the event he prevailed on the premature closure issue. The Referee agreed that the claim was prematurely closed; he set aside the Determination Order and approved an attorney fee payable out of the increased temporary disability compensation, not to exceed \$1,050.

On review, claimant has, for the first time, contended that his counsel was entitled to an extraordinary approved attorney fee for prevailing on the premature closure issue. We disagree.

We have previously held that, where a claimant successfully obtains additional temporary disability benefits by prevailing on a premature closure issue, his counsel is entitled to an approved attorney fee, *i.e.*, a fee payable out of the additional compensation. *E.g.*, Doris S. Klager, 44 Van Natta 982, 986 (1992); Earl F. Childers, 40 Van Natta 481, 485 (1988). OAR 438-15-045 provides:

"If the referee awards additional compensation for temporary disability the referee shall approve a fee of 25 percent of the increased compensation, but not more than \$1,050, to be paid out of the increased compensation."

Claimant argues that the complexity of the issue, the value of temporary disability benefits obtained, and the amount of time spent by his counsel in obtaining those benefits entitle his counsel to an approved attorney fee in excess of the standards set forth in OAR 438-15-045. We have not previously addressed a request by a claimant's counsel for an extraordinary attorney fee payable out of an award of additional temporary disability benefits. The authority for an extraordinary attorney fee is provided in OAR 438-15-025, which states:

"Except in situations where a claimant's attorney fee is an assessed attorney fee, in settlement of disputed claims or claim disposition agreements and in cases under third-party law, unless there is a finding in a particular case by a referee or the Board that extraordinary circumstances justify a higher fee, the established fees for attorneys representing claimants are as set forth in OAR 438-15-040, 438-15-045, 438-15-055(1) and 438-15-080."

The language of this rule is ambiguous. The rule appears to limit its application to "settlement of disputed claims or claim disposition agreements and in cases under third-party law." Yet, the rule also suggests that if there is a finding of extraordinary circumstances, a higher fee may be approved than is allowed under OAR 438-15-040, 438-15-045, 438-15-055(1) and 438-15-080. However, those cited rules do not apply to disputed claim settlements, claim disposition agreements, or third party cases; rather, they authorize approved fees in cases where additional permanent or temporary disability benefits are awarded by a referee or the Board. Thus, OAR 438-15-025 contemplates that extraordinary fees may be approved in cases where additional temporary or permanent disability benefits are awarded.

Our conclusion is supported by the Board's own interpretation of OAR 438-15-025 when it was revised, effective January 1, 1988. *See* WCB Admin. Order 5-1987. In its Order of Adoption, the Board summarized the maximum limits set for approved fees in cases where additional temporary disability or permanent disability benefits are awarded. The Board added, however, that it "retained a provision that

in truly extraordinary cases the referee or Board has discretion to award a fee in excess of the maximum, if the worker agrees to such a fee." Based on the language and intent of the rule, we conclude that OAR 438-15-025 permits an award of an extraordinary approved fee if a referee or the Board finds extraordinary circumstances in a particular case to justify a higher fee and finds that the worker agrees to the higher fee.

In this case, however, claimant did not request an extraordinary approved fee at hearing but, instead, made the request for the first time on Board review. An extraordinary approved fee, because it is paid out of compensation, reduces the amount of compensation that is ultimately received by the claimant. For that reason, it is essential that the forum awarding the additional benefits have a sufficiently developed record on the issue of whether extraordinary circumstances exist to justify a higher fee. We conclude, therefore, that the extraordinary fee request must first be made to the forum awarding the additional benefits from which the fee would be paid. Compare Linda K. Jones, 41 Van Natta 780 (1989) (held that requests for lump sum payments of attorney fees pursuant to OAR 438-15-085(1) must be made while the referee who granted the increased compensation award retained jurisdiction over the merits of the case). Our conclusion is also consistent with our previous approach to addressing requests for extraordinary carrier-paid attorney fees under our former rules. See Roger A. Shoff, 38 Van Natta 163 (1986).

Consequently, since claimant's request for an extraordinary "out-of-compensation" attorney fee was not presented to the Referee, we decline to consider the request on review. Therefore, the request is denied as untimely raised.¹

Accordingly, on reconsideration, as supplemented herein, we republish our May 4, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ Claimant's request could also be interpreted as a motion to remand for raising of the "extraordinary" attorney fee request, supplementation of the record, and consideration of the request. To the extent that claimant's request could be so interpreted, we would deny the remand motion. Although no Board decision has addressed this specific issue until today's holding, the rule as drafted and the Board's Order of Adoption have existed and been in effect since January 1, 1988. In light of such circumstances, we would not find a compelling reason to remand this case for further development concerning a request which could have been made in the exercise of due diligence at the time of hearing.

November 22, 1993

Cite as 45 Van Natta 2212 (1993)

In the Matter of the Compensation of
BRETT A. JOHNSON, Claimant
 WCB Case Nos. 91-16735 & 91-05514
 ORDER ON REVIEW
 Francesconi & Busch, Claimant Attorneys
 Garrett, et al., Defense Attorneys
 Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Mills' order that: (1) upheld SAIF Corporation's denial, on behalf of Reghitto Produce, of claimant's aggravation claim for a low back condition; and (2) upheld SAIF Corporation's denial, on behalf of D. Rhyne Painting, of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility.

We affirm and adopt the Referee's order with the following exception and supplementation (we do not adopt the Referee's findings of ultimate fact).

The Referee found that claimant had not established compensability of his low back condition either as an aggravation or a new injury. We agree.

Claimant has had a prior compensable back injury (lumbar strain) and has been diagnosed by his treating physician (Dr. Sirounian) with preexisting, bilateral spondylolysis. Where disability or need for treatment is due to the combination of an injury and a preexisting 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). For purposes of ORS 656.005(7)(a)(B) and ORS 656.308(1), a preexisting condition may be compensable or noncompensable. SAIF v. Drews, 318 Or 1 (1993).

Here, there are three medical opinions concerning whether claimant sustained a "new injury" while employed at D. Rhyne Painting/SAIF on December 1, 1990. Dr. Sirounian, an osteopath is claimant's treating physician. He opined that the major contributing cause of claimant's low back condition was a new injury which occurred on December 1, 1990.

Dr. Rich, a neurologist, and Dr. McKillop, an orthopedic surgeon, saw claimant for an independent medical examination. They opined that claimant suffered a contusion of his back on December 1, 1990 which has long since resolved.

Finally, Drs. Tesar, orthopedist, and Wilson, neurologist, also saw claimant for an independent medical examination. They opined that claimant's 1985 compensable injury (with SAIF/Reghitto) caused a lumbosacral strain/sprain and a lumbar pain syndrome. They concluded that claimant's preexisting lumbar pain syndrome is the major contributing cause of his current low back condition. They felt that claimant did not suffer a new injury on December 1, 1990.

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We generally defer to the treating physician, absent persuasive reasons not to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we find Dr. Sirounian's opinion to be conclusory and lacking in explanation and analysis. Specifically, Dr. Sirounian's opinion is a bare conclusion which does not discuss claimant's prior compensable low back injury and its effect, if any, on claimant's current low back condition. For these reasons, we find Dr. Sirounian's opinion unpersuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Likewise, we are unpersuaded by the opinions of Drs. Rich and McKillop. Their theory that claimant suffered a back contusion is not supported by Dr. Sirounian's contemporaneous reports or the history he took from claimant. Although Dr. Sirounian mentions a December 1, 1990 incident, he notes only that claimant has increased back pain. He does not mention a "contusion" which occurred as a result of a December 1, 1990 incident. On this basis, we find the opinion of Drs. Rich and McKillop concerning a "contusion" sustained on December 1, 1990 to be unpersuasive.

On the other hand, we find the opinion of Drs. Tesar and Wilson persuasive. In a well reasoned and complete report, they discuss claimant's prior low back injury and its effect on his present condition. Based on the report of Dr. Tesar and Dr. Wilson, we are persuaded that the major contributing cause of claimant's condition is the 1985 injury rather than a new injury occurring on December 1, 1990.

Having found that claimant's current condition is related to the 1985 injury, we address whether claimant has sustained a compensable worsening. The persuasive medical evidence does not support a conclusion that claimant's condition has compensably worsened since the last arrangement of compensation (a December 1987 referee's order which awarded 10 percent unscheduled permanent disability). Although Drs. Tesar and Wilson causally relate claimant's current back condition to the 1985 injury, their report does not support a conclusion that this condition has worsened since the last arrangement of compensation. Specifically, they concluded that there was no objective evidence supporting claimant's continuing problems from the 1985 injury. In addition, they found no evidence of permanent impairment. Based on their opinion, we conclude that claimant has not established a worsening of his condition since the last arrangement of compensation.

Because we conclude that claimant's current low back condition is not compensable as an aggravation or a new injury, we do not reach the responsibility issue.

ORDER

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

In the Matter of the Compensation of
CHARLES A. LAMERE, Claimant
WCB Case No. 92-09684
ORDER ON REVIEW
Belcher & Associates, Attorneys
Carolyn Ladd (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Kurt Gruen, an alleged noncomplying employer, requests review of that portion of Referee Mongrain's order which found that the Hearings Division lacked jurisdiction to set aside the Department of Insurance and Finance's (DIF) order of noncompliance. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

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

On April 24, 1992, the Workers' Compensation Division (WCD) of DIF issued an order finding Gruen to be a noncomplying employer. The noncompliance order contained appeal rights which stated in relevant part:

"If you disagree with this Order, you may request a hearing. Your request for hearing must be in writing, delivered to the Compliance/NCE Program at the address at the top of this document. Your request for hearing must state your grounds for disagreement and must be received by the Compliance/NCE Program within 20 days after you receive this Order. If a request for hearing is not received by the Compliance/NCE Program within the time specified above, this Order will become final by operation of ORS 656.740(3) and thereafter shall not be subject to review by any agency or court." (Emphasis in original).

The address listed on the top of the Division's order was "Workers' Compensation Division, Compliance/Noncomplying Employer Program, Labor & Industries Building, Salem, Oregon 97310." The order also listed a telephone number for the parties to call if there were questions concerning the order.

Attached to the Division's order was a notice explaining the rights of any alleged noncomplying employer. The notice explained that if the alleged noncomplying employer did not agree that he employed any subject workers during the relevant time period, he should request a hearing to contest the noncompliance order. The notice indicated that the instructions for requesting such a hearing (including the requisite time limit to do so) were contained in the noncompliance order. The notice also explained that if the alleged noncomplying employer objected to the worker's claim, the employer could request a hearing from the "Hearing Division, Workers' Compensation Board, 480 Church Street SE, Salem, OR 97310."

Gruen received the Division's noncomplying employer order on April 28, 1992.

On May 15, 1992, Gruen requested a hearing contesting the noncompliance order. Gruen's request referenced the Division's noncomplying employer order and stated, "In reply to your above mentioned order, dated April 24, 1992, I find that your claims are preposterous and a hearing would certainly be in order."

However, the request for hearing was not sent to the address given on the noncomplying employer order. Rather, Gruen sent the request to the Hearings Division of the Workers' Compensation Board at 480 Church St. SE, Salem, OR, 97310. The request was received by the Board on May 18, 1992, the 20th day after Gruen received the noncompliance order. Thereafter, the Board forwarded Gruen's request for hearing to the Workers' Compensation Division who received it on May 21, 1992, the 23rd day after the noncompliance order was issued.

On May 26, 1992, WCD denied Gruen's request for hearing on the basis that it was not received within 20 days of Gruen's receipt of the noncompliance order.

CONCLUSIONS OF LAW AND OPINION

The Referee found that Gruen had not filed with WCD a request for hearing concerning the noncompliance order within the statutory 20-day period. See ORS 656.740(3). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to review the noncomplying employer order. We agree.

ORS 656.740(1) provides that 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 hearing." (Emphasis supplied). In conjunction with this provision, ORS 656.740(3) provides that a hearing relating to a proposed order of noncompliance shall be held by a referee of the Workers' Compensation Board's Hearing Division. However, that provision also states:

" . . . but a hearing shall not be granted unless the 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 or penalty, or both, as proposed shall be a final order of the department and shall not be subject to review by any agency or court."

Here, Gruen received the noncomplying employer order on April 28, 1992. Gruen requested a hearing on the order, but mailed the hearing request to the Workers' Compensation Board, not the Department. The Board received the hearing request on May 18, 1992 and promptly forwarded it to the Department. However, the Department did not receive the request until May 21, 1992, which was more than 20 days after Gruen's receipt of the noncomplying employer order. Thus, pursuant to ORS 656.740(3), the Department's order of noncompliance is final and not subject to review. Consequently, we agree with the Referee that the Hearings Division did not have jurisdiction to consider Gruen's contentions with regard to the noncompliance order.

In reaching this conclusion we are mindful of Gruen's contention that he "complied" with ORS 656.740(1) by mailing the request for hearing to the Workers' Compensation Board. However, as clearly noted in the noncompliance order, the request for hearing was to be filed with the Department of Insurance and Finance's "Workers' Compensation Division, Compliance/Noncomplying Employer Program, Labor & Industries Building, Salem, Oregon 97310," not the Workers' Compensation Board. While both the Board and the Division are a part of the Department of Insurance and Finance (now Department of Consumer and Business Services), the two are distinct entities with separate functions and duties for purposes of workers' compensation law.¹ See ORS 656.005(3); 656.005(9). In this regard, ORS 656.740(1) clearly states that the filing of a request for hearing in these circumstances must be with the Department. For purposes of ORS Chapter 656, ORS 656.005(9) defines "Department" as "the Department of Insurance and Finance". Conversely, ORS 656.005(3) defines "Board" as the "Workers' Compensation Board."

Our decision in Barbara A. Gilbert, 36 Van Natta 1485 (1984), is instructive. In Gilbert, the claimant requested a hearing on the carrier's closure of his claim. The claimant did not request a Determination Order from the Evaluation Division prior to requesting a hearing. The claimant contended that his request for hearing satisfied his obligation to request a Determination Order from the Evaluation Division.

The Gilbert Board disagreed, finding that the claimant had to first request a Determination Order from the Evaluation Division prior to requesting a hearing. In reaching its conclusion, the Board found that the statutory scheme for contesting claim closure contemplated that a worker must first request a Determination Order from the Evaluation Division of DIF prior to requesting a hearing. Id. at 1487. The Board noted that requesting a hearing was not a procedural remedy that was available as an alternative to requesting a Determination Order, nor did the filing of a hearing request with the Board satisfy the statutory obligation to request a Determination Order from the Evaluation Division. Id.

¹ From the employer's brief, it appears that the employer is under the impression that the Workers' Compensation Board and the Department are housed in the same building. However, as explained in the noncomplying employer order and accompanying notice, the Department is at the Labor and Industries Building while the Workers' Compensation Board is at 480 Church Street SE. The Department and the Board reside in different buildings which are blocks apart.

Similarly, the Workers' Compensation Division has the statutory authority, under ORS 656.740(1), over hearing requests concerning orders of noncompliance. Likewise, in order to contest such an order, the filing of a hearing request with the Workers' Compensation Board does not satisfy the statutory obligation to direct that challenge to the Department. Therefore, we cannot agree with Gruen's contention that he complied with ORS 656.740(1) by mailing the hearing request to the Board.

ORDER

The Referee's order dated January 27, 1993 is affirmed.

November 22, 1993

Cite as 45 Van Natta 2216 (1993)

In the Matter of the Compensation of
MICHAEL R. McMAHON, Claimant
WCB Case No. 92-00041
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Barber's order that: (1) upheld the insurer's denial of his current low back condition; (2) found that claimant was not entitled to additional temporary disability benefits; and (3) declined to assess a penalty for the insurer's allegedly unreasonable termination of temporary disability. The insurer cross-requests review of that portion of the Referee's order which awarded a \$300 penalty-related attorney fee. On review, the issues are compensability, temporary disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We make the following additional findings.

On January 2, 1992, claimant's hearing request was received by the Board. That hearing request raised the issues of compensability, entitlement to medical services and penalties and attorney fees.

The insurer began paying temporary disability compensation on May 13, 1991. It continued to pay temporary disability until claimant was released by Dr. Hickerson for regular work on November 4, 1991. On November 20, 1991, Dr. Hickerson took claimant off work and the insurer resumed payments of temporary disability compensation. The insurer terminated temporary disability payments on December 10, 1991. On December 24, 1991, the insurer denied claimant's current low back condition.

Claimant's claim was closed by Notice of Closure on July 21, 1992. On July 22, 1992, claimant wrote to the Referee raising the additional issues of entitlement to further temporary disability after December 10, 1991 and penalties and attorney fees for failure to pay those benefits.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that his current low back condition was related to his May 1991 compensable injury. In addition, the Referee held that claimant was not entitled to further temporary disability compensation. Finally, despite concluding that claimant was not entitled to further temporary disability compensation, the Referee found that the insurer's conduct in terminating temporary disability compensation was unreasonable and awarded claimant's counsel a \$300 assessed attorney fee pursuant to ORS 656.382(1).

Compensability

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

The insurer denied the claim on the basis that claimant's current back condition was related to his prior compensable back injuries rather than the May 8, 1991 injury at its insured. On review, the insurer characterizes the prior compensable back injuries as "preexisting conditions" and contends that ORS 656.005(7)(a)(B) should be applied. Although it contended that claimant's back condition was a result of prior work injuries, it did not issue a responsibility disclaimer. We note that since the insurer did not issue a disclaimer of responsibility, it may not contend that another employer/insurer is responsible for claimant's condition. ORS 656.308(2); Richard F. Howarth, 44 Van Natta 1531, on recon 44 Van Natta 1673 (1992); Byron E. Bayer, 44 Van Natta 1686 (1992).

Turning to the merits, we agree with the Referee that claimant has failed to establish compensability of his back condition. Two physicians, Dr. Gambee, an orthopedist who saw claimant in an independent medical examination and who has treated claimant in the past, and Dr. Hickerson, claimant's attending physician, address the causation of claimant's back condition. Neither physician opines that the May 8, 1991 compensable injury is either a material or the major contributing cause of claimant's current back condition. (Exs. 62; 74; 75; 77-8). Because the medical evidence does not relate claimant's current back condition to the May 1991 compensable injury, claimant has not established compensability of his current back condition.

Temporary Disability

On review, claimant contends that the insurer improperly unilaterally terminated temporary disability since none of the bases for termination of temporary disability under ORS 656.268(3) had been met. Claimant seeks procedural temporary disability from December 10, 1991 until the July 21, 1992 Notice of Closure.

In Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992), we held that the Hearings Division has jurisdiction to address a worker's procedural entitlement to temporary disability, because that issue is ripe for adjudication prior to claim closure. However, as we emphasized in Yoakum, we may not make a determination regarding a worker's substantive entitlement to temporary disability benefits, since we lack jurisdiction over such matters. As we explained in our Order on Reconsideration in Yoakum, our order there was limited to the legality of the insurer's unilateral termination of procedural temporary total disability while the claim was in open status. We emphasized that we did not impose a requirement on the insurer to pay a greater amount of procedural temporary disability than the claimant's substantive entitlement.

Here, claimant seeks payment of temporary disability compensation from December 10, 1991 until claim closure. Since the Notice of Closure did not award temporary disability compensation during that period of time, we conclude that claimant seeks a greater temporary disability award than that granted by the Notice of Closure. In accordance with our holding in Yoakum, we conclude that inasmuch as claimant seeks a greater temporary disability award than granted by the Notice of Closure, the proper method of challenging the insurer's award of permanent disability is through a direct appeal of the Notice of Closure. Accordingly, we decline to address claimant's entitlement to further temporary disability.¹

Penalties and Attorney Fees

Since we have found that we may not address claimant's entitlement to further temporary disability compensation, there is no evidence that there are "amounts then due" upon which to base a penalty. However, ORS 656.382(1) warrants an attorney fee when a carrier engages in conduct which constitutes an unreasonable resistance to the payment of compensation.

In its brief, the insurer acknowledges that it paid temporary disability until the date it issued its current condition denial of claimant's back condition. However, such a denial does not entitle the insurer to terminate claimant's temporary disability under ORS 656.268(3). See Nancy G. Brown, 45 Van Natta 548 (1993). Moreover, the current condition denial was issued on December 24, 1991 and the insurer concedes that it terminated payments of temporary disability on December 10, 1991.

¹ We note that the present case is also distinguished from Yoakum in that, here, claimant did not raise the issue of entitlement to temporary disability after December 10, 1991 until July 22, 1992, one day after issuance of the Notice of Closure. Thus, unlike in Yoakum, claimant's hearing request concerning the insurer's unilateral termination of temporary disability was not filed prior to closure of the claim.

Considering the insurer's acknowledgments concerning when and why it terminated claimant's temporary disability, we conclude that the insurer's conduct constituted an unreasonable resistance to the payment of compensation. Accordingly, we affirm the Referee's assessment of a \$300 assessed attorney fee. Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's attorney is not entitled to an attorney fee for services on review concerning the insurer's cross-request. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

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

November 22, 1993

Cite as 45 Van Natta 2218 (1993)

In the Matter of the Compensation of
THOMAS D. PORTER, Claimant
 WCB Case No. 92-12279
 ORDER ON REVIEW
 Olson, et al., Claimant Attorneys
 Williams, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Baker's order that increased claimant's unscheduled permanent disability award from 11 percent (35.2 degrees), as awarded by Order on Reconsideration, to 26 percent (83.2 degrees). Claimant cross-requests review of that portion of the Referee's order that decreased the Order on Reconsideration award of 5 percent (6.75 degrees) scheduled permanent disability for the left foot and 5 percent (6.75 degrees) scheduled permanent disability for the right foot, to zero. Claimant contends that the Referee improperly relied on Exhibit 41, a "post-reconsideration order" report, in determining the extent of claimant's scheduled permanent disability. On review, the issues are extent of scheduled and unscheduled disability and evidence. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his findings that claimant's doctor has restricted him to light work; that claimant returned to light work; and that claimant's adaptability is 3 for a residual functional capacity adjustment from medium to light.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 11 percent, as awarded by Order on Reconsideration, to 26 percent. In addition, the Referee decreased claimant's scheduled awards to zero. The Referee admitted Exhibit 41 into evidence; however, he ruled that the exhibit could not be used to make findings regarding impairment.

Unscheduled Permanent Disability

The parties have stipulated to the values for age (1), formal education (0), training (1), and impairment (11). In its brief, the employer also agrees with the Referee's finding that the SVP for claimant's job as a forklift operator (DOT# 921.683-050) is 3, for a value under the "standards" of 3. OAR 436-35-300(3)(e). Thus, the only dispute between the parties concerning the unscheduled award is the correct value for the adaptability factor.

The "standards" in effect on the date of the May 7, 1992 Notice of Closure apply. WCD Admin. Order 6-1992. In addition, 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). The requirements listed in OAR 436-35-300(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 has worked as a forklift operator DOT# 921.683-050, which is described by the DOT as a medium strength job. The Referee concluded that claimant had returned to his regular job as a forklift operator. However, based on claimant's testimony, the Referee found that claimant performed this job as a light work occupation. On this basis, the Referee found that claimant's adaptability factor was 3 (medium to light). We disagree.

While we consider the record as a whole, including the job duties and the physical demands of the relevant job, in determining which DOT is most applicable, the fact remains that the most applicable DOT determines the strength category for that job. See OAR 436-35-300(3); OAR 436-35-270(3)(g); Kathryon D. Parsons, 45 Van Natta 954 (1993); William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993).¹ Claimant's testimony is relevant to the determination of which DOT most accurately describes his at-injury job. Kathryon D. Parsons, *supra*. However, claimant's testimony may not be relied on to determine that no DOT description accurately describes his job, and that, therefore, his strength category must be determined without regard to the DOT. *Id.*

Here, claimant does not contend that the DOT job description assigned by the Referee is inaccurate. Rather, he contends that he modified the forklift driver job after the injury such that it was a light job rather than a medium strength job. We do not find claimant's contentions persuasive.

First, as stated above, the strength requirement for claimant's job must be determined by the DOT job description. In any case, we would conclude, based on this record, that claimant returned to his regular work as a forklift driver. In this regard, we are not convinced that claimant modified his job significantly after his injury. His testimony indicates that his primary job duties both before and after his injury consisted of driving and operating the forklift.

As an incidental part of his job, claimant is required to lift objects. He essentially testified that he now avoids lifting and getting on and off the forklift when he can. Since his injury, claimant has relied more on co-workers to assist him with lifting. This testimony does not establish that claimant's job is substantially different than the job he held at the time of his injury. See OAR 436-35-270(3); Harrison v. Taylor Lumber & Treating, 110 Or App 325 (1992). Finally, we note that Dr. Stevens, claimant's physician, has stated that claimant "can continue on his regular job." (Ex. 34). Accordingly, we conclude that claimant returned to his regular work.

OAR 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. Here, claimant's RFC is the same as it was prior to the compensable injury. Accordingly, claimant's adaptability factor is 1. OAR 436-35-310(2); England v. Thunderbird, 315 Or 633 (1993); Melvin E. Schneider Jr., *supra*.

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).

¹ The cited cases apply an earlier version of the standards. However, the standards which apply to this case also contain language which indicates that prior strength is to be derived from the DOT description. We note that under current OAR 436-35-310(1) the highest prior strength is determined by looking at all of the jobs the worker has performed during the ten years preceding determination, whereas under the prior standards, only the job at injury was considered in determining prior strength.

Applying these rules 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 (11), the result is 16. Therefore, claimant's unscheduled permanent disability under the "standards" is 16 percent.

Scheduled Permanent Disability/Evidence

Reasoning that the record did not establish that claimant's loss of sensation in the feet was due to the compensable injury, the Referee reduced claimant's scheduled disability award to zero. In reaching this decision, the Referee relied in part on Exhibit 41 a medical report from Dr. Battalia, who reviewed claimant's records at the request of the employer. Dr. Battalia's report addresses whether claimant's sensory loss in the feet was causally related to the compensable injury. The Referee admitted the document into evidence "but not for purposes of making findings of impairment."

Claimant objects to Exhibit 41 on the grounds that it is a "post-reconsideration" report that is inadmissible under ORS 656.268(7). Claimant contends that the Referee improperly relied on Exhibit 41 to rate claimant's permanent disability since he used Dr. Battalia's report as the basis to reduce claimant's scheduled disability award to zero.

We agree with the Referee that inasmuch as Exhibit 41 is not from the attending physician, and the attending physician has not concurred with that report, Exhibit 41 may not be considered in evaluating the extent of claimant's disability. ORS 656.245(3)(b)(B); Eilene E. Harding, 45 Van Natta 2017 (1993) (on reconsideration); Dennis E. Connor, 43 Van Natta 1799 (1991).

In addition, there is some question whether Exhibit 41, authored by Dr. Battalia, can be considered inasmuch as the Director appointed a medical arbiter. ORS 656.268(7) provides that the findings of a medical arbiter shall be submitted to the Department for reconsideration purposes and "no subsequent medical evidence of the worker's impairment is admissible before the department the board or the courts for purposes of making findings of impairment on the claim closure." See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993) (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself).

However, we need not determine whether Dr. Battalia's report is inadmissible under ORS 656.268(7), because we would still reach the same conclusion even if that exhibit was not considered. The medical record, in the absence of Exhibit 41, does not establish that any loss of sensation claimant has is "due to" the compensable injury. See ORS 656.214(2); OAR 436-35-010(2). Dr. Zirschky, an orthopedist who saw claimant in consultation, opined that the etiology of claimant's foot complaints was unclear. He also opined that a portion of the problem might be due to claimant's noncompensable diabetes. Based on this record, excluding Exhibit 41, claimant has not established that his sensory loss in the feet is due to the compensable injury. Accordingly, we agree with the Referee that claimant has not established entitlement to an award of scheduled disability.

ORDER

The Referee's order dated February 24, 1993 is modified in part and affirmed in part. In lieu of the Referee's unscheduled permanent disability award and in addition to the Order on Reconsideration award, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability giving him a total award to date of 16 percent (51.2 degrees). Claimant's attorney fee shall be adjusted accordingly. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOSEPH REAVES, Claimant
WCB Case Nos. 92-14379, 92-09892, 92-13886 & 92-14378
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys
Jerome Larkin (Saif), Defense Attorney
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's and Liberty Northwest Insurance Corporation's (Liberty) denials of claimant's aggravation claims. On review, the issue is aggravation.

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

The Referee found that claimant failed to prove his aggravation claim, based on Dr. Phipps' statement that he could find no evidence of objective worsening in claimant's back condition. We agree that the aggravation claims, with Liberty (for the cervical condition)¹ and SAIF (for the cervical and/or lumbar conditions) are not proven, based on the following reasoning.

To establish an aggravation claim for his unscheduled back conditions, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991).

Claimant argues that his gradual symptomatic worsening supports his aggravation claim, despite the medical evidence indicating that his underlying cervical and lumbar conditions have not worsened "objectively" or "materially." (See Exs. 88, 94, 95, 102). Claimant is correct in that a symptomatic worsening may be sufficient for claim reopening, so long as the other requirements of ORS 656.273 are also fulfilled. See Lucas v. Clark, supra at 690 ("A worsened condition occurs when the claimant's physical condition or symptoms become exacerbated and cause . . . diminished earning capacity." (emphasis added) (citation omitted)). However, "[i]ncreased symptoms in and of themselves are not compensable and do not require payment of additional compensation, unless the worker suffers pain or additional disability that results in loss of the worker's ability to work and the worker thereby suffers a loss of earning capacity." Smith v. SAIF, 302 Or 396 (1986) (citation omitted); see also Fred Meyer v. Farrow, 122 Or App 164, 167 (1993) ("An aggravation of an unscheduled injury is measured by increased loss of earning capacity").

In this case, the evidence regarding claimant's earning capacity is provided by claimant, Dr. Berkeley, former treating surgeon, and Dr. Phipps, current attending physician. On May 20, 1991, Berkeley noted claimant's complaint that pain interfered with his work. (Ex. 68-1). After examining claimant, Berkeley recommended conservative treatment and opined that claimant should keep working. (Ex. 68-2). On September 26, 1991, Berkeley opined that claimant's symptoms had been severe enough to require emergency room evaluation, but that claimant was "still capable of performing his work duties[.]" (Ex. 78-1).

¹ Neither claimant nor SAIF dispute the Referee's finding that claimant filed no low back injury claim with Liberty and Liberty accepted no such claim. (O&O p. 2). In addition, there is no evidence suggesting that the nondisabling cervical condition accepted by Liberty is part of the current claim for a worsened low back condition. Moreover, there is no contention that claimant's current low back problems are related to his exposure with Liberty's insured.

Dr. Phipps first examined claimant on April 2, 1992. He noted that claimant quit working two months previously, "perhaps related to his pain, but also for other reasons." (Ex. 88-1; see Tr. 41-42). On June 26, 1992, Phipps noted claimant's belief that he is unable to work because of his pain. (Ex. 102-2). Claimant returned to work in September 1992 and was working as of the January 1993 hearing.

Since claimant's recovery from his third back surgery, no physician has advised claimant to refrain from working. On the contrary, Dr. Berkeley recommended that claimant "should" keep working. Furthermore, although Dr. Phipps noted claimant's history that he had left work because of his pain, Phipps also reported that the work departure had been "for other reasons." Under these circumstances, we are not persuaded that claimant's earning capacity has diminished since his last arrangement of compensation. Consequently, his aggravation claims with Liberty and SAIF fail.

ORDER

The Referee's order dated February 2, 1993 is affirmed.

November 22, 1993

Cite as 45 Van Natta 2222 (1993)

In the Matter of the Compensation of
PAULINE TAYLOR, Claimant

WCB Case Nos. 92-12152 & 92-07260

ORDER ON REVIEW

Benjamin W. Ross, Claimant Attorney

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Referee Thye's order that set aside its denial of claimant's injury claim for a left shoulder contusion. In her brief, claimant requests review of that portion of the order that upheld the insurer's denial of her injury claim for a neck and upper back strain. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except we do not find that claimant injured her left shoulder as a result of the August 27, 1992 work incident involving falling plastic plate covers.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the Referee's "Conclusions and Opinion" concerning the alleged March 13, 1992 work incident involving claimant's neck and upper back.

The Referee found that claimant proved an August 27, 1992 left shoulder injury at work, despite his negative "demeanor-based" credibility finding regarding claimant and his difficulty in believing claimant's account of the mechanism of this injury. We disagree, based on the following reasoning.

As the Referee noted, the employer's director of health services observed that claimant was standing immediately in front of the toaster upon which the plate covers were stacked, when several of the covers fell. On this evidence, we believe that the covers could have contacted claimant's left shoulder when they fell. However, because we agree with the Referee that claimant is not credible, we are not persuaded that claimant was injured by this incident.

In reaching this conclusion, we again note the Referee's negative "demeanor-based" credibility finding regarding claimant. In addition, we find inconsistencies in the record which support a conclusion that claimant is not credible. Specifically, when claimant sought treatment for thoracic symptoms in March 1991 she told one doctor that she had not previously injured her thoracic area and another that she had had no prior back problems. However, claimant did have a prior accepted 1989 claim involving her cervical and thoracic spine.

Under these circumstances, we conclude that the Referee's negative "demeanor-based" credibility finding regarding claimant is corroborated by claimant's failure to accurately report her history to her physicians. Moreover, since the medical opinions were likewise based on an inaccurate history, we do not rely on them. Because we agree that claimant is not credible and there is no persuasive evidence substantiating claimant's contention that she injured her left shoulder at work on August 27, 1992, we conclude that the claim fails.

ORDER

The Referee's order dated February 9, 1993 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 an August 27, 1992 left shoulder contusion is reversed. The denial is reinstated and upheld. The Referee's \$1,500 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

November 22, 1993

Cite as 45 Van Natta 2223 (1993)

In the Matter of the Compensation of
CAROLINE F. WOOD, Claimant
WCB Case No. 92-13837
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Livesley's order which declined to award an attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services in obtaining payment of certain medical bills without a hearing. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks an attorney fee pursuant to ORS 656.386(1) for his counsel's efforts in setting aside an alleged "de facto" denial of certain medical bills without a hearing. The Referee declined to award an attorney fee pursuant to ORS 656.386(1). Based on the following reasoning, we affirm.

From October 18, 1990 to March 26, 1991, claimant received medical treatment for her accepted psychological condition. The medical bills for these treatments were not paid until after claimant filed a request for hearing in October 1992. SAIF stipulated that it had paid the disputed medical bills late and agreed to pay a 25 percent penalty for unreasonable resistance to the payment of compensation. According to SAIF's claims examiner, the medical bills were paid late because SAIF initially questioned whether the treatment was palliative. SAIF's examiner never intended to deny compensability of the psychological condition. (Tr. 6-7; 12). The medical bills were finally paid after claimant's psychiatrist, Dr. Brown, informed SAIF that the treatment claimant was receiving was curative, not palliative. (Tr. 8).

On review, claimant relies on our decision in Deborah K. Atchley, 44 Van Natta 1435 (1992) in support of her contention that she is entitled to a fee under ORS 656.386(1). However, citing its decision in SAIF v. Allen, 124 Or App 183 (1993), the court has subsequently reversed our decision in Atchley. SAIF v. Atchley, 124 Or App 201 (1993).

In Allen, the court reversed that portion of a Board order which awarded the claimant a carrier-paid attorney fee under ORS 656.386(1) for prevailing against a carrier's "de facto" denial of medical bills without a hearing. Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute." The Allen court concluded that inasmuch as the hearing pertained to the carrier's nonpayment of some medical bills and since the compensability of the claimant's injury was never disputed, claimant's attorney was not entitled to an attorney fee award under ORS 656.386(1).

In the present case, the dispute involves unpaid medical bills in an accepted claim. Based on SAIF's claims examiner's un rebutted testimony, the compensability of the condition was never in question. Rather, the bills were unpaid because the examiner was unsure whether they were for palliative or curative treatment. Based on the court's holding in Allen, an attorney fee may not be awarded under ORS 656.386(1) since the subject of the hearing was a dispute about payment of medical bills rather than the compensability of claimant's injuries. Accordingly, based on the above reasoning, we affirm the Referee's order.

ORDER

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

November 23, 1993

Cite as 45 Van Natta 2224 (1993)

In the Matter of the Compensation of
FRANK L. TAYLOR, Claimant
 WCB Case No. MS-93001
ORDER ON REVIEW OF DIRECTOR'S ORDER (ORS 656.327 (1) (b)) (REMANDING)
 Francesconi, et al., Claimant Attorneys
 Beers, Zimmerman, et al., Defense Attorneys

Claimant requests review of a Medical Director's order under ORS 656.327(1)(b) which found no bona fide medical services dispute concerning claimant's request for reimbursement for physical therapy. On review, the issue is whether the Director's order is supported by substantial evidence. We set aside and remand.

Claimant compensably injured his back in 1978. His claim for that injury was closed in 1984. Claimant has received unscheduled permanent disability awards totalling 70 percent. His 5-year aggravation rights have expired and he was not working when this medical services dispute arose.

In 1992, Dr. Currier, claimant's attending physician, prescribed a course of physical therapy. Those treatments were conducted without prior authorization from the insurer. Claimant sought payment for those services from the insurer.

Asserting that the treatments constituted palliative care, the insurer sought additional information from Dr. Currier. In response, Dr. Currier contended that the treatments were not palliative, but rather had been prescribed to address a significant deterioration in claimant's pain control and a decrease in his functional level.

The insurer declined claimant's request for authorization for physical therapy. The insurer reasoned that: (1) claimant had not been declared permanently and totally disabled; (2) the proposed care was not necessary to monitor administration of prescription medication required to maintain a medically stationary condition; and (3) the proposed care was not needed to monitor the status of a prosthetic device. See ORS 656.245(1)(b).

Thereafter, claimant requested Director review of this dispute. Arguing that Dr. Currier's treatment was curative in nature and designed to address a worsening of claimant's compensable condition, claimant sought Director approval of physical therapy. In reply, the insurer relied on the reasoning expressed in its prior refusal. In addition, the insurer noted that, since claimant was not working, the treatments were not enabling him to continue his current employment. See ORS 656.245(1)(b).

The Director dismissed claimant's request for review. The Director reasoned that the requested services were palliative and that claimant had failed to comply with the established procedures for obtaining compensation for palliative care. See OAR 436-10-041(3). Claimant then requested a hearing with the Director challenging that dismissal.

Thereafter, the Director issued an order finding no bona fide medical services dispute. See ORS 656.327(1)(b). Continuing to find that the requested medical services were palliative and that Dr. Currier had not followed the appropriate procedures, the Director concluded that there was no bona fide medical services dispute. *Id.*

In reaching this conclusion, the Director reasoned that, since claimant's 5-year aggravation rights had expired and his claim was subject to the Board's "own motion" authority, "there is simply no legal recognition of and provision for deterioration [of a claimant's compensable condition] in a case such as [claimant's]." Consequently, in the absence of a Board or insurer reopening of the claim under ORS 656.278, the Director held that he was "constrained by the above rules and statutes in determining that [claimant's] care was palliative and that [claimant] did not, and does not fit any of the criteria that would permit him compensable palliative care." Thereafter, claimant requested Board review.

ORS 656.327(1)(b) provides that we shall set aside or remand the Director's order only if we find that the order is not supported by substantial evidence in the record. Substantial evidence exists to "support a finding," when the record would permit a reasonable person to make that finding. *Id.* (Emphasis supplied). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Queener v. United Employers Insurance, 113 Or App 364 (1992).

In conducting our review, we must determine if the findings necessary to support the Director's conclusion that no bona fide medical services dispute exists are supported by substantial evidence. Before conducting that inquiry, we must first determine what the essential findings are. See Cameron Logging v. Jones, 109 Or App 391, 395 (1991).

A Director's order comes directly to us only if the Director concludes that there is no bona fide medical services dispute. See ORS 656.327(1)(b); Jack H. Glubrecht, 43 Van Natta 1753 (1991). However, ORS 656.327 does not reveal when no bona fide medical services dispute exists. Instead, it tells us when such a dispute does exist. ORS 656.327(1)(a) provides:

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

In short, a bona fide medical services dispute exists when the Director, the claimant, and the insurer, or self-insured employer, are notified that one of those parties is seeking Director review of some aspect of the medical treatment the claimant is receiving as being inappropriate, excessive, ineffectual or in violation of the medical services rules. See OAR 436-10-046. Conversely, a bona fide medical services dispute would not exist if the medical services the claimant is receiving is not being challenged on one or more of the bases provided in ORS 656.327(1).

Consequently, we can uphold the Director's order only if the Director finds, based on substantial evidence, that the request for relief under ORS 656.327 does not present a challenge concerning whether the medical services are inappropriate, excessive, ineffectual or in violation of medical service rules. Following our review of the record, we are unable to reach such a conclusion regarding the Director's order.

The record reflects that the insurer refused to pay for claimant's physical therapy, claiming that the treatment was noncompensable palliative care. Claimant requested Director review of that refusal, contending that the physical therapy was curative. The Director recognized that claimant's request for review raised the issue of whether his care was palliative, rather than curative. Nevertheless, the Director concluded that such a dispute does not concern whether the requested care is inappropriate, excessive, ineffectual, or in violation of the medical service rules under ORS 656.327(1). Therefore, the Director concluded that this is not a bona fide medical services dispute. We disagree.

In Gladys M. Theodore, 44 Van Natta 905 (1992), we confronted the issue of whether the Director or the Board has original jurisdiction over disputes over whether care is palliative or curative (palliative care disputes). We concluded that the resolution of that issue depended upon whether palliative care disputes are medical services disputes under ORS 656.327(1)(a). Because a palliative care dispute "generally concerns the effectiveness and appropriateness of the medical treatment at issue," we concluded that such disputes are medical services disputes under ORS 656.327. Id.¹

Consistent with the Theodore rationale, we hold that whenever a claimant and a carrier have a genuine dispute over whether care is palliative rather than curative, and the party requesting Director review has some evidence to support its position, a bona fide medical services dispute exists under ORS 656.327. Here, based on Dr. Currier's opinion, we find some evidence to support claimant's contention that the proposed medical treatment is curative. Therefore, we conclude that the Director's order finding no bona fide medical services dispute is not supported by substantial evidence. Consequently, the Director's order is set aside and the case remanded. See ORS 656.327(1)(b).

The insurer also contends that, because claimant's attending physician did not follow the procedures outlined in OAR 436-10-041(3) to obtain prior authorization for the requested medical services, there can be no bona fide medical services dispute as a matter of law. We disagree.

OAR 436-10-041(3) provides the procedure that must be followed to obtain compensation for a medical service "[w]hen the worker's attending physician believes that palliative care, which would otherwise not be compensable, is appropriate to enable the worker to continue current employment * * * . Under the express terms of that rule, the specified procedures are applicable only if the requested medical services constitute palliative care. As we have already said, claimant contends that the physical therapy is curative, not palliative.

Compliance with the procedures outlined in OAR 436-10-041(3) was only necessary if claimant's treatments were palliative rather than curative. Because this dispute raised the issue of whether claimant's attending physician violated a Director's rule and since the resolution of that issue was contingent upon whether the disputed services are palliative or curative, it follows that this issue likewise raises a bona fide medical services dispute. See ORS 656.327(1).

Finally, the Director concluded that no bona fide medical services dispute existed because the requested physical therapy was noncompensable palliative care as a matter of law. In reaching this conclusion, the Director reasoned that in the absence of a Board or insurer reopening of the claim, the Director was constrained to hold that Dr. Currier's care was palliative and that claimant did not satisfy any of the statutory criteria for compensable palliative care. Inasmuch as the Director's order suggests that all medical services provided to a claimant whose claim is closed must be considered "palliative," we set aside that holding as contrary to the Director's medical rules.

ORS 656.245(1)(a) grants workers the right to medical services for a compensable injury "for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability." Notwithstanding that provision, however, "after the worker has become medically stationary, palliative care is not compensable, except [under circumstances not applicable to this case]." ORS 656.245(1)(b) (Emphasis supplied.)

"Palliative care" is not defined by statute; however, it is defined by the Director's rules as:

¹ In Theodore, we relied on our holdings in Stanley Meyers, 43 Van Natta 2643 (1991), that under ORS 656.327, the Director has exclusive, original jurisdiction over disputes concerning whether medical treatment is "excessive, inappropriate, ineffectual or in violation of [medical service] rules." The Court of Appeals recently reversed our decision in Meyers. Meyers v. Darigold, Inc., 123 Or App 217 (1993). The court held that the Director's jurisdiction under ORS 656.327 is exclusive only if a party or the Director "wishes" for Director review of the treatment and notifies the parties and the Director.

Here, claimant "wished" Director review of the physical therapy and notified the insurer and the Director pursuant to ORS 656.327(1)(a). Therefore, we apply the Theodore "palliative vs. curative" rationale in this case and find that the present dispute presents a medical services dispute under ORS 656.327.

"[A] medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to diagnose, heal or permanently alleviate or eliminate an undesirable medical condition."
OAR 436-10-005(31).

The rule does not support the Director's conclusion that medical services rendered on a closed claim must be considered palliative care. The rule makes no mention of whether the claim is in open or closed status. Rather, it is focused on whether the medical services are rendered to maintain a stable medical condition.

The Director's order suggests that, as a matter of law, a claimant whose claim is closed has a stable medical condition and, therefore, all treatment rendered for that condition is palliative care. We disagree with that reasoning. A claimant's medical condition is stable, or "medically stationary," when no further improvement in the condition is expected from medical treatment or the passage of time. ORS 656.005(17); see generally Timothy H. Krushwitz, 45 Van Natta 158 (1993). While it is true that a claimant must be medically stationary before his claim may be closed, see ORS 656.268(1), it does not follow that all claimants with closed claims are medically stationary.

This is demonstrated by the following example. A claimant whose claim is closed suffers a worsening of his compensable condition after the expiration of his aggravation rights. His physician recommends physical therapy to improve his condition. However, because the claimant's claim is in "own motion" status (due to the expiration of aggravation rights), he cannot qualify for claim reopening because his worsened condition does not require surgery or hospitalization. See ORS 656.278(1)(a). Thus, notwithstanding the medical evidence that the claimant's condition is not medically stationary, his claim must remain in closed status. Under the Director's interpretation of "palliative care," because this claimant's claim is closed, he would be precluded from establishing that the recommended physical therapy is anything other than palliative care, even though it would permanently alleviate his worsened condition. That interpretation is in direct conflict with OAR 436-10-005(31).

Rather, we conclude that OAR 436-10-005(31) requires an evaluation of the medical purpose of the disputed medical service, without regard to the legal determination of whether or not a claim qualifies for reopening. Thus, finding medical services as either palliative or curative will necessarily require a case-by-case determination. Consequently, we cannot conclude that there is substantial evidence to support the Director's finding that claimant's requested physical therapy was noncompensable palliative care as a matter of law.

Based on the foregoing reasoning, we hold that the Director's order is not supported by substantial evidence. See Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988). Accordingly, we set aside the order and remand to the Director for further proceedings consistent with this order.

ORDER

The Director's order dated February 8, 1993 is set aside. In accordance with ORS 656.327(1)(b), this case is remanded to the Director.

November 23, 1993

Cite as 45 Van Natta 2227 (1993)

In the Matter of the Compensation of
PRUITT WATSON, Claimant
WCB Case No. 92-04422
ORDER ON RECONSIDERATION
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.

On September 14, 1993, we withdrew our August 24, 1993 Order for Reconsideration. We have not received claimant's response to the employer's motion. Nevertheless, the time allowed for claimant's response having expired, we proceed with our review.

The employer contends that our decision in Daryl G. Richmond, 37 Van Natta 1168 (1985), authorizes an offset of money paid pursuant to a Disputed Claim Settlement (DCS) against all future compensation paid on the claim, not just against future permanent disability compensation. We disagree. On reconsideration, we reversed the Referee's order setting aside the DCS in that case. Daryl G. Richmond, *supra*, on recon 38 Van Natta 220 (1986), *aff'd Richmond v. SAIF*, 85 Or App 444 (1987). Thus, because neither we nor the Court of Appeals authorized an offset in the Richmond case, we do not consider it authority for allowing an offset against all future compensation.

Moreover, subsequent to our orders in Richmond, we held that overpaid compensation is recoverable only against future permanent disability awards. See Walter R. Olinger, 44 Van Natta 2544 (1992); Buddy Tillman, 41 Van Natta 239 (1989); William J. Dale, 39 Van Natta 632 (1987); Harold C. Bates, 38 Van Natta 992 (1986). Furthermore, ORS 656.268(13) permits crediting temporary disability payments only against permanent disability awards when a claim is closed under ORS 656.268.

Although our authority to allow an offset is not limited by ORS 656.268(13), we have nevertheless restricted the recovery of overpayments to offsets against future permanent disability awards. See Steve E. Maywood, 44 Van Natta 1199 (1992), *aff'd mem* 119 Or App 511 (1993) (duplicate payment under a stipulated order recoverable against future permanent disability). The policy behind not allowing offsets against future temporary disability benefits embodies the legislative purpose of insuring that workers receive income benefits when forced to leave work due to a compensable injury. See Catarino Garcia, 40 Van Natta 1846 (1988). We find no basis to depart from our current practice of authorizing offsets only against future permanent disability awards, simply because the overpayment in this case resulted from payment under a Disputed Claim Settlement.

Accordingly, we withdraw our August 24, 1993 order. On reconsideration, as supplemented herein, we adhere to and republish our August 24, 1993 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 24, 1993

Cite as 45 Van Natta 2228 (1993)

In the Matter of the Compensation of
DEBORAH G. PORTENIER, Claimant
 WCB Case No. 92-10299
 ORDER ON REVIEW
 Doble & Associates, Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of that portion of Referee Daughtry's order that set aside its partial denial of claimant's left dorsal wrist ganglion. On review, the issue is compensability.

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

The Referee relied on claimant's current treating physician, Dr. Layman, to conclude that claimant had established the compensability of her left wrist condition as a consequence of her compensable bilateral de Quervain's disease. See ORS 656.005(7)(a)(A). On review, the insurer contends that the Referee erred by discounting the opinions of Dr. Nathan and Dr. Button. After reviewing the medical opinions, we agree with the Referee that claimant's compensable de Quervain's disease is the major contributing cause of her current left wrist condition.

Dr. Layman reported that a July 13, 1992 bone scan revealed a "hot area" or soft tissue inflammation near the distal radial ulnar joint and radial carpal joint on the left side, related in major part to her July 1990 compensable work injury. In interpreting the bone scan results, Dr. Layman relied upon the opinion of Dr. Gates, the physician who interpreted claimant's bone scan images. Dr. Gates

found that the "hot area" on the bone scan was objective findings of a soft tissue inflammation and distinguishable from a bone abnormality. Dr. Layman explained that findings of soft tissue inflammation coupled with fullness over the dorsum of claimant's wrist, tenderness to pressure and an increase in nodule size in connection with increased pain, was clinical evidence of a left dorsum wrist ganglion.

In response to Dr. Button's opinion that surgery on claimant would represent "psychosurgery," Dr. Layman reported that: "It would be my opinion that this patient has sufficient clinical evidence that she has an organic process going on in both her right and left wrists, that it is unlikely that this patient's pain that she currently experiences is something that originated in her mind and that she is just seeking surgery for mental purposes at this time." 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 and January 1991 left wrist surgery for her compensable bilateral de Quervain disease. Dr. Nathan did not note any psychological factors operating as a motive for claimant's prior surgeries. However, concerning the issue of compensability of claimant's dorsal wrist ganglion, he believed that there was a possibility of psychological factors involved in claimant's seeking surgical treatment. On that basis, Dr. Nathan concluded that claimant's diagnosed dorsal wrist ganglion was not related to her de Quervain disease.

Dr. Button performed an independent medical examination. Disagreeing with the accuracy of a bone scan test for determining wrist ganglion, Dr. Button concluded that claimant's complaints were not caused by her de Quervain's disease. Dr. Button believed that claimant's desire for further surgical procedures was related to psychological factors concerning secondary gains from surgery.

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 supported by the tests he has performed. Somers v. SAIF, 77 Or App 259 (1986). Further, Dr. Layman persuasively rebutted Dr. Button's concerns regarding the bone scan test and any possible psychological factors relating to claimant's surgical treatment. Finally, Dr. Button saw claimant on only one occasion. Consequently, because Dr. Layman has had a greater opportunity to observe claimant and her behavior during the course of her treatment, we defer to his observations and conclusions.

We also agree with the Referee's conclusion that Dr. Nathan's opinion is not persuasive. Although he performed claimant's prior surgeries, Dr. Nathan has not seen claimant since August 1991. Further, Dr. Nathan did not address the results of the bone scan test, nor Dr. Layman's opinion.

Therefore, 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 opinion to be more persuasive. Further, we note that the opinion of Dr. Gates (the physician who interpreted claimant's bone scan images) was supportive of Dr. Layman's opinion. Accordingly, we find Dr. Layman's opinion to be more complete and well-reasoned than that of Drs. Nathan and Button. Further, we conclude that Dr. Layman effectively rebutted the contrary medical conclusions of Drs. Nathan and Button. Therefore, we find Dr. Layman to be the more persuasive medical opinion. Inasmuch as Dr. Layman's opinion established the compensability of claimant's dorsal wrist ganglion, we affirm the Referee.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$850, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 26, 1993 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$850, to be paid by the insurer.

In the Matter of the Compensation of
RUSSELL D. SARBACHER, Claimant

WCB Case No. 92-01491

ORDER ON REVIEW

Whitehead & Klosterman, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of that portion of Referee Michael V. Johnson's order that increased claimant's scheduled permanent disability for a right hand injury from 0 percent, as awarded by Order on Reconsideration, to 5 percent (7.5 degrees). Claimant cross-requests review of that portion of the Referee's order which found that, because the award had already been paid, the insurer was not responsible for payment of an approved attorney fee. On review, the issues are extent of scheduled permanent disability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

A November 12, 1991 Notice of Closure awarded claimant 5 percent scheduled permanent disability. In requesting reconsideration, claimant indicated that he objected to the impairment findings used in rating his scheduled permanent disability. Claimant also requested a medical arbiter's examination.

Following the arbiter's examination, the Appellate Unit, relying upon the medical arbiter's report, reduced claimant's permanent disability award to 0.

Claimant requested a hearing from the January 28, 1992 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee concluded that the Appellate Unit erred in reducing the 5 percent award which claimant was granted by the June 4, 1991 Notice of Closure. The Referee concluded that the Department was without authority to reduce claimant's award as claimant had appealed the Notice of Closure and sought an increased award and the insurer had not requested a reduction of the award.

Subsequent to the Referee's order, we concluded that the Department could modify unscheduled permanent disability values on reconsideration, even where a claimant had not specified disagreement with those particular values. See Darlene K. Bentley, 45 Van Natta 1719 (1993).

Under the circumstances, we conclude that the Department did have the authority to reduce claimant's award in the present case. We, therefore, proceed to the merits of the issue of extent of scheduled permanent disability.

Claimant's claim was closed on June 11, 1991 and he was medically stationary on December 12, 1990. Therefore, WCD Admin. Order 2-1991 applies to the rating of claimant's permanent disability.

Impairment is established by a preponderance of evidence, considering any medical arbiter's findings and any prior impairment findings. Timothy W. Reintzell, 44 Van Natta 1534 (1992).

Here, closing examinations were performed by claimant's treating physician, Dr. Lawton, and Dr. Moore, Salem Hospital's Rehabilitation Center physician. The Salem Hospital Discharge Summary stated that claimant's grip and pinch strength was below the 10th percentile for occasional handling with the right hand. Dr. Moore expected that at some time in the future that claimant would regain "good return of function in the right upper extremity." (Ex. 13). Dr. Lawton's closing report provided that claimant had pain and tenderness with activity. Dr. Lawton reported that claimant "has gained somewhat overall function but still has times where he has diffuse pain throughout the hand and wrist." (Ex. 14). Dr. Lawton opined that claimant was not able to manage heavy repetitive use of his wrist and only had a 50/50 chance of full recovery, if any, and only after a period of several years. (Ex. 14A).

Dr. Avery, the medical arbiter, found that claimant had no valid range of motion results. Based on this finding, Dr. Avery opined that claimant "has no objective findings" to indicate that his subjective complaints equate to a chronic or permanent medical condition. (Ex. 18).

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). Here, we find persuasive reasons to defer to the opinion of Dr. Lawton.

Dr. Lawton has treated claimant since his initial injury. Further, his conclusions are supported by Dr. Moore's findings. In contrast, Dr. Avery only examined claimant on one occasion and his opinion is contrary to the remaining medical evidence.

Based upon the evidence discussed above, we conclude that there is evidence of objective findings of measurable impairment. Therefore, we conclude that claimant is entitled to an award of scheduled permanent disability for an inability to repetitively use his right hand due to his chronic and permanent medical condition. See former OAR 436-35-010(6). Accordingly, we agree with that portion of the Referee's conclusion which affirmed the Notice of Closure award of 5 percent scheduled permanent disability.

Attorney Fee/Hearings Level

In his October 1, 1992 order, the Referee awarded claimant's counsel 25 percent of the increased scheduled permanent disability award created by his order, not to exceed \$2,800. However, the Referee concluded that the "award was already paid out so the attorney shall look to the claimant for payment of the above-awarded fee."

On review, claimant contends that the Referee erred by not directing the insurer to pay the approved fee. The insurer asserts that claimant's attorney is not entitled to a fee because the Referee did not award additional permanent disability, inasmuch as he reinstated the permanent disability awarded by the Notice of Closure.

We agree that, because claimant has apparently been paid the benefits awarded by the Referee that claimant is not entitled to receive additional payment as a result of the order. However, we do not agree that the order did not award "increased" scheduled permanent disability. The fact that the insurer has already paid the 5 percent permanent disability award does not detract from the fact that the Referee awarded, and we have affirmed, increased permanent disability from that awarded by the reconsideration order. See Judy A. Jacobson, 44 Van Natta 2450 (1992). In this regard, the effect of the Referee's order and this order is to establish claimant's entitlement to scheduled permanent disability of 5 percent. See Anthony E. Cochrane, 42 Van Natta 1619 (1990), aff'd mem 108 Or App 191 (1991) (claimant entitled to out-of-compensation fee where, at hearing, counsel establishes substantive entitlement to temporary disability benefits previously paid during processing of claim).

Moreover, to adopt the insurer's argument would be to contravene the provisions of OAR 438-15-085(2). That rule states:

"An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon a prior overpayment of compensation to the claimant."

Based on our conclusion that claimant's compensation was increased at hearing, claimant's attorney was entitled to a fee out of those increased benefits. OAR 438-15-040 & 438-15-055.

In reaching our conclusion, we distinguish the facts of this case from the case of Ralph D. Stinson, Jr., 44 Van Natta 1274 (1992). In Stinson, the claimant first received an award of 8 percent permanent disability. On reconsideration, the claimant's award was reduced to 3 percent. Following a hearing, the claimant's award was subsequently increased to 15 percent. The claimant contended that he was entitled to an out-of-compensation attorney fee based on the increased compensation between the referee's 15 percent award and the 3 percent award on reconsideration. We disagreed. Instead, we awarded a fee based on the difference between the 8 percent Determination Order award and the 15 percent awarded by the Referee. In doing so, we relied on a pre-hearing stipulation between the parties to the effect that the claimant was entitled to the 8 percent award made by Determination Order. Accordingly, the claimant's compensation was increased by the referee from 8 percent to 15 percent.

Here, by contrast, no such stipulation exists. To the contrary, the insurer asserted at hearing and on review that the Order on Reconsideration award of no permanent disability was correct and should be affirmed. Therefore, as we have previously concluded, claimant is entitled to a fee for increased compensation awarded beyond the Order on Reconsideration which awarded no permanent disability. Consequently, we modify the out-of-compensation attorney fee awarded by the Referee's order and direct the insurer to pay the out-of-compensation attorney fee award to claimant's counsel. See Judy A. Jacobson, supra at 2451.

Assuming that the permanent disability award granted by the Notice of Closure has been paid, as the insurer contends, our order will have created an overpayment of compensation, equal to the attorney fee awarded by the Referee. Should those circumstances exist, the insurer is authorized to recover the overpayment created by this order against claimant's future awards of permanent disability.

Inasmuch as the insurer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review concerning the permanent disability issue is \$700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 1, 1992 is modified in part and affirmed in part. The insurer is directed to pay the attorney fee awarded by the Referee's order directly to claimant's counsel. The insurer is allowed an offset, equal to the attorney fee awarded by the Referee, against future awards, if any, of permanent disability. The remainder of the Referee's order is affirmed. For services on Board review, claimant's counsel is entitled to an assessed fee of \$700.

November 26, 1993

Cite as 45 Van Natta 2232 (1993)

In the Matter of the Compensation of
DEBBIE L. SAYRE, Claimant
 WCB Case No. 92-08275
ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Westerland and Gunn.

The insurer requests and claimant cross-requests review of Referee Hoguet's order that increased claimant's unscheduled permanent disability award for a low back condition from 23 percent (73.6 degrees), as awarded by Determination Order and Order on Reconsideration, to 28 percent (89.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion," with the following modification.

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 contest the values assigned by the Referee for the education and adaptability factors used in rating claimant unscheduled permanent disability.¹ Regarding the education factor, the parties contend that the Referee erred in assigning a value of 2.5 for skills. We agree.

The value for skills is determined based on the jobs claimant has performed during the 10 years preceding the March 18, 1992 Determination Order. See OAR 436-35-300(3). We determine the job for which claimant has met the highest Specific Vocational Preparation (SVP) time, and then assign the corresponding value in OAR 436-35-300(3)(e).

At the time of her injury, claimant had been working for the employer as both an order entry clerk (DOT 249.362-026) and trade show representative (DOT 297.367-010). She has met the SVP level for both jobs. See OAR 436-35-300(3)(c). The order entry clerk job has an SVP level of 4, which corresponds to a value of 3; the trade show representative job has an SVP level of 5, which corresponds to a value of 2. See OAR 436-35-300(3)(e). The Referee averaged those values to arrive at 2.5; however, we find no provision in the rules for averaging skills values. Rather, as we stated above, the skills value must be based on the highest SVP level attained. Here, we find that claimant attained the highest SVP level of 5 as a trade show representative. Therefore, the skills value is 2.

The adaptability factor is based on a comparison of the highest prior strength (physical demand) required in the jobs claimant has performed during the 10 years preceding the March 18, 1992 Determination Order, and claimant's maximum residual capacity at the time of the Determination Order. See OAR 436-35-310(1).

We find that the job requiring the highest strength was trade show representative; according to the Dictionary of Occupational Titles, that job required light strength. We reject the insurer's argument that the job did not actually require claimant to lift items weighing more than 10 pounds. Claimant testified that the large, 30 to 40-pound boxes in which the individual items were packed usually had to be moved from the front of the booth, where they were delivered, to the back of the booth for unpacking. (Tr. 10).

Regarding claimant's maximum residual functional capacity at the time of the Determination Order, we rely on the narrative report by claimant's physical therapist, with which the attending physician concurred. (Ex. 70b). They impose a 10-pound lifting limitation and restrict claimant from repetitive lifting (even occasionally), both of which reflect restricted sedentary strength. See OAR 436-35-270(3)(e)(A) & (3)(g)(A). However, the report is internally inconsistent because it also provides that claimant is placed in the sedentary/light category of residual functional capacity. (Ex. 70b).

Notwithstanding the internal inconsistency, we are persuaded that claimant's actual functional capacity is restricted sedentary. In this regard, we find the specific functional limitations more reliable than the general strength category selected. Further, unlike the Referee, we do not find that claimant's testimony supports a sedentary/light residual functional capacity. Claimant testified that she believed she had the training and skills necessary to be a physical education teacher. (See Tr. 27). However, she did not state that she has the physical capacity to perform that job. Even if she believed that she has the physical capacity to do so, her belief would be contrary to the expert medical evidence.

Comparing claimant's highest prior strength demand (light) with her current maximum functional capacity (restricted sedentary), we find that the adaptability value is 4. Having determined each of the values necessary under the standards, we now calculate claimant's unscheduled permanent disability. The sum of the age value (0) and education value (2) is 2. The product of that sum and the adaptability value (4) is 8. The sum of that product and the impairment value (23) is 31. Therefore, claimant's unscheduled permanent disability award is increased to 31 percent. OAR 436-35-280.

¹ The insurer argues that claimant is not entitled to any values for education and adaptability because she allegedly was released for regular work. 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's temporary rules in WCD Admin. Order 93-052 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., supra.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of unscheduled permanent disability issue is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, claimant's attorney is also awarded an "out-of-compensation" fee payable from the increased compensation created by this order, provided that the total "out-of-compensation" attorney fee awarded by the Referee's order and this order does not exceed \$3,800. ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated November 2, 1992 is modified. In addition to the Determination Order/Order on Reconsideration and Referee awards of 28 percent (89.6 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, giving her a total unscheduled permanent disability award of 31 percent (99.2 degrees). Claimant's attorney is awarded an additional out-of-compensation attorney fee of 25 percent of the additional compensation created by this order, provided the total of fees approved by the Referee and this order shall not exceed \$3,800. In addition, claimant's attorney is awarded an assessed fee of \$1,000 for services on Board review, to be paid by the insurer.

November 29, 1993

Cite as 45 Van Natta 2234 (1993)

In the Matter of the Compensation of
WILLIAM W. CLUNAS, Claimant

WCB Case Nos. 92-05561, 92-05560, 92-04807, 92-03721, 92-01395 & 91-14513

ORDER ON REVIEW

Hollander & Lebenbaum, Claimant Attorneys
Pamela A. Schultz, Defense Attorney
Stoel, Rives, et al., Defense Attorneys
Williams, et al., Defense Attorneys
Scott Terrall & Associates, Defense Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Liberty Northwest Insurance Corporation, on behalf of Ron Construction, requests review of those portions of Referee Neal's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for bilateral carpal tunnel syndrome and bilateral rotator cuff tendinitis; (2) upheld the denial by Scott Wetzel Services, on behalf of Performance Contracting, of responsibility for the same conditions; and (3) upheld the denial by Liberty Northwest, on behalf of Fred Shearer & Sons, of responsibility for the same conditions. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and related attorney fees for allegedly unreasonable denials and claim processing. On review, the issues are responsibility and penalties and attorney fees. We affirm in part and reverse in part.

Responsibility

We affirm and adopt the Referee's order concerning this issue.

Penalties and Attorney Fees

Claimant requests the assessments of penalties and/or attorney fees against: (1) Ron Construction/Liberty Northwest (Ron/LNW) for its allegedly unreasonable denial of compensability; (2) Performance Contracting/Scott Wetzel Services (Performance/SWS) for its allegedly unreasonable denial of compensability; (3) Gunderson Drywall/Liberty Northwest (Gunderson/LNW) for its allegedly unreasonable failure to accept or deny the claim within 90 days; and (4) Beaverton Walls & Ceilings/Liberty Northwest (Beaverton/LNW) for its allegedly unreasonable failure to accept or deny the claim within 90 days.

A denial is unreasonable if the insurer has no legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). The reasonableness of the denial is determined on the basis of the facts and circumstances in existence on the date of the denial. Hutchison v. Fred Meyer, Inc., 118 Or App 288, 291 (1993); Ginter v. Woodburn United Methodist Church, 62 Or App 118, 122 (1983).

Ron/LNW

When Ron/LNW issued its compensability denial on January 24, 1992, all of the existing evidence supported the compensability of claimant's bilateral carpal tunnel syndrome. (Exs. 2, 5-2, 9-4). Further, contrary to the Referee's implied finding, there was no evidence to support a finding that claimant's claim filing was untimely. Hence, we conclude that Ron/LNW's denial of the carpal tunnel syndrome was unreasonable.

Accordingly, Ron/LNW is assessed a penalty equal to 25 percent of all amounts of compensation due at the time of hearing as a result of the Referee's order for the carpal tunnel syndrome. See ORS 656.262(10)(a). In this regard, we note that the penalty may be based on medical benefits that became due as a result of the setting aside of the denial of compensability. See Conagra, Inc. v. Jeffries, 118 Or App 373, 376 (1993). Because of the penalty assessment, we may not also assess a penalty-related attorney fee under ORS 656.382(1) for the unreasonable denial. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

We find that Ron/LNW had a legitimate doubt as to the compensability of claimant's shoulder tendinitis condition. Drs. Wilson and Neufeld of First Northwest Health found that claimant's shoulder complaints far outweighed any objective findings. Based on "significant" psychologic interference, they found it difficult to evaluate shoulder symptoms. (Ex. 9-4). Based on that report, we conclude that the compensability denial of the shoulder tendinitis was reasonable.

Beaverton/LNW

For the same reasons discussed above, we find that Beaverton/LNW's refusal to concede the compensability of claimant's carpal tunnel syndrome was unreasonable. Its refusal effectively prevented the designation of a paying agent pursuant to ORS 656.307. Accordingly, Beaverton/LNW is assessed a penalty equal to 25 percent of all amounts of compensation due at the time of hearing as a result of the Referee's order for the carpal tunnel syndrome. See ORS 656.262(10)(a). In this regard, we note that ORS 656.262(10)(a) allows a maximum penalty of 25 percent to be assessed against a single insurer or employer, but it does not prohibit the assessment of a penalty against each insurer or employer for separate unreasonable conduct even though that insurer or employer is not responsible for the claim. See Alfred M. Norbeck, 35 Van Natta 802, 804 (1983), aff'd SAIF v. Norbeck, 70 Or App 270 (1984); Michael L. Whitney, 45 Van Natta 446 (1993).

Performance/SWS

For the same reasons discussed above, we find that Performance/SWS's October 3, 1991 denial of the compensability of the carpal tunnel syndrome was unreasonable. Although Performance/SWS later conceded compensability of the claim on April 8, 1992, its delay in conceding compensability prevented the designation of a paying agent pursuant to ORS 656.307, thereby delaying claimant's receipt of compensation. Inasmuch as there were no amounts of compensation due at the time Performance/SWS rescinded its compensability denial, there are no amounts "then due" on which to assess a penalty pursuant to ORS 656.262(10). See Linda M. Akins, 44 Van Natta 108, 111 (1992).

However, we may assess an attorney fee under ORS 656.382(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 concerning Performance/SWS's unreasonable resistance to the payment of compensation is \$500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Gunderson/LNW

For the same reasons discussed above, we find that Gunderson/LNW's delay in conceding the compensability of claimant's carpal tunnel syndrome was unreasonable. Its delay effectively prevented the designation of a paying agent pursuant to ORS 656.307. Inasmuch as there were no amounts of compensation due at the time Gunderson/LNW rescinded its compensability denial, there are no amounts "then due" on which to assess a penalty pursuant to ORS 656.262(10). See Linda M. Akins, supra.

However, we may assess an attorney fee under ORS 656.382(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 concerning Gunderson/LNW's unreasonable resistance to the payment of compensation is \$500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 21, 1992 is reversed in part and affirmed in part. Ron Construction/Liberty Northwest Insurance Corporation and Beaverton Walls & Ceiling/Liberty Northwest Insurance Corporation are each assessed a penalty equal to 25 percent of the amounts of compensation due at hearing as a result of the Referee's order for the carpal tunnel syndrome, payable in equal shares to claimant and his attorney. Performance Contracting/Scott Wetzel Services is assessed an attorney fee of \$500 under ORS 656.382(1), payable to claimant's attorney. Gunderson Drywall/Liberty Northwest is assessed an attorney fee under ORS 656.382(1) of \$500, payable to claimant's attorney. The remainder of the Referee's order is affirmed.

November 29, 1993

Cite as 45 Van Natta 2236 (1993)

In the Matter of the Compensation of
PAULETTE G. LAYMAN, Claimant
 WCB Case No. 91-17699
ORDER ON REVIEW
 Ronald A. Fontana, Claimant Attorney
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of claimant's occupational disease claim for a psychological disorder. In her brief, claimant argues that the Referee erred in declining to admit certain testimony. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONEvidentiary matters

The Referee declined to admit testimony regarding claimant's supervisor's alleged prostitution conviction and the effect that knowledge of this conviction had on claimant. In this regard, claimant contends that knowledge of her supervisor's alleged conviction reasonably explains her perceptions and responses to his overtures. Consequently, claimant argues that the Referee erred in excluding this evidence. We need not resolve this question because even if we consider the disputed testimony it would not alter our conclusion.

In reaching this conclusion, we first note that claimant does not dispute the Referee's finding that claimant is not credible concerning the details of her relationship with her former supervisor. Specifically, the Referee found that the personal aspect of the relationship between claimant and her former supervisor ended before claimant transferred to a different shift in March 1989. We agree with the Referee that claimant's testimony in this regard is rebutted. (See O&O pp. 4 & 6). We further find that claimant's problems with her former supervisor ended long before her psychological problems began in 1991. Accordingly, even if evidence of the former supervisor's alleged conviction (and the effect this knowledge had on claimant) is considered, such evidence would be of little assistance in establishing the compensability of claimant's psychological claim.

The Referee also excluded claimant's testimony about what others allegedly told her concerning the plant manager's words and actions. Claimant offered the latter testimony to show its effect on her, specifically to establish the reasonableness of her perception of being picked on and otherwise singled out by the plant manager. (See Tr. 344).

We need not resolve this evidentiary issue, because the record already establishes that the plant manager did eventually single claimant out, for valid disciplinary reasons. Consequently, even if we were to consider what co-workers allegedly told claimant about the plant manager's words and actions, we would reach the same conclusion. In other words, as we explain below, to the extent that the plant manager did treat claimant differently from other workers, such differential treatment was reasonable disciplinary action, a noncompensable stressor.

Compensability

We adopt the Referee's opinion on the merits, with the following exception and supplementation.

We agree with the Referee that claimant has not established the real and objective existence of most of the stressors claimed. However, we do not find that there is "no evidence" to support claimant's perception that her employer's plant manager stared at her or that the machine claimant worked on was positioned so that the employer could watch her. (O&O p. 6, fourth and fifth full paragraphs).

Instead, we find that the plant manager did stare out his window, claimant believed that he stared at her, and this was stressful to claimant. Accordingly, we find that this particular stressor existed in a real and objective sense. However, there is persuasive evidence indicating that the manager's staring often had nothing to do with claimant. Moreover, to the extent that the manager did look for and at claimant, we find his action to be reasonable corrective action by the employer.

The plant manager began noticing that claimant was often not at her work station when claimant was on light duty following her first (noncompensable) foot surgery. At this time, claimant began perceiving that the manager stared at her. After the manager was repeatedly unable to locate claimant, he ordered her work station repositioned so that he could keep an eye on her. Accordingly, claimant's work station was moved to be within the manager's direct line of sight. Under these circumstances, we find that the plant manager's conduct was reasonable corrective action. As such, it does not qualify as a compensable stressor under ORS 656.802(3)(b). Accordingly, on this evidence we agree that claimant has not proven her claim.

ORDER

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

In the Matter of the Compensation of
MARY A. MURPHY, Claimant
WCB Case Nos. 92-01452, 91-15429 & 91-16504
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Marcia Barton (Saif), Defense Attorney
Eileen G. Simpson, Defense Attorney

Reviewed by Board Members Westerland, Haynes, and Gunn.

Claimant requests review of Referee Myzak's order that upheld the SAIF Corporation's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Referee found that no physician was provided with a complete and accurate history. On that basis, the Referee concluded that claimant had failed to establish the compensability of her mental disorder. We agree.

In order to establish compensability of a stress-related mental condition, the worker must prove that the employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Claimant has the burden of proof to establish compensability of her occupational disease. ORS 656.266. We conclude that claimant has failed to carry her burden.

Claimant is a part-time teacher of talented and gifted (TAG) students. Her job required her to teach talented and gifted children at five different elementary schools.

There is no dispute in this case that claimant suffers from a mental disorder generally recognized in the medical community. The dispute between the parties is over the question of causation. Four doctors address that question.

Dr. Heck, psychiatrist, saw claimant for an independent medical examination. He diagnosed adjustment disorder with mixed emotional features and opined that claimant's employment conditions did not produce the mental disorder. He believed that claimant's disability resulted from her grave disappointment when she was not hired as a full time classroom teacher.

Dr. Stipek, claimant's treating psychologist, identified several "work-related" stressors as the major contributing cause of claimant's mental disorder. In his opinion, these stressors were the following: claimant's failure to obtain a full-time regular classroom teaching position; being supervised by a hostile principal (Dr. Painter); having to teach at five different schools and work with five different staffs; a lack of evaluations; not having a place to keep her teaching materials; seemingly indifferent school district personnel; elimination of a peer group; and a new State mandate for TAG education which brought changes in the manner by which claimant performed her job and which would increase the number of students for which she was responsible.

Dr. Turco, psychiatrist, saw claimant for an independent medical examination. He opined that the major contributing cause of claimant's mental disorder was the change in the curriculum in the TAG program as a result of the new State mandate. Dr. Turco stated that as a result of the curriculum change, claimant faced new job expectations, different job duties, and additional responsibilities. Dr. Turco also stated that claimant felt she was reporting to too many people. Dr. Turco opined that these stressors constituted 98 percent of the reason claimant developed the mental disorder.

Dr. Holland, psychiatrist, also saw claimant for an independent medical examination. In his initial report, Holland opined that the stressors identified by Stipek and Turco were the major contributing cause of her need for medical services. However, after Dr. Holland was informed that claimant had received negative evaluations and corrective job performance actions, he stated that claimant's "perception" of her employment conditions was the major contributing cause of her mental disorder. He explained that the trier of the facts would have to decide how much weight should be given to claimant's perceptions or whether the employer's negative assessment of claimant's work performance was valid.

The problem Dr. Holland had reaching an opinion on causation is the primary problem with claimant's case. As stated previously, a mental condition is not compensable if it is the result of reasonable disciplinary or corrective job performance actions. Here, the evidence establishes that claimant was under heavy pressure from corrective job performance actions. These actions began when Dr. Painter became claimant's supervisor in 1989. They primarily involved the administration's responses to claimant's failure to write lesson objectives, and addressed, to a lesser extent, other issues such as absences framework, problems of communication with administrators, and claimant's failure to timely complete a science unit for second grade teachers. As stated previously, the most important problem concerned the lesson objectives. There is un rebutted evidence that writing lesson or teaching objectives which are congruent with lesson plans is a fundamental teaching skill possessed by all teachers in the school district, except claimant. The record further indicates that having objectives for lessons is necessary to ensure that the teacher's efforts are effective in that the students benefit from the lessons taught. Because of claimant's failure to satisfy the employer's job performance expectations; particularly with regard to lesson objectives, the employer was considering formal disciplinary action at the time claimant left work due to her mental disorder.

Although generally supportive of claimant's case, neither Dr. Stipek nor Dr. Turco was aware of the corrective job performance actions being undertaken contemporaneous with the onset of claimant's disability. Accordingly, they did not have an accurate history upon which to base an opinion on the question of causation. For this reason, their opinions are not persuasive.

In reaching our decision, we note that the testimonies of Dr. Painter (claimant's supervisor) and Dr. Riley (Assistant Superintendent for Personnel and Employee Relations) suggest to us that they bore a considerable degree of hostility toward claimant. For example, in spite of their supervisory positions, they were unfamiliar with claimant's considerable qualifications and professional achievements, or characterized them as "minimal." (Tr. 215-216; 152). Their hostility and/or indifference places in question their objectivity and good faith. In fact, the hostility demonstrated by their testimony at hearing is the primary basis for claimant's argument that the corrective actions taken were not reasonable. We might have a legitimate reason to agree with that argument had the employer imposed some serious discipline not commensurate with the performance problems addressed (*e.g.*, wage reductions, suspension, or discharge). However, the employer's concerns were legitimate, and its responses to them were not excessive. Rather, the corrective actions were preliminary to the first level of formal discipline, which is the imposition of a formal work performance plan. We conclude that claimant has failed to carry her burden of proving that the corrective actions were unreasonable.

Furthermore, another stressor prominently identified in the medical reports as a cause of claimant's mental condition is the new state mandate for TAG education which changed the way claimant performed her job. We have previously held that operating within everchanging legal parameters is a condition generally inherent in every work place. See Barry M. Bronson, 44 Van Natta 1427 (1992). Here, the changes to the TAG program are an example of rules and guidelines which affect all jobs. Thus, even though the changes to claimant's job as a result of the state mandate might understandably produce some degree of stress in a TAG teacher, changes in regulations or laws which affect the manner in which a worker performs his or her job is a type of stressor which is generally inherent in every work place. The opinions of Dr. Stipek and Turco must be discounted, because they identify the TAG program changes as a significant stressor in claimant's case.

Likewise, claimant's failure to secure a full-time regular teaching position, another substantial stressor identified by Dr. Stipek, further diminishes the persuasive force of his opinion. As stated previously, 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 work environment. We conclude that an individual's inability to obtain a desired job is not, in and of itself, an "employment condition" within the meaning of ORS 656.802. Here, the only evidence linking claimant's unsuccessful job search to her "conditions of employment" is her assertion that the gap in her performance evaluations affected her ability to find work as a teacher. However, we find no evidence that the gap in evaluations was the cause of claimant's failure to obtain new employment. In fact, the record indicates that claimant was offered a part-time, regular classroom position, but turned it down.

Dr. Stipek's report specifically refers to claimant's failure to obtain a teaching position at Maple School as a stressful event. (Ex. 40-10, 11). However, Dr. Riley testified that the reason claimant was not chosen for the Maple job was that when he checked the references in the principal's recommendation, they did not accurately reflect the opinions of the people alleged to have recommended claimant for the position. (Tr. 140). There is no persuasive evidence to the contrary. We are unable to conclude that claimant's failure to obtain a regular teaching job was related to her employment conditions.

We acknowledge that some of the conditions claimant experienced in her job, such as being required to work in five different schools without a permanent teaching space or a place to store records and materials, are stressful conditions which are not experienced by teachers in general. However, Drs. Stipek, Turco, and to a lesser degree, Holland also based their opinions on the conditions discussed above which cannot be considered. There is no medical opinion in the record except for Dr. Holland's which acknowledges and attempt to factor out the work performance problems claimant was having, the corrective actions being taken, and claimant's substantial frustration (about which she testified at hearing) due to her inability to meet the employer's expectations. Thus, based upon our careful examination of the record as a whole, we must agree with the Referee that claimant has failed to carry her burden of proof.

ORDER

The Referee's order dated September 8, 1992, as amended September 15, 1992 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's finding that the employer's conduct here constituted reasonable corrective action. Claimant is a qualified teacher of talented and gifted students with considerable expertise in this area of teaching. She has taught TAG classes at the University of Oregon and was also a member of the science and math cadres in Lane county. Claimant began working for the school district in 1984 and consistently received good performance evaluations until Dr. Painter became her supervisor.

As explained in my concurring opinion in Daniel Jackson, 43 Van Natta 2361 (1991), among other things, a reasonable employer disciplines in good faith; considers the employee's length of service and prior service record; and does not, through its own actions, exacerbate disciplinary problems.

Here, upon becoming claimant's supervisor, Dr. Painter's main objection to claimant's performance was that claimant's writing of lesson goals (objectives) was inadequate. However, instead of offering a supportive environment to claimant, Dr. Painter treated claimant with hostility which was clearly evident in Painter's testimony at the hearing. (In fact, the hostility of Painter and the other school administrators was so evident at the hearing that even the Referee remarked upon it in her order). Painter's aggressive and negative approach toward claimant's writing exacerbated claimant's relatively minor performance problems and her doubts about implementation of the new state mandate. The goal of reasonable corrective action should have been to aid claimant to once again perform her job in an acceptable manner.

During my experience as a union public employee representative, the scenario which occurred in this case was all too common. In that scenario, a good employee would be hounded and harassed by a supervisor over minor problems until that employee would leave the job. I, as the union representative, could do little because no formal discipline had been used. Under that scenario, instead of formal discipline, the supervisor would engage in arbitrary and aggrecious actions which aggravated the employee's problems and induced the employee to leave the job.

Although the employer's defense at hearing was that claimant was an unsatisfactory employee, no formal discipline was ever instituted against claimant and claimant's union was never notified of impending discipline or that claimant's performance was unsatisfactory. In short, claimant was a good employee who developed minor performance problems, which should have been dealt with in an objective manner by the employer.

As a part-time itinerant TAG teacher, claimant worked at five different schools with five separate principals and staffs. She had no permanent teaching space and no area to store her records and teaching supplies. She was required to haul all of her teaching supplies and records in the trunk of her car to each school. These stressors existed in a real and objective sense. In addition to the generally stressful nature of claimant's work, changes were being made to the TAG program which would change how claimant would perform her job. It was not known exactly what impact the new state mandate would have on claimant's job.

Into this already stressful environment, was added a hostile and indifferent supervisor. Claimant's supervisor and the school district administrators were unaware or indifferent to the unique stresses of her job. For example, the employer's superintendant for personnel and employee relations, Dr. Riley, believed that claimant's job, which entailed working in five different schools and hauling all of her teaching supplies and records around in her car, was not more stressful than a regular teaching job in a single classroom. In addition, although he testified that he believed claimant's employment was "in jeopardy," Riley had no knowledge at all of claimant's background and qualifications for the job. (Tr. 152; 153). Dr. Painter testified that she felt claimant was "minimally" qualified and was "surprised" to learn that claimant had taught graduate level classes in talented and gifted education and been appointed by the Department of Education to the TAG leadership cadre. (Tr. 215-217).

Based on their testimony, it is evident that these administrators reacted without objectivity and in an unreasonable manner to claimant's minor performance problem. Given claimant's past performance as a TAG teacher and the length of her service, the employer's actions were unreasonable. Because of what was essentially one defect in her performance, Painter and Riley decided that claimant should be forced out of her job. The appropriate response from the employer should have been to work with claimant who had previously always received good evaluations. Instead, Painter, Riley and the others exacerbated claimant's minor problems and caused the stress that led to the development of claimant's mental disorder.

The medical evidence from both the attending psychologist and from two IME psychiatrists establishes that claimant has a mental disorder which was caused, in major part, by her employment conditions. I do not agree that these medical opinions should be discounted. Dr. Stipek clearly knew that claimant was having difficulties with the administration. In addition, claimant was never formally or informally disciplined. I do not believe the physicians had inaccurate histories. Dr. Holland was eventually aware of the corrective action and he opined that claimant's perception of her employment conditions was the major contributing cause of her mental disorder. He left it to the trier of fact to determine whether those perceptions were accurate. I conclude that they were. Since claimant sought a full time regular classroom position, I likewise find it insignificant that the physicians did not know that claimant had once turned down a part-time regular job.

The employer's aggressive corrective action taken in regard to claimant's minor performance problems and the indifferent, hostile and unsupportive supervisors, were sufficient, in a time of change in the TAG program, to cause claimant's mental disorder. I would find that the employer's corrective actions were unreasonable and I would find the stress claim compensable. For these reasons, I must dissent.

In the Matter of the Compensation of
JUDITH K. NIX, Claimant
 WCB Case No. 92-12884
 ORDER ON REVIEW
 Schneider, et al., Claimant Attorneys
 Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Referee Peterson's order that authorized the self-insured employer to offset overpaid permanent disability benefits against any future award of permanent disability compensation. On review, the issue is offset.

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

Claimant requested a hearing on the self-insured employer's failure to timely pay unscheduled permanent disability as awarded by a Determination Order. The Referee ordered the employer to pay the permanent disability compensation, less amounts already paid, and authorized an offset against any future award of permanent disability.

Claimant contends that the Referee had no authority to authorize an offset at hearing, because there was no overpayment at the time the Referee's order issued. Claimant further contends that the employer must claim an offset at a later time or in a separate proceeding. We disagree.

ORS 656.268(13) authorizes adjustments in compensation due to overpayment only at the time of closure by Determination Order or Notice of Closure. However, the Board's authority to authorize recovery of overpayments is not confined to the Determination Order/Notice of Closure process of ORS 656.268(13) and, if a request is properly made at hearing, an offset may be authorized, even where there is no outstanding compensation against which an offset could be taken. Steven F. Sutphin, 44 Van Natta 2126 (1992); Robert E. Kubala, 43 Van Natta 1495 (1991). Accordingly, we conclude that the Referee had the authority to order an offset against any future award of permanent disability compensation. Sutphin, *supra*; Kubala, *supra*.

ORDER

The Referee's order dated January 21, 1993 is affirmed.

November 29, 1993

Cite as 45 Van Natta 2242 (1993)

In the Matter of the Compensation of
JO WANDA ORMAN, Claimant
 Own Motion No. 91-0707M
 SECOND 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, as reconsidered on September 9, 1993, 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.

On October 8, 1993, we withdrew our prior orders for reconsideration and granted the SAIF Corporation an opportunity to respond to claimant's motion. SAIF's response has been received.

After review of claimant's motion, along with SAIF's response, we adhere to our prior conclusions. Accordingly, we republish our August 10, 1993 order, as reconsidered on September 9, 1993, 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
LINDA D. RENALDS, Claimant
WCB Case No. 92-05094
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Westerband, Gunn and Haynes.

The self-insured employer requests review of those portions of Referee Herman's order that: (1) set aside its denial of claimant's bilateral hand condition; and (2) awarded claimant's counsel an assessed attorney fee of \$2,700 for prevailing over that denial. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in 1979 as a material handler in its Corvallis plant. She was responsible for packing calculators. In 1983 she transferred to the employer's plant in Santa Rosa, California, where she assembled signal analyzers. The assembly work involved extensive and repetitive use of both hands and wrists, though she occasionally used power tools. After working in the Santa Rosa plant for more than two years, she transferred to the employer's McMinnville plant in early 1986. Prior to her transfer to McMinnville, claimant had no hand or wrist symptoms.

In the McMinnville plant, claimant continued to perform assembly work, first assembling defibrillators and, later, heart monitors. The assembly work required extensive and repetitive use of both hands and wrists. In 1987 she began experiencing bilateral hand and forearm symptoms, including numbness, tingling, swelling and pain. In December 1988 claimant sought treatment from Dr. Miller and filed a claim with the employer.

Dr. Miller diagnosed right arm overuse syndrome and referred claimant for nerve conduction studies. Those studies revealed bilateral carpal tunnel syndrome, mild on the right and minimal on the left. Thereafter, on January 1, 1989, the employer issued a letter notifying claimant that it had accepted "right arm overuse syndrome" as a nondisabling injury. (Ex. 7).

In April 1989 Dr. Miller diagnosed overuse strains of the right forearm and left thumb. He advised claimant to discontinue production line work requiring heavy, repetitive use of both arms. On April 4, 1989, Dr. Miller declared her medically stationary with no permanent impairment. Later in April 1989, claimant transferred to the employer's accounting department, where she remained for more than two years. Her symptoms subsequently improved, but she continued to have numbness, pain and tingling in both hands and pain in both arms.

In late August 1991, claimant quit her job with the employer to return to school. In September 1991 claimant became self-employed cleaning houses on a part-time basis while she attended school. After cleaning the first house, she experienced increased symptoms of numbness and swelling in both hands with shooting pains in both forearms, worse on the right. Claimant began treating with Dr. Pribnow and stopped housecleaning for about a month. Dr. Pribnow diagnosed recurrent bilateral hand and wrist pain and paresthesias and referred claimant for occupational therapy. Nerve conduction studies in October 1991 revealed bilateral mild carpal tunnel syndrome, greater on the right, with a slight progression since the 1988 studies.

Claimant was referred to Dr. Yamanaka, an orthopedist, who requested surgical authorization for right carpal tunnel release in December 1991. In February 1992 claimant changed her attending physician to Dr. Haddeland, who diagnosed carpal tunnel right wrist and left elbow tendinitis. On April 2, 1992, the employer issued a letter denying the compensability of the carpal tunnel syndrome. The letter stated, in part:

"[I]t has been determined that the bilateral carpal tunnel syndrome is unrelated to your compensable workers' compensation claim for right arm overuse syndrome and, additionally, that your employment at [the employer] is not the major contributing cause of your bilateral carpal tunnel syndrome.

"Therefore, we must issue this denial. Our denial is based on the fact it does not appear your condition was worsened by or arose out of and in the course of your employment, either by accident or occupational disease, within the meaning of the Oregon Workers' Compensation Law." (Ex. 35).

Claimant requested a hearing from the denial. At hearing, the parties agreed with the Referee's statement that "the sole issue before me is an aggravation denial for bilateral carpal tunnel syndrome conditions." (Tr. 1). During opening argument, claimant's counsel contended that claimant's conditions "are the result of the original work exposure." (Tr. 3).

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed claimant's claim for bilateral carpal tunnel syndrome (CTS) condition as a claim for aggravation of the accepted 1988 claim for right arm overuse syndrome. Finding that the accepted 1988 claim was a material contributing cause of claimant's current CTS condition, the Referee concluded that the current condition is compensable. The Referee also concluded, however, that claimant did not prove a worsened condition. Claimant does not challenge the Referee's finding that her condition did not worsen. Rather, the sole issue on review is the compensability of claimant's current CTS condition.

The Referee's compensability analysis focused on the causal relationship between the accepted right arm overuse syndrome and the current CTS condition. We believe that analysis is too limited. Claimant's current condition claim was based on two alternative theories of compensability: (1) the condition is related to the accepted right arm overuse syndrome ("aggravation theory"); and (2) the condition is related to the employer's work conditions ("occupational disease theory"). Both theories were denied in the employer's April 2, 1992 denial letter, and claimant requested a hearing concerning that denial. Hence, both compensability theories were raised for hearing. At the commencement of hearing, the parties agreed with the Referee that the sole issue is an "aggravation denial." In opening argument, however, claimant's counsel asserted that the current condition is related to the original work exposure.

Based on these circumstances, we find that claimant properly raised the occupational disease theory at hearing. The employer's denial letter, by asserting that work conditions were not the major contributing cause of the carpal tunnel syndrome, denied the occupational disease theory for the claim. Claimant placed that denial at issue by filing her hearing request. Although claimant agreed at hearing that only an aggravation denial was at issue, we do not view that as a waiver of the occupational disease theory, particularly in the light of claimant's counsel's opening argument that the current condition is related to the original work exposure. Moreover, after claimant's counsel's opening argument, the employer did not claim surprise and did not request postponement of the hearing.

On the merits, in order to establish her occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that her work activities were the major contributing cause of her disease or its worsening. ORS 656.802(1)(c), (2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). "Major 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).

The medical evidence is divided. Dr. Hales, consulting orthopedic surgeon, opined that claimant's work activities in the employer's McMinnville plant were the major contributing cause of her bilateral CTS condition and need for treatment. (Exs. 36, 37). He based his opinion on claimant's history that the symptoms have persisted since they first arose while she was working in the McMinnville plant. (*Id.*) Dr. Haddeland, the attending physician, opined that claimant's work activities with the employer were a material contributing factor in her condition. Like Dr. Hales, Dr. Haddeland based his opinion on the history that claimant's symptoms first arose while working for the employer. (Ex. 34).

Drs. Pribnow, Button and Yamanaka reached contrary opinions. They opined that claimant's self-employed housecleaning activity was the major contributing cause of her need for treatment. Exs. 32, 33, 36A, 38). After reviewing the record, however, we are most persuaded by the opinion of Dr. Hales. His opinion is consistent with claimant's history that her symptoms first arose while

performing hand-intensive work in the McMinnville plant and that her symptoms improved when she transferred to less hand-intensive work in the accounting department. Further, Drs. Button, Yamanaka and Pribnow do not adequately explain why, after cleaning only one house, claimant's symptoms flared up to a level remarkably similar to claimant's symptoms when her condition first arose. In our view, claimant's symptomatic flare-up after cleaning only one house supports Dr. Hales' opinion that claimant already had bilateral CTS as a result of her earlier work exposure at the McMinnville plant.

Based on Dr. Hales' opinion, we find that claimant has proved that her work activities were the major contributing cause of her bilateral CTS condition and need for treatment. The results of nerve conduction studies establish the existence of the CTS by medical evidence supported by objective findings. Accordingly, we conclude that claimant has established her occupational disease claim for bilateral CTS.

Finally, we reject the employer's argument that claimant sustained a new injury or occupational disease involving her compensable condition so as to shift responsibility away from the employer pursuant to ORS 656.308(1). The employer relies primarily on Dr. Pribnow's opinion that the increased symptoms following claimant's housecleaning activity indicated a pathological worsening of the CTS condition. (Ex. 38-25). However, as we stated above, we do not find Dr. Pribnow's opinion to be persuasive. Therefore, assuming without deciding that ORS 656.308 is applicable, we do not find that a new occupational disease was established. See Donald C. Moon, 43 Van Natta 2595 (1992).

The employer also argues that the diagnosis of left elbow tendinitis or tennis elbow in 1991 supports a finding of a new injury. We disagree. Although Dr. Pribnow suspected tennis elbow or tendinitis, he added that the forearm pains may be associated with the CTS condition. (Ex. 26). Dr. Hales later opined that claimant's arm symptoms could be due to the CTS condition, rather than tennis elbow. (Ex. 36-2). Based on those opinions, again assuming without deciding that ORS 656.308 is applicable, we are not persuaded that claimant sustained a new injury in 1991.

Attorney Fees

The employer contends that the Referee's assessed fee award of \$2,700 is excessive. We disagree. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$2,700 is a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the issue of the compensability of the bilateral CTS condition and the resultant need for treatment. 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.

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

ORDER

The Referee's order dated January 11, 1993 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the self-insured employer.

Member Haynes specially concurring.

I agree with the majority that claimant has established the compensability of her bilateral carpal tunnel syndrome (CTS) condition. I write separately, however, because the majority's analysis relies on a theory which claimant did not raise at hearing.

Claimant expressly agreed on the record that the sole issue at hearing is an "aggravation denial." Having so agreed, claimant was bound to establish the compensability of her claim under an aggravation theory. That is, she must prove that her carpal tunnel syndrome "resulted from" the accepted right arm overuse syndrome. See ORS 656.273(1).

Yet, based on a few words in claimant's opening argument, the majority finds that an occupational disease theory was also raised. I find that claimant's counsel did not intend to raise an occupational disease claim. During or after her opening argument, claimant could have amended the statement of issue to include an occupational disease theory, thereby allowing the employer sufficient notice to defend against that theory. Because claimant failed to do so, I would conclude that she did not timely raise the occupational disease theory at hearing. The majority's application of that theory on review contravenes the Board's policy of refusing to consider on review an alternative theory of compensability that was not first raised at hearing. See Rollie R. Rilatos, 45 Van Natta 1012 (1993). See also Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991); Donat E. Flores, 45 Van Natta 1241 (1993); Mary E. Matthews, 45 Van Natta 1080 (1993).

Rather than deciding this case on a theory not raised at hearing, I would affirm and adopt the Referee's application of the aggravation theory in finding the claim to be compensable. For that reason, I specially concur.

November 29, 1993

Cite as 45 Van Natta 2246 (1993)

In the Matter of the Compensation of
BRIAN G. VANOSDOL, Claimant

WCB Case No. 92-05999

ORDER ON REVIEW

Empey & Dartt, Claimant Attorneys

David Lillig (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Referee Crumme's order that: (1) set aside its denial of claimant's current headache condition; and (2) set aside its denial of claimant's aggravation claim. On review, the issues are compensability and aggravation.

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

On review, SAIF contends that since claimant's migraine condition preexisted the compensable injury, the Referee incorrectly analyzed this claim under ORS 656.005(7)(a)(A) rather than under ORS 656.005(7)(a)(B).

The Referee relied on the opinion of claimant's attending physician, Dr. Larson, to conclude that claimant's 1985 compensable injury was the major contributing cause of his disability and need for treatment for his current headache condition. Based on the persuasive medical evidence from Dr. Larson, we agree with the Referee that claimant has established compensability.

Dr. Larson has explained that claimant's current headache condition is a combination of two conditions, occipital neuralgic headaches (which he opines are caused in major part by claimant's 1985 compensable neck injury) and a preexisting migraine headache condition. Dr. Larson has opined that claimant's 1985 injury amplified claimant's preexisting migraine condition. Referring to both the occipital neuralgic headaches and the migraine condition, Dr. Larson opined that the 1985 injury was the major contributing cause of claimant's current condition and need for treatment. (Ex. 85-3). Under such circumstances, we conclude that claimant's current headache condition is compensable whether analyzed under ORS 656.005(7)(a)(A) or 656.005(7)(a)(B). Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590 (1993).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability and aggravation issues is \$1,200, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated April 14, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,200, payable by SAIF.

November 30, 1993

Cite as 45 Van Natta 2247 (1993)

In the Matter of the Compensation of
RODNEY T. BUCKALLEW, Claimant
WCB Case Nos. 91-11590 & 91-03798
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Referee Schultz' order that set aside its denial of claimant's claim for a right ankle condition. On review, the issue is compensability.

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

Relying on our prior decision, Rodney T. Buckallew, 44 Van Natta 358 (1992), the Referee reasoned that it was the "law of the case" that claimant's diabetic neuropathy created a predisposition (as opposed to a cause) of claimant's Charcot's Joint condition. We agree that our prior decision addressed whether claimant's neuropathy constituted a predisposition or a cause of claimant's Charcot's Joint condition. However, that prior litigation addressed that issue as it pertained to claimant's left ankle condition. See Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1992). Inasmuch as this case concerns the "predisposition/causation" question regarding claimant's right ankle Charcot Joint condition, that previous litigation does not establish the "law of the case" regarding his current claim.

Claimant's right ankle condition is claimed as an indirect consequence of his compensable left ankle condition. Because we agree with the Referee that claimant has established that his compensable left ankle condition is the major contributing cause of his right ankle condition, we further agree that the claim for a consequential right ankle condition is compensable. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (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 \$1,224, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 25, 1993 is affirmed. For services on review, claimant's counsel is awarded a \$1,224 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
DORETHA J. CARLIN, Claimant
WCB Case Nos. 91-13802 & 91-12963
ORDER ON REVIEW

Michael B. Dye, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Westerland, Haynes, and Gunn.

Claimant requests review of those portions of Referee Herman's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of her aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of her "new injury" claim for the same condition. Liberty cross-requests review of that portion of the Referee's order which set aside its denial, and awarded an assessed attorney fee, to the extent it denied medical services for the compensable condition. On review, the issues are aggravation, compensability, attorney fees, and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Aggravation

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

Compensability of "New Injury"

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

Responsibility

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

Attorney Fees

SAIF denied the compensability of and responsibility for claimant's "new injury" claim for his current low back condition. Liberty denied claimant's aggravation claim for his current low back condition on the basis that his compensable low back injury had not worsened. The Referee found that claimant had not sustained a "new injury" and therefore upheld SAIF's denial of compensability and responsibility. The Referee further found that claimant's compensable low back condition had not worsened and therefore upheld Liberty's aggravation denial.

However, the Referee found that in addition to denying claimant's aggravation claim on the basis of no worsening, Liberty also denied medical services. Consequently, the Referee set aside Liberty's denial to the extent it denied compensability of medical services, and awarded claimant's attorney an assessed fee under ORS 656.386(1) for having prevailed on the issue of medical services. The attorney fee awarded was premised on the Referee's conclusion that Liberty had denied the existence of a causal relationship between claimant's condition and the April 1988 compensable injury.

On review, Liberty contends that the Referee misconstrued the denial. Specifically, Liberty argues that compensability of the medical services was never contested, and that Liberty denied the aggravation claim on the sole ground that claimant's condition had not worsened. We agree.

Liberty's denial states in relevant part:

"We have recently received information that you wish to reopen your claim because of an aggravation of your industrial injury of April 17, 1988. We can re-open a claim and pay medical and disability benefits for aggravation only when the aggravation results from a natural worsening of an industrially related injury, is causally connected to the condition for which the claim was originally filed, and when no new injury intervenes.

Medical information in your file indicates that your condition has not worsened since your claim was previously closed. Therefore, without waiving further questions of compensability, we submit this denial of aggravation for your claim for benefits.

Please be advised that payment for medical benefits will continue to be authorized pursuant to ORS 656.245." (Emphasis supplied).

The first paragraph of the denial paraphrases several conditions provided in ORS 656.273 that a worker must meet to establish a valid aggravation claim. As the denial states, two of those conditions are that there must be a worsening and the worsening must be causally related to the compensable injury. However, notice of the specific reason for Liberty's denial is given in the second paragraph. It states that the aggravation claim is denied because "your condition has not worsened since your claim was previously closed." As for medical services, the final paragraph states that they will "continue to be authorized pursuant to ORS 656.245." Thus, we conclude that the language of the denial did not place into issue a question as to the compensability of medical services concerning the Liberty claim.¹

In addition, we do not find that Liberty Northwest's counsel's action at hearing brought compensability of claimant's medical services claim with Liberty into issue. While counsel for Liberty agreed with the Referee's statement of the issues, we are not persuaded that the Referee's statement indicated that compensability of medical services was disputed by Liberty Northwest.

The Referee stated that the "parties have identified to me that the issue is one of responsibility and compensability of a back condition, specifically Liberty Northwest denies an aggravation." The Referee did not say, however, that Liberty Northwest was contesting the compensability of claimant's medical services under the Liberty claim. Nor does the Referee's statement indicate that Liberty was contesting claimant's aggravation claim on a causation basis. The Referee does use the word "compensability," but does not specify whether it is SAIF, the other insurer, or Liberty Northwest that is raising compensability. In fact, SAIF did deny compensability of claimant's "new injury" claim.

The Referee did specify that "Liberty Northwest denies an aggravation." However, an aggravation may be denied solely on the basis that claimant did not sustain a worsening, since a worker cannot have a compensable aggravation if the requisite worsening is not established. See Bertha M. Gray, 44 Van Natta 810 (1992) aff'd Gray v. SAIF, 121 Or App 217 (1993)(A claim for aggravation has two components: causation and worsening).

Finally, there is no evidence to suggest that Liberty Northwest did not continue to pay claimant's medical benefits following its denial. There are no unpaid medical billings in the record and there is no other evidence indicating that Liberty Northwest acted contrary to its specific statement that "payment of medical benefits will continue to be authorized pursuant to ORS 656.245."

Under these circumstances, we find that Liberty Northwest did not deny claimant's aggravation claim based on a lack of causal relationship between the compensable injury and the alleged worsening. Moreover, we also find that Liberty Northwest did not deny medical services. Consequently, we conclude that claimant's attorney is not entitled to an assessed attorney fee.

ORDER

The Referee's order dated August 18, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which awarded a \$2,500 assessed attorney fee, payable by Liberty Northwest, is reversed. The remainder of the order is affirmed.

¹ If claimant had not requested a hearing on Liberty Northwest's denial and had subsequently sought medical services for her worsened condition, we would not find that Liberty's denial precluded claimant's subsequent claim for medical services. According to our reading of it, this denial was solely based on Liberty's contention (which proved to be meritorious) that claimant's condition had not worsened. Therefore, had it not been appealed, the denial would not bar claimant from later asserting that her need for medical treatment was causally related to the compensable injury. Compare Popoff v. J. J. Newberrys, 117 Or App 242 (1992). If finality of the denial would not preclude claimant from later asserting that her need for medical treatment is causally related to the compensable injury, it necessarily follows that the medical services were not denied and therefore claimant's counsel is not entitled to an attorney fee.

Member Gunn, dissenting:

The majority concludes that Liberty Northwest did not deny the compensability of claimant's medical services. Based on this conclusion, the majority finds that claimant's counsel is not entitled to an assessed attorney fee for overcoming Liberty Northwest's "denial." Because I believe Liberty Northwest denied claimant's medical services, I dissent.

Liberty Northwest's denial states:

"We have recently received information that you wish to reopen your claim because of an aggravation of your industrial injury of April 17, 1988. We can re-open a claim and pay medical and disability benefits for aggravation only when the aggravation results from a natural worsening of an industrially related injury, is causally connected to the condition for which the claim was originally filed, and when no new injury intervenes."

"Medical information in your file indicates that your condition has not worsened since your claim was previously closed. Therefore, without waiving further questions of compensability, we submit this denial of aggravation for your claim for benefits."

"Please be advised that payment for medical benefits will continue to be authorized pursuant to ORS 656.245." (Emphasis supplied).

The majority emphasizes the latter portion of denial as clearly indicating that Liberty Northwest did not deny medical services. While that portion of the denial can be read to indicate that Liberty Northwest had not denied compensability of the medical services, the emphasized portions of the denial indicate to the contrary. At best, the denial is ambiguous. Inasmuch as Liberty Northwest drafted the denial, such ambiguity should be construed against Liberty Northwest.

Moreover, the scope of the denial was not limited by Liberty Northwest at hearing. On the contrary, at hearing, the following exchange took place:

Referee: "The parties have identified to me that the issue is one of responsibility and compensability of a back condition, specifically Liberty Northwest denies an aggravation. It's dated September 17, 1991. SAIF issued a denial dated October 26, 1991 as well as a disclaimer on August 30, 1991. Is that the correct issue with regard to the parties?"

Mr. Elmer: "Yes, ma'am."

Mr. Stevens: "That's correct."

Mr. Motley: "Yes."

(Day Two Tr. 1-2).

Like the language of the denial, Liberty Northwest counsel's conduct at hearing was ambiguous at best with regard to the scope of its denial. In addition, there is no indication given by Liberty Northwest's counsel that medical services were not being denied.

As noted above, I find Liberty Northwest's denial ambiguous with regard to whether Liberty Northwest was contesting compensability of medical services and its counsel's conduct at hearing did not shed any light on the ambiguities of the denial. When the ambiguities are considered in conjunction with the fact the denial was drafted by Liberty Northwest, I would conclude that the issue of the compensability of claimant's need for medical benefits (i.e., a question of causation) was before the Referee, and the Referee acted reasonably in so finding. Accordingly, I agree with the Referee that claimant's counsel was entitled to an assessed attorney fee.

In the Matter of the Compensation of
MICHAEL D. DEMAGALSKI, Claimant
WCB Case No. 92-10198
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Crumme's order which set aside its denial of claimant's left wrist fracture. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty-related attorney fee for the insurer's allegedly unreasonable resistance to the provision of vocational services. On review, the issues are compensability and penalty-related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant sustained a left wrist fracture when he fell from his bicycle on May 2, 1992. Claimant asserts that he fell because he was unable to adequately use the right hand brake due to a cast on his right wrist. (See Tr. 5-6). Claimant's right wrist was placed in a cast following surgery in February 1992 for his compensable right wrist condition.

Claimant originally sustained a right hand strain in 1985, which the insurer accepted as nondisabling. In 1990, the insurer accepted a claim for a disabling aggravation of the 1985 injury. Claimant's treating physician, Dr. Nye, performed surgery in 1991 and 1992 for claimant's accepted right wrist condition.

Claimant contends that his left wrist fracture resulted from treatment for his compensable right wrist condition (*i.e.*, the right wrist cast). There is no evidence that the left wrist fracture is a direct consequence of his 1985 compensable work injury to his right wrist. Accordingly, ORS 656.005(7)(a)(A) is applicable to this case.¹ Therefore, claimant must prove that his compensable work injury was the major contributing cause of his "consequential condition," the left wrist fracture. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Hicks v. Spectra Physics, 117 Or App 293 (1992).

In Hicks, the court affirmed our order which found that an injury the claimant sustained in a motor vehicle accident while returning from treatment for her compensable injury was not compensable, because the work injury was not the major contributing cause of the subsequent injury. In so holding, the court recognized that the 1990 amendments to the workers' compensation law legislatively overruled its earlier decision in Fenton v. SAIF, 87 Or App 78, *rev den* 304 Or 311 (1987) (an injury sustained en route to or from medical treatment for a compensable injury is compensable because it is "a direct and natural consequence" of the compensable injury). Hicks, supra.

We find Hicks applicable in this case. Here, we find that the major contributing cause of claimant's left wrist fracture was the fall from his bicycle, not his compensable work injury. There is no medical evidence establishing that the compensable work injury caused the left wrist fracture. While claimant's work injury may have indirectly contributed to the fall, because claimant's arm was in a cast as a result of treatment for his compensable injury, the compensable work injury was not the major contributing cause of claimant's subsequent injury, the left wrist fracture.

Accordingly, we reverse that portion of the Referee's order which found claimant's left wrist fracture compensable.

¹ There is no contention that claimant's left wrist injury occurred in the course and scope of employment. Therefore, the "exception" in ORS 656.005(7)(b)(B) is not applicable.

Penalty-Related Attorney Fees

After our review of the record, we affirm and adopt that portion of the Referee's order which declined to assess a penalty-related attorney fee under ORS 656.382(1), based on a finding that the insurer did not unreasonably resist the payment of compensation regarding the provision of vocational services.

ORDER

The Referee's order dated January 8, 1993 is affirmed in part and reversed in part. That portion of the order which set aside the insurer's July 17, 1992 denial of claimant's left wrist fracture and awarded claimant an assessed attorney fee for prevailing on the denial is reversed. The denial is reinstated and upheld. The remainder of the order is affirmed.

November 30, 1993

Cite as 45 Van Natta 2252 (1993)

In the Matter of the Compensation of
JESUS FLETES, Deceased, Claimant

WCB Case No. 92-02935

And, In the Matter of the Compensation of

GABRIEL L. ALVAREZ, Claimant

WCB Case No. 92-01344

And, In the Matter of the Complying Status of

EDWIN HAYES, Noncomplying Employer

WCB Case No. 92-02586

ORDER OF DISMISSAL

Bischoff & Strooband, Claimant Attorneys

Jeffrey W. Foxx, Attorney

Cowling & Heysell, Defense Attorneys

James Dodge (Saif), Defense Attorney

Edwin Hayes, an alleged noncomplying employer, has requested Board review of Referee Holtan's July 30, 1993 order which: (1) affirmed the Director's order finding Hayes to be a noncomplying employer; (2) awarded each of claimants' counsels attorney fees, payable by the SAIF Corporation on behalf of Hayes; and (3) declined to award Hayes' counsel an attorney fee under ORS 656.740(3). Both claimants and the Department have moved for dismissal of Hayes' request for Board review, contending that appellate authority over the Referee's order rests with the Court of Appeals.

FINDINGS OF FACT

On December 16, 1991, the Department of Insurance and Finance (DIF) published a Proposed and Final Order declaring Edwin Hayes to be a noncomplying employer. Hayes requested a hearing contesting this order.

The Department referred each claimant's claim to the SAIF Corporation for processing under ORS 656.054. Thereafter, SAIF accepted each claim. Hayes requested a hearing, objecting to SAIF's acceptances of the claims. All of Hayes' hearing requests were consolidated.

At the commencement of the hearing, the Referee made the following announcement concerning the parties' positions:

"Next, I wish to say and make it clear that compensability has been contested on both cases by Mr. Hayes and basically we believe at this point that if subjectivity is found to exist, that is, if there are subject employees and a subject employer, that the compensability issue will be resolved by that. And conversely, if subjectivity is found not to exist, then the claims will be not compensable as to Mr. Hayes." (Tr. 4-5).

The parties did not object to the Referee's framing of the issues. Specifically, Hayes' counsel agreed with the Referee's "initial statement that the issues today are going to be narrowly focused on whether this employment situation falls within the scope of ORS 656.027(3)." (Tr. 8). As a final clarification of the issues, the Referee stated that "[i]n other words, if these workers are subject workers under the law, then of .027(3) of Chapter 656, then the proposed order stands and SAIF Corporation's acceptances of the claims also stands." (Tr. 20).

Following the hearing, the Referee found that the claimants were not "casual workers" when their injuries occurred and that, therefore, Hayes was a subject employer. Consequently, the Referee affirmed the Department's noncomplying employer order. In addition, the Referee directed SAIF to continue to process the claimants' claims.

The Referee's July 30, 1993 order included a notice to all parties of their right to appeal to the Court of Appeals within 60 days. On August 6, 1993, the Board received Hayes' request for Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

We lack appellate jurisdiction to review a referee's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); Ferland v. McMurtry Video Productions, 116 Or App 405 (1992); Spencer House Moving, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993). However, when an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review of the Referee's order shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

When an employer requests a hearing from SAIF's claim acceptance under ORS 656.054, but only contests the Department's noncomplying employer order at the hearing, we lack appellate authority over the Referee's order. See Sunset Siding Construction, 44 Van Natta 1476, on recon 44 Van Natta 1587, on recon 44 Van Natta 1662 (1992). In addition, when the issue at hearing regarding the Department's noncomplying employer order is whether the claimant was a subject worker and whether the employer was a subject employer, appellate jurisdiction lies with the Court of Appeals under ORS 656.740(4). Spencer House Moving, NCE, supra at page 2523. Finally, appellate authority rests with the court even if the employer attempts to raise the same "subjectivity" issue separate from the employer's hearing request from the Department's noncomplying employer order. Elias S. Jones, 45 Van Natta 1691 (1993).

Here, in addition to requesting a hearing regarding the Department's noncomplying employer order, Hayes also filed hearing requests concerning SAIF's acceptances of the claims. Nevertheless, as clarified prior to the presentation of the documentary and testimonial evidence at hearing, Hayes was not contesting whether the incident which resulted in the claimants' disabilities and need for medical treatment occurred. See Michael D. Owings, 42 Van Natta 626 (1990) (Where the employer contested NCE order and SAIF's claim acceptance at same hearing and issues involved both subjectivity and compensability/responsibility for disputed conditions, Board had appellate review authority over referee's order).

Instead, Hayes was contending that the claimants were "casual workers" and, as such, Hayes could not be considered to be a subject employer. In other words, if the claimants were found to be subject workers, Hayes acknowledged that the Department's order and SAIF's claim acceptances would stand. Although Hayes describes its challenge to the claims as "compensability," such an objection is based on a subjectivity ground; i.e. the claimants were not subject workers for Hayes. See Patricia A. Hinsen, 45 Van Natta 1563 (1993).

In light of such circumstances, we conclude that the issues at hearing were solely confined to whether the claimants were subject workers and whether Hayes was a subject employer. Inasmuch as these issues were encompassed within the Referee's review of the Department's noncomplying employer order, we hold that the Department's order was not contested at the same hearing as a matter concerning a claim. Consequently, the Referee's order constitutes a final order of the Department and must be appealed directly to the Court of Appeals. ORS 656.740(1), (3); ORS 183.480(1), (2); Ferland, supra; Spencer House Moving, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

November 30, 1993

Cite as 45 Van Natta 2254 (1993)

In the Matter of the Compensation of
SUSAN J. JOHNSON, Claimant
WCB Case No. 92-16251
ORDER OF DISMISSAL
Bruce Smith, Claimant Attorney
Ron Pomeroy (Saif), Defense Attorney

On November 2, 1993, we received an October 29, 1993 letter from the Workers' Compensation Division, which enclosed an October 13, 1993 letter from the employer. We have reviewed the employer's letter to determine whether we have jurisdiction to consider the letter as a request for Board review of the Referee's September 30, 1993 order. Assuming, without deciding, that the employer's letter objecting to the Division's October 11, 1993 Order on Reconsideration constitutes a request for Board review of the Referee's September 30, 1993 order, we conclude that the request is untimely. Consequently, the request for review is dismissed.

FINDINGS OF FACT

On September 30, 1993, the Referee issued an order setting aside the SAIF Corporation's denial (on behalf of the employer) of several enumerated conditions. The Referee's order included notice of when (within 30 days) and where (with the Workers' Compensation Board) a request for review of the order should be filed.

On November 2, 1993, the Board (through its permanently staffed Medford office) received an October 29, 1993 letter from the Workers' Compensation Division. Enclosed with that letter was an October 13, 1993 letter from the employer, responding to the Division's October 11, 1993 Order on Reconsideration. In its reply, the employer expressed the desire "to go on record as objecting to the final ruling in this case . . ." Thereafter, the employer listed three reasons which pertained to the compensability of claimant's claim.

On November 15, 1993, the Board mailed a computer-generated letter acknowledging the employer's letter as a request for Board review of the Referee's September 30, 1993 order.

ULTIMATE FINDINGS

The employer's letter was not received by the Board within 30 days of the Referee's order.

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). 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 September 30, 1993 order was October 30, 1993, a Saturday. Consequently, the final day to perfect an appeal from the Referee's order was Monday, November 1, 1993. Anita L. Clifton, 43 Van Natta 1921 (1991).

For the sake of argument, we shall assume that the employer's October 13, 1993 letter to the Workers' Compensation Division pertaining to the October 11, 1993 Order on Reconsideration represents a request for Board review of the Referee's September 30, 1993 order. Although the employer's letter was dated within 30 days of the Referee's order and received by the Workers' Compensation Division within that statutory period, it was not received by the Board until November 2, 1993.

Inasmuch as the final day to perfect a timely appeal of the Referee's order with the Board was November 1, 1993, the employer's request for Board review was untimely filed. 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 the employer has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Moreover, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986). Finally, as previously noted, it would appear that in actuality the employer's letter was in response to the Division's October 11, 1993 Order on Reconsideration rather than seeking Board review of the Referee's September 30, 1993 order.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

November 30, 1993

Cite as 45 Van Natta 2255 (1993)

In the Matter of the Compensation of
GLORIA J. MODISETTE, Claimant
WCB Case Nos. 92-01727 & 92-01726
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Herman's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a right shoulder 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 reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not established compensability of her right shoulder condition as an occupational disease. We disagree.

In order to establish her occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that her work activities were the major contributing cause of her disease or its worsening. ORS 656.802(1)(c), (2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). "Major 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).

Claimant suffered a compensable injury to her low back in July 1990. (Exs. 1; 2). The record contains three medical opinions concerning the causation of claimant's right shoulder condition. Claimant's attending physician, Dr. Orwick, opined that claimant's right shoulder condition was an "aggravation" of the 1990 injury. (26A; 32; 33). Claimant's accepted 1990 claim involved injuries to her hip and low back, but did not involve the right shoulder. (Exs. 2; 3; 6). Orwick also related claimant's right shoulder symptoms to her repetitious work activities. (Ex. 22-1).

Claimant was seen for an independent medical examination by Dr. Woolpert. Based on claimant's history, Woolpert related claimant's right shoulder condition to a strain caused by work

activity. Drs. Orwick and Anderson, a prior treating physician, concurred with his report. (Exs. 28; 29). Dr. Anderson believed that if claimant's right shoulder condition was work-related, it was a new incident rather than an aggravation of her 1990 injury.

Based on the record as a whole, we conclude that claimant has established compensability of her right shoulder condition as an occupational disease. In reaching this decision, we rely especially on Dr. Woolpert's opinion which is supported by the concurring opinions of Drs. Orwick and Anderson. Our conclusion is also supported by Dr. Anderson's opinion that the right shoulder condition was a "new" condition and was not related to the 1990 low back injury. In addition, we note that in his chart notes, Dr. Orwick implicates claimant's repetitious work activities as a cause of her right shoulder condition.

Although none of these physicians expressly states that claimant's repetitive work activities are the major contributing cause of her right shoulder condition, no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). On this record, we interpret Dr. Woolpert's opinion, with which Drs. Orwick and Anderson concurred, to mean that claimant's repetitive work activities are the major contributing cause of her right shoulder condition. Under such circumstances, we conclude that claimant has established a compensable occupational disease.

On reconsideration before the Referee, claimant raised, for the first time, the compensability of her condition as a consequence of the 1990 compensable injury. Reasoning that it would be fundamentally unfair to address an issue not raised and litigated at hearing, the Referee declined to address this issue. Because we have found claimant's right shoulder condition compensable as an occupational disease, we need not address claimant's alternative contention.

Claimant contends that SAIF's denial of an occupational disease was unreasonable. We disagree.

The reasonableness of a carrier's denial must be gauged based upon the information available to it at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim. Id. However, a legitimate doubt does not exist where a decision is made quickly without independent investigation. Kenneth A. Foster, 44 Van Natta 148, aff'd mem, SAIF v. Foster, 117 Or App 543 (1992).

At the time it issued its December 20, 1991 denial, SAIF had a form 827 which diagnosed "shoulder impingement - excess use strain." In addition, a progress note from Dr. Anderson dated October 2, 1991 suggested that claimant's right shoulder condition could be related to vacuuming at work although Anderson "could not assuredly" relate the condition to work since no specific incident precipitated the symptoms. (Ex. 20). Furthermore, an October 1991 chart note from Dr. Orwick indicated that claimant had a mild shoulder impingement which was "aggravated by work and brought on by repetitious use."

Based on Dr. Anderson's October 2, 1991 report, and Dr. Orwick's October 1991 chart note, we conclude that SAIF had a legitimate doubt as to its liability for the claim when it issued its December 1991 denial.

Claimant contends that SAIF's denial became unreasonable after it received Dr. Woolpert's report which related the shoulder condition to work. However, reports from Dr. Orwick, dated before and after Dr. Woolpert's report, also suggested that claimant's condition was an aggravation of the prior compensable injury rather than a new occupational disease. (Exs. 26A-1; 32; 33). Given this conflicting evidence concerning whether claimant's condition was a new occupational disease or was related to the prior injury, we conclude that SAIF's occupational disease denial did not become unreasonable. Accordingly, penalties are not appropriate.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation'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 claimant's attorney'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 issue (as represented by claimant's statement of services and appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 30, 1992, as reconsidered October 21, 1992, is reversed in part. The SAIF Corporation's occupational disease denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded \$4,500 payable by SAIF. The remainder of the order is affirmed.

November 30, 1993

Cite as 45 Van Natta 2257 (1993)

In the Matter of the Compensation of
JUDITH A. WEEKS, Claimant
WCB Case No. 92-11280
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband, Neidig, and Gunn.

Claimant requests review of Referee Bethlahmy's order that: (1) declined to assess a penalty for the self-insured employer's allegedly unreasonable denial; and (2) assessed a \$1,500 attorney fee for claimant's counsel's services in obtaining compensation for claimant without a hearing. In its brief, the employer argues that the Referee's attorney fee award should be reduced. On review, the issues are penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONPenalty

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the employer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

The employer contends that its denial was reasonable, on two bases. First, it argues that it had a legitimate doubt about its liability, because claimant was not scheduled to work on August 9, 1992 (the date of injury) and it therefore reasonably believed that the injury occurred outside the course and scope of claimant's employment. Alternatively, the employer argues that it reasonably doubted its liability because it had information that claimant's injury resulted from physical abuse off work, rather than from a work accident. We conclude that the denial was reasonable on the first basis only.

It is undisputed that claimant was injured on a day she was not regularly scheduled to work, that she was not preauthorized to work that day, and that working without preauthorization was against the employer's rules. Under the employer's work policy (which employees signed indicating acknowledgment), an employee was subject to disciplinary action for violating the rule against working at unscheduled times without preauthorization. (See Ex. A). In our view, these facts suggest that claimant was disobeying the employer's rules when she was injured.

In light of the case law concerning the effect of employee misconduct on the compensability of an injury suffered in conjunction with such misconduct,¹ we have held that an employer's "belief that the claim would not be compensable if claimant consciously violated a known work policy is not

¹ See e.g. Davis v. R & R Trucking Brothers, 112 Or App 485 (1992); Patterson v. SAIF, 64 Or App 652 (1983).

unreasonable." Willis W. Stamm, 44 Van Natta 79, 80 (1992). Because this is such a case, we conclude that the denial was not unreasonable, insofar as it was based on the employer's legitimate doubt that claimant was acting within the course and scope of her employment when she was injured.

Attorney fee

We adopt the Referee's opinion on this issue.

ORDER

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

Board Member Gunn dissenting.

The Workers' Compensation Board is not a disciplinary tribunal. A worker's violation of her employer's work rules is a matter for the employer to remedy, not the Board.

The question properly before us is whether the employer had a legitimate doubt that claimant was working when she was injured. Regardless of the employer's rules regarding working at unscheduled times, it is clear that claimant was working at the time of her injury and the employer knew it. The employer had the "801" form signed by claimant and an employer's representative indicating that claimant was injured in the course and scope of her employment. It had claimant's recorded statement concerning the injury, which described the injury as occurring within the scope of the ultimate work performed by claimant for the employer. In addition, the "801" form indicates that there was a witness to the injury.

Nonetheless, the employer failed to interview a single one of claimant's coworkers, not even the one listed as a witness to the injury on the "801" form.

I believe that the evidence available to the employer should have prompted further investigation before issuance of a denial. See Karen L. Lewis, 45 Van Natta 1079 (1993); Philip A. Parker, 45 Van Natta 728 (1993). However, this denial issued only eleven days after notice of the claim, without meaningful investigation. Under these circumstances, I would hold that the employer did not have a legitimate doubt regarding its liability. See Kenneth A. Foster, 44 Van Natta 148 (1992); aff'd mem, SAIF v. Foster, 117 Or App 543 (1993) (An employer cannot have a legitimate doubt for lacking knowledge of facts that would have been disclosed by a reasonable investigation). By ignoring the employer's unreasonable failure to investigate and focussing unnecessarily on the employer's work rules, the majority effectively finds claimant at fault, when her injury should be covered by our "no fault" insurance system. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
VIRGIL W. CLARK, Claimant
WCB Case No. 92-06839
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Referee Schultz' order that: (1) set aside its denial of claimant's aggravation and current condition claims for post-traumatic disequilibrium; and (2) assessed an attorney fee for allegedly setting aside its "defacto denial of claimant's tinnitus and disequilibrium problems." In addition, the insurer objects to the Referee's findings of fact concerning withdrawn Exhibit 15. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the third full paragraph on page four.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's conclusions and reasoning on this issue.

Attorney Fees

At hearing, the insurer conceded that it had "de facto denied" claimant's tinnitus and neuralgic headache claims, but contended that its written denial of claimant's "motor coordination problems" encompassed claimant's disequilibrium claim. The Referee set aside both the written and "de facto" denials. On review, the insurer does not challenge that portion of the Referee's order that set aside its "de facto" denial of claimant's tinnitus and neuralgic headache claims. Rather, the insurer contends that the Referee erred in awarding a separate attorney fee for also setting aside its alleged "de facto" denial of claimant's disequilibrium claim.

To the extent the insurer is challenging the assessment of two attorney fee awards for setting aside two denials, we affirm. However, we clarify as follows. The Referee agreed that the insurer's written denial encompassed claimant's disequilibrium condition. In the "Order" section, however, the Referee inadvertently referenced the insurer's "defacto denial of claimant's tinnitus and disequilibrium problems." Therefore, consistent with the Referee's conclusions, we replace the third "Order" clause with: "For successfully setting aside Liberty's "de facto" denial of claimant's right ear tinnitus and neuralgic headache problems, claimant's counsel is entitled to an assessed attorney fee in the amount of \$1,500."

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable carrier-paid fee for claimant's counsel's services on review concerning the compensability issue is \$1,000. See ORS 656.382(2). 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.

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 Referee's attorney fee assessments. 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 January 21, 1993, as clarified, is affirmed. For services on review concerning the compensability issue, claimant is awarded a reasonable attorney fee of \$1,000, to be paid by the insurer.

In the Matter of the Compensation of
MAGED W. GADAFFI, Claimant
WCB Case No. 93-00872
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of that portion of Referee Hoguet's order which set aside its denial of claimant's occupational disease claim for his chronic allergic rhinitis, allergic conjunctivitis, and reactive airways conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's conditions were the result of his genetic predisposition. Relying on Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), the Referee concluded that the predisposition could not be considered in determining whether claimant had proven that the work exposure was the major cause of his occupational disease. The Referee further concluded that claimant's symptoms were the disease, and therefore, his condition was compensable. We disagree.

We do not find that the medical evidence establishes that claimant has a susceptibility to or is predisposed to respiratory problems. Dr. Montanaro, independent medical examiner, opined that claimant's conditions were "genetically predetermined conditions." Dr. Gill, claimant's treating doctor, concurred with that portion of Dr. Montanaro's opinion. Additionally, Dr. Gill later referred to claimant's condition as a "preexisting asthma" condition. Under the circumstances, we find that, although claimant may have a preexisting respiratory condition, there is insufficient evidence to establish that he has a susceptibility or predisposition to respiratory problems. Accordingly, we do not find Spurgeon, supra, to be dispositive. See also Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993).

The Referee also relied upon Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990), for the proposition that, in a case in which the symptoms are the disease, the condition may be compensable. In Vorderstrasse, the claimant had Reynaud's Phenomenon, which was only manifested by its characteristic symptoms. The court found substantial evidence to support the Board's finding that the changes in the claimant's fingers, while temporary, were physical changes, not just symptoms. Consequently, the court concluded that it could not say, as a matter of law, that the Reynaud's Phenomenon was not a disease. Vorderstrasse, supra.

However, in the present case, we do not find that the opinions of Drs. Montanaro and Gill establish that claimant's symptoms are the disease itself. Rather, Dr. Montanaro opined that claimant may have experienced a transient aggravation of symptoms, but Montanaro reported that there was no evidence that claimant's workplace exposure led to a "worsening of the pathologic nature of his underlying conditions." Although Dr. Gill stated that he believed that Dr. Montanaro had understated the importance of the contribution from the workplace exposure, Dr. Gill agreed with the remainder of Dr. Montanaro's opinion. Considering the distinction made between claimant's symptoms and an underlying pathological condition, we disagree with the Referee that the medical evidence establishes that claimant's symptoms are the disease.

Consequently, we conclude that claimant is required to prove that his work exposure was the major contributing cause of his respiratory conditions or of the worsening of those conditions. ORS 656.802(2). As explained above, Dr. Montanaro did not find that work caused claimant's respiratory conditions. Furthermore, Dr. Montanaro did not find that any underlying conditions had been worsened. Moreover, Dr. Gill agreed with the majority of Dr. Montanaro's opinion, although he disagreed with Montanaro's inference that the workplace had not affected claimant's condition. Dr. Gill stated that, although claimant's workplace exposure was "probably not the cause" of the respiratory conditions, it "likely is a contributing factor."

Under the circumstances, we do not find that Dr. Gill's opinion is sufficient to establish that the workplace exposure was the major cause of claimant's respiratory conditions, or of a worsening of those conditions. We, therefore, reverse the Referee's order. The attorney fee award is also reversed.

ORDER

The Referee's order dated April 30, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the SAIF Corporation's denial of claimant's occupational disease claim for his chronic allergic rhinitis, allergic conjunctivitis and reactive airways conditions, is reversed. SAIF's denial is reinstated and upheld. The Referee's assessed attorney fee of \$2,200 is also reversed. The remainder of the Referee's order is affirmed.

November 30, 1993

Cite as 45 Van Natta 2261 (1993)

In the Matter of the Compensation of
GRETCHEN LAVELLE, Claimant
WCB Case No. 88-22318
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Hoguet's order that found that claimant's psychological claim was not prematurely closed. The insurer cross-requests review of that portion of the order that increased claimant's unscheduled permanent disability award for her psychological condition to 35 percent (112 degrees), whereas an Order on Reconsideration had awarded her 6 percent (19.2 degrees). Should we find that claimant's claim was not prematurely closed, claimant contends that she is entitled to an additional award of unscheduled permanent disability benefits. On review, the issues are premature closure and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact. We supplement as follows.

Claimant's psychological condition worsened in about May 1991. She required an increase in antidepressant medication and more frequent therapy. Claimant's condition improved by Fall 1991 and she continued to do well into early 1992.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant was medically stationary at the time of the December 11, 1991 closure. We affirm with the following supplementation.

As a preliminary matter, claimant contends that ORS 656.245(3)(b)(B) and OAR 436-10-080 preclude the Referee from relying on any opinion other than that of the attending physician or an opinion with which the attending physician concurs, in determining claimant's medically stationary status. We disagree.

ORS 656.245(3)(b)(B) provides, in relevant part:

"Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." (Emphasis added). ORS 656.245(3)(b)(B).

OAR 436-10-080 provides, in relevant part:

"(1) The attending physician shall notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness and whether or not the worker is released to any form of work.

"(2) If the attending physician determines that the injury related condition has resolved, returning the worker to pre-injury status, the attending physician shall so state. If there is permanent residual loss of use or function, a closing examination as described in this rule shall be performed. * * *

"(5) If the attending physician refers the worker to a consulting physician for all or any part of a closing examination, the attending physician must review the report and concur in writing, or write a report describing any findings with which the attending physician disagrees. * * *"

We have held that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician may make impairment findings to be used in rating a claimant's disability under the "standards." Dennis E. Connor, 43 Van Natta 2799 (1992); Lydia L. Kent, 44 Van Natta 2438, 2439 (1992). However, a worker's medically stationary status is not determined under the "standards." Rather, it is defined and governed by statute. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). On the other hand, the "standards" govern the worker's entitlement to specific values for measured impairment for an award of permanent disability. Further, the rules providing for determination of medically stationary status are found separately in Division 30 of the Department's rules, rather than in Division 35, which contains the standards. See OAR 436-30-035.

Claims shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). It is claimant's burden to establish that she was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). Claimant's condition and the reasonable expectation of improvement are evaluated as of the date of closure, without consideration of subsequent changes in her condition. Sullivan v. Argonaut Ins. Co, 73 Or App 694 (1985); Alvarez v. GAB Business Service, 72 Or App 524 (1985). Medical reports authored after closure may be considered if claimant has had no post-closure change in her condition and the only question is whether claimant was medically stationary at the time of closure. Id.; William K. Porter, 44 Van Natta 937, 943 (1992).

Claimant's claim was closed on December 11, 1991. Claimant's condition changed in 1992. We do not consider the subsequent change in her condition or medical reports authored after closure regarding that change. Sullivan v. Argonaut Ins. Co, *supra*; Alvarez v. GAB Business Service, *supra*; William K. Porter, *supra*. We accordingly evaluate claimant's condition and the reasonable expectation of improvement as of the December 11, 1991 date of closure.

In support of his conclusion that claimant was medically stationary at the time of claim closure, the Referee adopted the carrier's closing argument as his conclusions and opinion. In its closing argument, the carrier contended that the record as a whole establishes that it was not reasonable at closure to expect material improvement from further treatment or the passage of time. (Ins. cl. arg. at 6). In support of this contention, the insurer cited the opinions of Drs. Smith, Colbach, Davies and Glass. (Ins. cl. arg. at 3-5).

Two of these reports, by Drs. Smith and Colbach, were dated September 5, 1990 and February 19, 1991, respectively. Dr. Smith did not opine that claimant was medically stationary, and, in fact, recommended further treatment. Dr. Colbach opined that claimant's condition at the time of his examination was due to something other than the sequelae of her accepted industrial injury. He also opined that claimant was medically stationary.

On June 14, 1991, subsequent to Dr. Smith's and Dr. Colbach's reports, Dr. Weinstein, claimant's treating psychiatrist, reported that claimant had suffered a relapse of her major depression and had once again become symptomatic. Because claimant's condition worsened after Dr. Smith and Dr. Colbach gave their reports, we do not find their reports persuasive evidence of claimant's condition in December 1991, after the worsening.

In order to stabilize claimant's relapsed condition, Dr. Weinstein saw claimant for one hour therapy sessions every two weeks and prescribed antidepressant and anti-anxiety medication. (Ex. 19). He reported that claimant was doing reasonably well by the Fall of 1991 and continued to do well into 1992. (Ex. 34-15). He nevertheless opined that, although claimant's condition had improved, she still needed additional psychiatric treatment to enable her to return to work and, therefore, was not medically stationary as of the time of claim closure. (Ex. 34-5).

Dr. Davies, clinical psychologist, performed a psychological evaluation for the insurer on October 16, 1991, and on October 17, 1991, Dr. Glass, psychiatrist, performed another. Both concluded that claimant was medically stationary.

The resolution of the medically stationary date is primarily a question for the medical experts. Harmon v. SAIF, 54 Or App 121, 125 (1985). When there is a dispute between medical experts, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1990).

We are more persuaded by the opinions of Drs. Glass and Davies. At the time they examined claimant, she reported that she was doing very well, and their observations verified her assertions. (Exs. 20 and 21). Both noted that she did not complain of or exhibit any psychiatric symptoms. They each opined that claimant had reached a plateau of improvement in her major depression, which is congruent with the report of claimant's improved condition by Dr. Weinstein, and that claimant was medically stationary. Given the duration of claimant's treatment and Dr. Weinstein's own report of claimant's improvement, we are not persuaded by his conclusory disagreement with their evaluation. Furthermore, he does not indicate that he expected material improvement in her condition, aside from his hope that she would be able to return to work in the future. Consequently, we conclude that claimant has failed to establish that she was not medically stationary on the date of closure. Scheuning v. I.R. Simplot & Company, *supra*.

Extent of Unscheduled Permanent Disability

The Order on Reconsideration awarded claimant 6 percent unscheduled permanent disability for her psychological condition. Based on the findings of Dr. Weinstein, the Referee awarded an additional 29 percent, for a total of 35 percent unscheduled permanent disability. The insurer argues that the Order on Reconsideration should be affirmed. Claimant contends that she is entitled to a 46 percent unscheduled permanent disability award.

Claimant has the burden to prove the extent of disability resulting from her compensable injury or occupational disease. ORS 656.266. Unscheduled permanent partial disability is rated on the permanent loss of earning capacity. ORS 656.214(5). 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 a medical arbiter. ORS 656.245(3)(b)(B); 656.268(7); 656.283(7). We rely on an attending physician's findings in evaluating a worker's permanent disability unless a preponderance of the medical evidence undercuts the reliability of those findings. Debra L. Godell, 45 Van Natta 34 (1993).

The insurer first argues that the findings of Drs. Davies and Glass, who each concluded that claimant's major depressive episode had resolved without permanent impairment, are more persuasive than the findings of claimant's attending physician. Next, it argues that claimant's impairment was no greater than 6 percent, based on the findings of Dr. Colbach, who examined claimant on February 19, 1991, prior to her worsening.

We reject Dr. Colbach's findings for the same reasons that we rejected his opinion regarding claimant's medically stationary status. We are also not persuaded that the preponderance of the remaining evidence undercuts the reliability of Dr. Weinstein's findings. Both Drs. Davies and Glass conceded that claimant had a psychological condition. However, they attributed it to preexisting personality trait characteristics and concluded that claimant had no impairment related to her work. Dr. Weinstein, on the other hand, had treated claimant for job-related anxiety and depression. He evaluated claimant's disability in light of permanent changes in her residual reactions, including anxiety and depression, that may require extended treatment. See OAR 436-35-400(5)(b). Accordingly, we too rely upon his findings in evaluating claimant's permanent disability.

Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f). This calculation is made by determining the appropriate values assigned by the standards to the worker's age, education (including skills), adaptability and impairment.

Claimant's claim was closed on December 11, 1991. 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); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

Impairment

Dr. Weinstein found that claimant had a moderate class II psychoneurosis, which results in a 35 percent impairment rating. OAR 436-35-400(5)(b).

Age

For workers age 40 and above, the factor of age shall be given a value of 1. Because claimant is over 40 years old, the appropriate value for age is 1. OAR 435-35-290(2).

Adaptability

The adaptability factor is based upon 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).

Here, claimant's job title as a Legal Secretary is classified as sedentary. DOT # 201.362-010. Furthermore, 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. She has no lifting restrictions. Thus, claimant's residual functional capacity is sedentary. Accordingly, claimant's adaptability factor is calculated as 1. OAR 436-35-310(2) and (3).

Education

The education factor is based upon formal education, skills, and certification. For workers who have a high school diploma or GED certificate, the standards assign a value of 0. Because claimant has more than 12 years of school, her formal education value is 0.

A value for a worker's skills is allowed based on the highest Specific Vocational Preparation (SVP) time for jobs performed during the ten years preceding the time of determination. OAR 436-35-300(3). Claimant was employed as a legal secretary (DOT # 201.362-010). The SVP for this job is 6. Claimant met the SVP by performing for a year and a half with her employer. Thus, claimant's skills value is 2.

Because claimant has achieved an SVP of 5 or higher for the ten years preceding the time of determination, no additional value shall be allowed. OAR 436-35-300(4).

Calculation

Having determined each of the values necessary under the standards, we calculate claimant's unscheduled permanent disability. The sum of the value (1) for claimant's age and the value (2) for education is (3). The product of that value and the value (1) for claimant's adaptability is (3). The sum of that product and the value (35) for claimant's impairment is (38). That value represents claimant's unscheduled disability. OAR 436-35-280.

Attorney Fee

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

ORDER

The Referee's order dated January 20, 1993 is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the 6 percent (19.2 degrees) unscheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded 32 percent (102.4 degrees) unscheduled permanent disability, giving her a total award to date of 38 percent (121.6 degrees) unscheduled permanent disability for a psychological condition. The remainder of the order is affirmed. Claimant's attorney is awarded \$1,500 for services on Board review, to be paid by the insurer. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased permanent disability compensation awarded under this order, payable by the insurer directly to claimant's attorney. The total fees approved by the Referee and the Board shall not exceed \$3,800.

November 30, 1993

Cite as 45 Van Natta 2265 (1993)

In the Matter of the Compensation of
MARGARET A. LORD, Claimant
WCB Case No. 92-13447
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Davis, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Referee Podnar's order that upheld the insurer's partial denial of claimant's asthma condition. On review, the issue is compensability.

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

The insurer denied that claimant's asthma condition and need for treatment arose out of her employment with its insured. The Referee analyzed claimant's claim as one for an occupational disease, and found that claimant had failed to prove that work exposure was the major contributing cause of a worsening of her underlying asthma condition. ORS 656.802(2). On review, claimant contends that her "resultant respiratory condition" is compensable as an injury under ORS 656.005(7)(a)(B). Because the parties framed the issue at hearing as simply "compensability," and because claimant's condition purportedly resulted from a sudden, unexpected event, we address claimant's injury argument. See James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

A worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability, will be compensated for disability and treatment provided the compensable injury is the major contributing cause of the disability or need for medical treatment. ORS 656.005(7)(a)(B). Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). Thus, under either an injury or occupational disease theory, claimant must prove that: (1) her condition arose out of and in the course of her employment; and (2) that the event/exposure is the major contributing cause of her disability or need for treatment. ORS 656.005(7)(a); ORS 656.802.

On this record, claimant has failed to prove that her condition is the result of a workplace event/exposure; that the compensable injury is the major contributing cause of her resultant respiratory condition or need for treatment; or that work exposure was the major contributing cause of a worsening of her underlying asthma condition.

ORDER

The Referee's order dated February 2, 1993 is affirmed.

In the Matter of the Compensation of
SAMUEL C. MORENO, Claimant

WCB Case No. 92-07808

ORDER ON REVIEW

Michael B. Dye, Claimant Attorney

Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Barber's order that awarded 10 percent (15 degrees) scheduled permanent disability for his left leg (knee) condition, whereas an Order on Reconsideration awarded 16 percent (24 degrees) scheduled permanent disability. In his brief, claimant contends that the Referee should not have admitted a post-reconsideration medical report into evidence. The self-insured employer cross-requests review of the Referee's order, and requests a further reduction of claimant's award. On review, the issues are evidence and extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Over claimant's objection, the Referee admitted into evidence a concurrence letter signed by claimant's treating doctor. On review, claimant argues that the exhibit should not have been admitted because it was generated after the medical arbiter's exam, and was not submitted at the reconsideration proceeding as provided in ORS 656.268(5).

In the recent case of Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), the court 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 v. Smith; supra. We have 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.

Consequently, while we conclude that ORS 656.268(5) does not preclude consideration of the disputed exhibit, the inquiry does not end there. Exhibit 28 is a concurring letter from Dr. Poulson, claimant's treating doctor. Because Dr. Poulson is the attending physician, his letter satisfies the requirements of ORS 656.245(3)(b)(B). Nonetheless, there is some question whether Dr. Poulson's report can be considered inasmuch as the Director appointed a medical arbiter. ORS 656.268(7) provides that the findings of a medical arbiter shall be submitted to the department for reconsideration purposes and "no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." See Pacheco-Gonzalez v. SAIF, 123 Or App 132 (1993) (ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report itself); Eilene E. Harding, 45 Van Natta 1484, recon 45 Van Natta 2017 (1993).

However, we need not decide whether Exhibit 28 should have been excluded under ORS 656.268(7), as regardless of whether we consider the report of Dr. Poulson, or that of Dr. Gritzka, we conclude that claimant has failed to establish entitlement to a value for lost range of motion or for a chronic condition.

The Referee found that claimant was entitled to a value of 5 percent for his knee surgery and 5 percent for a chronic condition. However, relying upon the opinion of the treating doctor who reported that claimant had no impairment, the Referee found that claimant was not entitled to a value for loss of range of motion. We modify.

Here, we do not find that claimant is entitled to impairment values for either loss of range of motion or a chronic condition. As discussed above, claimant's treating doctor, Dr. Poulson, consistently reported that claimant had no impairment due to the injury. The medical arbiter, Dr. Gritzka, found that claimant had loss of range of motion and a chronic condition. However, in reaching that conclusion, Dr. Gritzka stated that claimant had no other injuries to his knee.

After reviewing the record and claimant's testimony, we find that claimant sustained an injury to the same knee several months before his May 1991 accident. Claimant testified that his knee pain began when he fell between two logs in January 1991. Consequently, because Dr. Gritzka did not have a complete history at the time he provided his opinion, we are unable to conclude that, due to the compensable injury, claimant has impairment in the form of a loss of range of motion or a chronic condition.

Although we find no entitlement to a value for loss of range of motion or a chronic condition, the employer has not challenged that portion of the Referee's order that awarded claimant 5 percent for his partial meniscectomy. OAR 436-35-230(5). Accordingly, we conclude that claimant's total scheduled permanent disability award is 5 percent.

ORDER

The Referee's order dated February 11, 1993 is modified. In lieu of the Referee's award and all prior awards, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for his left leg (knee). Claimant's total award to date is 5 percent (7.5 degrees) scheduled permanent disability. The Referee's attorney fee award is modified accordingly.

November 30, 1993

Cite as 45 Van Natta 2267 (1993)

In the Matter of the Compensation of
JESSIE G. SELLERS, Claimant
WCB Case No. 92-15339
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Hoffman, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of those portions of Referee Baker's order that: (1) set aside its denial of claimant's low back condition claim; and (2) awarded an assessed fee of \$3,000. On review, the issues are compensability and attorney fees.

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

In 1988, claimant fell in a boat and injured her back and right hip. In March 1992, claimant began working for the employer; her duties included moving furniture. In late March or early April 1992, claimant developed left hip pain. An MRI revealed a large herniated disc in her low back at L5-S1. Dr. Melgard, neurosurgeon, performed surgery. The Referee found that claimant proved that moving furniture at work caused the herniated disc.

The employer first asserts that claimant was not credible with regard to her testimony that she sustained an injury when moving furniture. The Referee found that claimant testified in a credible and sincere manner. Although not statutorily required, we generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). We find no reason not to do so here since the medical records do not contradict claimant's testimony that she developed hip pain shortly after beginning her job with the employer in March 1992.

The employer also contends that the appropriate standard for reviewing compensability is ORS 656.005(7)(a)(B) since there was evidence that claimant had preexisting back and hip problems, and that claimant failed to prove that her compensable injury was the major contributing cause of her need for treatment. The record contains one opinion regarding causation. Dr. Melgard, in response to a request from claimant's attorney, reported that "the most likely cause of [claimant's] herniated disc is the injury that she received while moving furniture in March of 1992[.]" (Ex. 13-1). He further indicated that such activity was the "pathophysiology and etiology of [claimant's] disc." (Id.)

The employer asserts that Dr. Melgard's opinion is not persuasive because he relied upon an inaccurate history regarding claimant's previous 1988 injury. In particular, the employer contends that Dr. Melgard erroneously presumed that claimant's previous injury did not involve her low back.

In reviewing the medical records pertaining to claimant's 1988 boat injury, there is some evidence of low back pain. (Exs. A-1, A-2). However, for the most part, the records show only that claimant had a "dorsal" contusion or sprain and that treatment was for claimant's "dorsal" spine. (Ex. A). Inasmuch as such evidence fails to specify the area of spine affected by the boat injury and in view of claimant's credible testimony that the injury did not involve her low back, we find a lack of proof showing that Dr. Melgard relied on an inaccurate history.

Thus, we find no persuasive reasons not to defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Based on Dr. Melgard's opinion, we find no evidence that claimant had a preexisting condition that combined with a compensable injury. Consequently, we conclude that ORS 656.005(7)(a)(B) is not applicable. In any case, based on Dr. Melgard's opinion, claimant proved causation, whether the appropriate standard is material or major contributing cause. See ORS 656.005(7). Accordingly, we agree with the Referee that claimant proved compensability.

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services on review is \$1,000. 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 case, and the value of interest involved. Finally, we note that claimant's attorney is not entitled to an assessed fee for services on review regarding the appropriate attorney fee for services at hearing. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated March 18, 1993 is affirmed. For services on review, claimant's attorney is awarded \$1,000, to be paid by the self-insured employer.

November 30, 1993

Cite as 45 Van Natta 2268 (1993)

In the Matter of the Compensation of
GEORGE E. SMITH, SR., Claimant

WCB Case No: MS-93002

ORDER ON REVIEW OF DIRECTOR'S ORDER (ORS 656.327(1)(b))

Olson & Rowell, Claimant Attorneys

Michael O. Whitty (Saif), Defense Attorney

Claimant requests review under ORS 656.327(1)(b) of a Director's order finding no bona fide medical services dispute. Reviewing for substantial evidence, we set aside the order and remand.

In August, 1983, claimant compensably injured his head, neck, and back. In March 1983, Dr. Gordon, D.O., became claimant's treating physician. On January 22, 1992, Dr. Gordon notified the SAIF Corporation that claimant's condition was "essentially unchanged" and that it was "very questionable that he will every [sic] improve [sic] where he is [sic]." (Ex. 171).

Based on this correspondence, SAIF informed Dr. Gordon that, "[s]ince [claimant's] medical condition has been found to be medically stationary, any further treatment will be deemed as palliative care. Consequently, in order to continue with treatment, we will need a treatment plan from you justifying the need for ongoing palliative care, its frequency and duration." (Ex. 181). The letter also stated that, "[w]ithout a treatment plan, we will no longer be able to continue authorizing any reimbursement for treatments provided." (Id.)

On June 5, 1992, Dr. Gordon notified SAIF that claimant "is stationary as far as any further improvement, but without continued treatment he will regress." (Ex. 182). Dr. Gordon further stated that claimant continued to experience "severe flareup[s]" when performing simple tasks. (Id.) Finally, Dr. Gordon stated that treatment could be weekly without flareups and twice a week with flareups. (Id.)

On November 20, 1992, SAIF informed claimant's attorney that "Dr. Gordon declared [claimant] medically stationary on June 5, 1992. Consequently, [claimant] became subject to enrollment in the managed care organization as of that date." (Ex. 201-1). The letter also stated that, under OAR 436-15-070, Dr. Gordon was not qualified to continue as claimant's treating physician and, therefore, claimant was obligated to choose a new attending physician participating in the MCO. (Id. at 1-2).

On November 16, 1992, Dr. Gordon responded to a questionnaire submitted by claimant's attorney indicating that claimant continued to need curative treatment for his TMJ syndrome and that claimant was only "temporarily" stationary with regard to his headache, neck and back conditions in January and June 1992. (Ex. 200). Dr. Gordon further stated that he saw "no prospect that [claimant's] condition will ever become stationary. He will have to continue regular treatment indefinitely or his condition will tend to worsen." (Id. at 2).

Claimant requested review by the Director, disputing SAIF's conclusion that claimant had been declared medically stationary. (Ex. 202). Claimant asserted that he was not required to change his attending physician and that SAIF was obligated to pay Dr. Gordon's outstanding medical bills. (Id.)

The Director subsequently issued an order finding that claimant had been declared medically stationary and, therefore, neither of the parties were alleging that his care was excessive, inappropriate, ineffectual or in violation of the rules. (Ex. 206-1). Thus, the order found no bona fide medical services dispute. (Id.)

Under ORS 656.327, review by the Director of medical treatment that is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" 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.

Although the statute does not contain a definition of "no bona fide medical services dispute," we construe the statute as providing that no bona fide medical services dispute exists if the medical services the claimant is receiving is not being challenged on one or more of the bases provided in ORS 656.327(1). Consequently, we uphold the Director's order finding no bona fide medical services dispute only if there is substantial evidence to support the Director's finding that the request for relief under ORS 656.327 does not present a challenge concerning whether medical treatment is inappropriate, excessive, ineffectual or in violation of medical service rules. After reviewing the record in this case, we are unable to reach such a conclusion regarding the Director's order.

When the worker's employer is subject to a Managed Care Organization (MCO) contract and the worker is receiving compensable medical services, the medical service provider may continue to treat the worker until the worker becomes medically stationary or changes physicians, whichever occurs first. OAR 436-10-050(1). Thereafter, any additional medical treatment must be provided in accordance with the provisions of the MCO contract. Id. However, the MCO must authorize a physician to provide medical services to the worker if the physician qualifies as a primary care physician. OAR 436-15-070(1).

In this case, SAIF informed claimant that it was necessary for him to change his treating physician to one that was participating in a MCO based on its determination that Dr. Gordon had declared claimant medically stationary and did not qualify as a primary care physician. Although not expressly articulated, SAIF essentially was contending that claimant's treatment was in violation of OAR 436-10-050(1) and 436-15-070(1). In light of these administrative regulations and SAIF's contentions, we

conclude that no reasonable person would find that the matter does not concern a dispute that medical treatment is in violation of rules regarding the performance of medical services. Consequently, we hold that the Director's findings are not supported by substantial evidence. Therefore, we set aside the order and remand to the Director for further action in accordance with ORS 656.327. ¹

ORDER

The Director's order dated February 1, 1993 is set aside. This matter is remanded to the Director for further action in accordance with law.

¹ Dr. Gordon reported that no further improvement in claimant's condition could be expected, (Exs. 171, 182), thereby indicating that claimant was medically stationary. See ORS 656.005(17). However, Dr. Gordon also disputed SAIF's contention that claimant was medically stationary by indicating that treatment improved claimant's condition after his periodic worsenings. (Ex. 200).

As a legal matter, it is likely that, based on the record, claimant is medically stationary. See Julio G. Mejia, 43 Van Natta 467, 469 (the claimant failed to prove that he was not medically stationary with evidence that his condition was expected to deteriorate since, under ORS 656.005(17), the test is whether further improvement is expected). However, as stated above, our role in reviewing the Director's orders finding no bona fide medical services dispute is to examine whether or not there is substantial evidence to support the finding that there is no challenge by the parties that medical treatment is inappropriate, excessive, ineffectual or in violation of medical services rules. If such a challenge exists, then we will set aside the order. See ORS 656.327(1)(b). Therefore, regardless of the ultimate medically stationary determination, claimant is entitled to the procedure provided in ORS 656.327(2).

December 2, 1993

Cite as 45 Van Natta 2270 (1993)

In the Matter of the Compensation of
AMBER D. APPLEBEE, Claimant
 WCB Case Nos. 92-01658 & 92-01657
ORDER ON REVIEW
 John Mayfield, Claimant Attorney
 Jerome Larkin (Saif), Defense Attorney
 David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Wausau Insurance Companies (Wausau), on behalf of Tyco Industries/Viewmaster International, requests review of Referee Hoguet's order that: (1) severed its October 20, 1992 amended denial of claimant's current low back condition from these proceedings and declined to address the compensability issue arising from that denial; (2) set aside its de facto denial of claimant's "new injury" claim for an October 30, 1991 incident; and (3) upheld the SAIF Corporation's denial, on behalf of Tualatin-Yamhill Press Inc., of claimant's aggravation claim, arising from the same incident. In her brief, claimant argues that SAIF is precluded from denying claimant's March 12, 1991 and October 30, 1991 aggravation claims. Alternatively, claimant contends that the Referee correctly found Wausau responsible for an October 30, 1991 "new injury." On review, the issues are bifurcation of the compensability issue raised by Wausau's October 20, 1992 amended denial, preclusion, compensability and responsibility or, alternatively, aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On April 25, 1991, Wausau denied claimant's "new injury" claim for a March 12, 1991 low back strain. Wausau contended that claimant's condition had not worsened and that her then-current symptoms were related to her 1986 low back strain with SAIF. (Exs. 55, 57A). On October 20, 1992, Wausau amended its denial, stating that "your current condition is the result of your degenerative disc disease which is in no way related to your employment with [our insured.]" (Ex. 63).

At hearing, the parties agreed that compensability was an issue.

Following the hearing, the Referee "bifurcated" the issue arising from Wausau's October 20, 1992 amended denial, *i.e.*, the Referee declined to address the compensability of the claim as to Wausau. The Referee also directed claimant to file a new request for hearing concerning the October 20, 1992 denial, if claimant desired to do so.

Claimant has since requested a hearing in WCB case number 92-16253.

CONCLUSIONS OF LAW AND OPINION

Bifurcation

Claimant filed a claim for a March 12, 1991 injury against Wausau. On April 25, 1991, Wausau denied the claim, stating that claimant's problems were related to a 1986 injury during SAIF's coverage. (Ex. 55). Claimant filed a request for hearing on February 5, 1992, listing compensability as an issue. Wausau moved to dismiss claimant's request as untimely filed. A hearing convened on April 28, 1992, for the sole purpose of taking evidence on the motion, which the Referee subsequently denied. That ruling is not contested on review.

On October 20, 1992, Wausau amended its April 1991 denial to include claimant's current condition. (Ex. 63). When the hearing on the substantive issues convened on November 6, 1992, the parties agreed that compensability was an issue before the Referee. (Tr. 24-25). Wausau stated that its defense was "two-fold." It argued that claimant's current problems are merely flare-ups of symptoms of the 1986 injury for which SAIF is responsible. Alternatively, Wausau contended that claimant's current condition is not related to any "instances," under either SAIF's or Wausau's coverage. (Tr. 31). No party contested Wausau's framing of the issues.

Notwithstanding claimant's failure to file a written hearing request from Wausau's October 1992 amended denial, we conclude that the denial was encompassed within the "compensability and responsibility" issues raised at hearing. Therefore, we hold that the October 1992 denial was properly before the Referee for resolution. See OAR 438-06-031 ("Amendments [to the issues] shall be freely allowed up to the date of hearing."); Kevin C. O'Brien, 44 Van Natta 2587 (1992) (Where it is apparent that compensability is disputed, referee has authority to consider compensability denial, notwithstanding claimant's failure to file a hearing request from that denial).

In his Opinion and Order, the Referee stated that the record had been inadequately developed to enable him to address Wausau's October 20, 1992 amended denial of claimant's current condition. Consequently, the Referee severed the issue and directed claimant to request a new hearing from the amended denial, if claimant wished to do so. We disagree.

No party claimed surprise or prejudice and no party requested a continuance, postponement or severance of issues. In fact, there was no disagreement that compensability and responsibility were at issue. (See Tr. 24-26). Apparently, the Referee decided, on his own motion, to sever the issue arising from Wausau's current condition denial from the proceeding before him. Because no such action was requested, we conclude that the Referee should not have bifurcated the issues. See Theodore W. Lincicum, 40 Van Natta 1760, 1762-63 (1988); Michael R. Petrovich, 34 Van Natta 98 (1982).

Finally, we note that the record contains numerous medical reports discussing claimant's condition and its etiology. Under these circumstances, we are not persuaded that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). Moreover, because the compensability issue was raised at hearing without objection and the issue was fully litigated, we find no compelling reason to remand the case for other action. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Accordingly, we proceed with our review.

Res judicata/whether SAIF's denials are precluded

On December 31, 1991, SAIF denied claimant's claim for a March 12, 1991 aggravation. (Ex. 57). On June 12, 1992, SAIF issued a "Disclaimer of Responsibility and Amended Claim Denial," contending that claimant suffered new injuries under Wausau's coverage. (Ex. 62).

Claimant argues that her current low back problems remain related to the 1986 low back strain which SAIF accepted. Insofar as her current condition is due to degeneration, claimant contends that it is part of the accepted claim. Claimant reasons that SAIF accepted claimant's 1988 aggravation claim by

stipulation and claimant was awarded permanent disability, based in part on two bulging discs, when that claim was closed on October 2, 1989. (See Exs. 28A, 44). Thus, claimant argues that SAIF is precluded from denying the current claim, by the 1988 stipulation and/or the 1989 Determination Order. We disagree.

Effect of 1988 stipulation

In Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993), the court stated that an agreement accepting a claim "has the finality and effect of a judgment." 122 Or App at 471, citing International Paper Co. v. Pearson, 106 Or App 121 (1991).

Here, SAIF's 1988 denial of claimant's aggravation claim stated, "Medical information in your file indicates that your condition has not worsened since your claim was previously closed." (Ex. 25A-1). Thus, the 1988 claim was denied on the basis of an alleged lack of worsening. (Ex. 25A). The stipulation, which resolved the dispute occasioned by that denial, provided in relevant part: "SAIF Corporation agrees to rescind the April 15, 1988 denial [of the] request to reopen this claim." (Ex. 28A-1).

The stipulation did not specify the identity of claimant's then-current condition. Rather, it determined only that SAIF would rescind the denial and reopen the claim. Under these circumstances, we do not find that the 1988 stipulation constituted an acceptance of a specific 1988 condition. Because SAIF did not accept claimant's condition by stipulation, we conclude that the 1988 agreement does not bar SAIF's 1991 denial. See International Paper Co. v. Pearson, *supra*; see also Safeway Stores, Inc. v. SENEY, 124 Or App 450 (1993) (The preclusive effect of a settlement agreement depends on the terms of the agreement).

Moreover, even if the terms of the 1988 stipulation were reasonably construed as an acceptance of claimant's then-current condition, the current denial would not be barred because claimant's condition has changed since 1988. See Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560 (1989). In reaching this conclusion, we rely on the reasoning set forth in the following section.

Effect of the 1989 Determination Order

Claimant also argues that SAIF is precluded from denying the current claim because it did not appeal the October 2, 1989 Determination Order which closed her prior 1988 aggravation claim. In this regard, claimant apparently argues that SAIF effectively waived challenging the compensability of claimant's current low back condition by failing to appeal the Determination Order's impairment values for two bulging discs. (See Ex. 44A-2). We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). Here, the October 2, 1989 Determination Order became final without "actual litigation." Therefore, issue preclusion does not apply.

Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, 1102 rev den, 289 Or 337 (1980).

Here, the 1989 Determination Order did not decide or litigate compensability of claimant's low back degeneration, to include the two bulging discs. Rather, the unappealed Determination Order settled only issues relating to temporary and permanent disability resulting from the compensable injury and the date claimant became medically stationary from that injury. See Walter Moore, 45 Van Natta 2073 (1993).

The medical evidence in this case indicates that claimant's condition has changed since the 1989 Determination Order issued. Her current disability and need for medical services result from muscular deconditioning as well as degeneration. (Exs. 52A, 54, 56, 59). There is no indication that claimant suffered from muscular deconditioning at the time of the 1989 Determination Order (or previously). Thus, the current claim arises from a new set of operative facts that could not have been litigated at the time of the 1989 Determination Order. Consequently, SAIF's denial is not precluded by the Determination Order. See Liberty Northwest Ins. Corp. v. Bird, *supra*.

Moreover, considering the uncontroverted evidence that claimant's degenerative condition lacks neurological involvement, (see Exs. 52A, 54), we are not persuaded that her bulging discs cause her current problems. Accordingly, we proceed to the merits.

Compensability

Considering the passage of time and the number of potential causes for claimant's current problems, the causation issue is a complex medical question which must be resolved by medical evidence. See Madewell v. Salvation Army, 49 Or App 713, 717 (1980). Circumstantial evidence is not sufficient. Compare Barnett v. SAIF, 122 Or App 279 (1993).

The current medical evidence regarding claimant's low back problems is provided by Drs. Gerry, Gavlick, Neuberg and Ushman.¹ This evidence is essentially uncontroverted.

Dr. Gerry opined that "the etiology of [claimant's 1991] complaints was predominantly muscular[.]" specifically, "the major contributing factors [are her] poor overall conditioning and her weakness in her abdominal and back musculature." (Exs. 52A-3, 56).

Dr. Gavlick stated that claimant's chronic recurrent low back pain "seemed mostly muscular and ligamentous in origin." (Ex. 54).

Dr. Neuberg examined claimant on March 12, 1992 and assessed "chronic low back pain with waxing and waning. Deconditioning. Degenerative disc disease L4-5, L5-S1." (Ex. 59).

Dr. Ushman examined claimant on October 30, 1991 and diagnosed a lumbosacral strain. He opined that the "major contributing cause of claimant's overall current condition" is now the degenerative disc disease, not a March 25, 1986 or October 30, 1991 strain. (Ex. 61-1-2).

The medical evidence unequivocally relates claimant's current back problems to muscular deconditioning and degenerative disease. No physician relates claimant's current condition to the accepted 1986 claim or an exacerbation thereof. Moreover, the medical evidence does not support a finding that either the March 12 or the October 30, 1991 incidents were a material cause of claimant's subsequent problems.² Finally, although claimant's compensable bulging discs may be part of her current degenerative condition, there is no medical evidence equating the two, explaining how they are the same or different, or suggesting that the current claim involves the bulging discs. Consequently, on this record, claimant has failed to prove that her current condition is related to any work injury or that it is otherwise work-related. Consequently, the claim is not compensable. See ORS 656.005(7)(a).

Finally, because claimant's current condition is not compensable, we do not reach the aggravation question and there is no responsibility issue. See William W. Trunkey, 43 Van Natta 2749 (1991) (Where claimant failed to prove compensability, even though compensability was raised at hearing and all evidence necessary to decide that issue was in the record, the responsibility issue was foreclosed and claimant was not denied fundamental fairness), aff'd mem, Trunkey v. Bohemia, Inc., 118 Or App 748 (1993).

ORDER

The Referee's order dated December 7, 1992 is reversed in part and affirmed in part. That portion of the order that severed the compensability issue arising from Wausau Insurance Companies' amended October 20, 1992 denial from the proceedings is reversed. That portion of the order that set aside Wausau's denial regarding the claimed October 30, 1991 incident is reversed. Wausau's denial is reinstated and upheld. The Referee's attorney fee awards are reversed. Wausau's October 20, 1992 denial is upheld. The remainder of the order is affirmed.

¹ Dr. Martens did not address causation.

² Dr. Ushman stated that claimant's March 12, 1991 incident was a material contributing cause of her current need for treatment (Ex. 61-1). However, Ushman's explanation reveals that he was referring to the October 30, 1991 incident. (Id.) Under these circumstances, Ushman's conclusions regarding the March and October 1991 incidents are not clear enough to be persuasive.

In the Matter of the Compensation of
LYNDA M. ENGLAND, Claimant
WCB Case No. 92-08135
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Claimant requests reconsideration of our November 16, 1993 Order on Review (Remanding) which vacated the Referee's order which found that the Director had jurisdiction over the issue of proposed surgery. On reconsideration, claimant objects to that portion of our order which remanded the case to the Referee.

Specifically, claimant contends that the only issue at hearing was whether the Director had jurisdiction to issue his order. Claimant argues that she has never raised the issue of a denial of proposed surgery and the only resolution she seeks is an order setting aside the Director's order. Finally, claimant disagrees with that portion of the Referee's order which found that an agreement existed between claimant's former counsel and the self-insured employer pertaining to withdrawal of claimant's request for hearing.

In order to further consider claimant's request, we withdraw our November 16, 1993 order. The employer is granted an opportunity to respond to claimant's motion. To be considered, the employer's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

December 2, 1993

Cite as 45 Van Natta 2274 (1993)

In the Matter of the Compensation of
ERMA J. JONES, Claimant
WCB Case No. 92-14879
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer has requested reconsideration of our November 5, 1993 Order on Review. Specifically, the employer contends that we erred in affirming the Referee's award of 19 percent unscheduled permanent disability. After reviewing the employer's motion and memorandum in support, we issue the following order.

The employer contends that the temporary rules (WCD Admin. Order 93-052) should not be applied to this case. In support of its contention, the employer notes that in the preamble to the Director's temporary rules it states, "the rule revision is necessary to adequately address the disability of a number of workers whose claim closure are currently being reconsidered by the Appellate Unit of the Workers' Compensation Division."

While the preamble can be interpreted to suggest that the temporary rules apply to only those cases that were in the reconsideration process at the time the rules were enacted, the actual rule concerning applicability of the standards clearly states otherwise. OAR 436-35-003(4) provides:

"Notwithstanding section (2) of this rule, the temporary rules contained in WCD Admin. Order 93-052 apply to all rating of permanent disability made on or after June 17, 1993." (Emphasis supplied).

Inasmuch as the Hearings Division and the Board both may rate a worker's permanent disability, on its face the rule clearly indicates that the temporary rules are applicable to ratings made by a Referee or the Board after June 17, 1993. We have previously relied on these rules in countless decisions, each of which involved a "retroactive" application of the Director's standards. See Pamella K. Doran, 45 Van Natta 1725 (1993); Edward K. Campanelli, 45 Van Natta 1641 (1993); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

Finally, ORS 656.295(5) provides that the Board shall apply the standards for the evaluation of disability as may be adopted by the Director pursuant to ORS 656.726. In light of this statutory mandate and given the clear language of OAR 436-35-003(4), we continue to find that the temporary rules apply to this case.

Accordingly, we withdraw our November 5, 1993 order. On reconsideration, as supplemented herein, we republish our November 5, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 2, 1993

Cite as 45 Van Natta 2275 (1993)

In the Matter of the Compensation of
RICHARD L. MANNING, Claimant
WCB Case No. 92-10417
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Jaime Goldberg (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Referee Galton's order that set aside an Order on Reconsideration on the basis that it was invalid. On review, the issue is validity of an Order on Reconsideration. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the August 5, 1992 Order on Reconsideration and the subsequent December 1, 1992 Order Denying Reconsideration were invalid. The Referee reasoned that, although a "record review" had been conducted by a medical arbiter, the procedure was invalid because there had not been a medical arbiter examination. Consequently, the Referee did not address claimant's contention that he was entitled to permanent disability. We disagree.

ORS 656.268(7) provides that if a party objects to the impairment findings used in closing a claim, the director shall refer the claimant to a medical arbiter or panel of medical arbiters appointed by the director. The statute goes on to state that:

"The medical arbiter or panel or medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. The costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid for by the insurer or self-insured employer." (Emphasis supplied).

While the statute requires the Director to refer the claim to a medical arbiter or panel of arbiters, it does not require the medical arbiter to perform an examination. The emphasized portion of the statute indicates that an examination is discretionary and also provides for the payment of costs by the insurer for a medical arbiter's review as well as an examination. In light of such statutory provisions, we conclude that a medical examination is not a prerequisite for a valid medical arbiter's report.

While Dr. Martens, medical arbiter, did not examine claimant, he submitted an opinion on the extent of claimant's permanent disability based on records provided by the Director. (Ex. 23). The Director then issued the reconsideration order relying on Dr. Martens' opinion. (Ex. 24). Accordingly, the reconsideration order was not invalid on the basis that the Director failed to appoint a medical arbiter.

Finally, even assuming that the reconsideration order was invalid, the Referee still had the authority to consider claimant's appeal of the reconsideration order. Subsequent to the Referee's order, the Court of Appeals issued its decision in Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). In Pacheco-Gonzalez, the court held the validity of an Order on Reconsideration is not a prerequisite for determining jurisdiction. The court noted that ORS 656.268(6)(b) allowed any party to request a hearing under ORS 656.283 if there was an objection to a reconsideration order. The court further noted that ORS 656.283(1) allowed any party or the Director to request a hearing on any question concerning a claim at any time. The court reasoned that "[n]either statute requires a 'valid' order on reconsideration for the referee to have jurisdiction. No statute divests the Board of its obligation where an 'invalid' order on reconsideration occurs." Id.

Accordingly, as explained by Pacheco-Gonzalez, the validity of an Order on Reconsideration has no bearing on the Referee's authority to consider the order. Consequently, the Order on Reconsideration was properly before the Hearings Division. Inasmuch as we find the record concerning the issue of extent of permanent disability fully developed, we proceed to the merits.

Dr. Chapman, claimant's attending physician, found that claimant was medically stationary as of November 19, 1991. At that time, Dr. Chapman released claimant to all pre-injury activities and opined that claimant had no permanent impairment as the result of the compensable injury. The only other medical evidence concerning claimant's extent of disability comes from Dr. Martens, the medical arbiter. Dr. Martens agreed with Dr. Chapman that claimant was medically stationary as of November 19, 1991 and had sustained no permanent impairment as a result of the compensable injury.

Under these circumstances, we conclude that claimant has not established that he has any permanent impairment as a result of his compensable injury. Accordingly, we affirm the August 5, 1992 Order on Reconsideration and the subsequent December 1, 1992 Order Denying Reconsideration.

ORDER

The Referee's order dated January 20, 1993 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the August 5, 1992 Order on Reconsideration and the subsequent December 1, 1992 Order Denying Reconsideration as invalid is reversed. The August 5, 1992 Order on Reconsideration and the subsequent December 1, 1992 Order Denying Reconsideration are reinstated and affirmed. The remainder of the order is affirmed.

December 2, 1993 Cite as 45 Van Natta 2276 (1993)

In the Matter of the Compensation of
ROSA M. PACHECO-GONZALEZ, Claimant

WCB Case No. 91-11930

ORDER ON REMAND (REMANDING)

Michael B. Dye, Claimant Attorney

Charles Cheek (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). The court has reversed our prior order, which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Reasoning that the Hearings Division had authority to consider a reconsideration order whether "invalid" or "valid," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A February 7, 1991 Notice of Closure closed claimant's injury claim with no award of permanent disability. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Notice of Closure in all respects. Claimant requested a hearing.

The Referee found the Order on Reconsideration invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order.

In our prior order, we affirmed the Referee's order dismissing claimant's request for hearing for lack of jurisdiction. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

The court has reversed our order. Pacheco-Gonzalez v. SAIF, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court has remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Accordingly, we proceed with our reconsideration.

Although the Referee admitted exhibits into the record, the "post-reconsideration order" medical arbiter's report was not admitted. (Tr. 8). Moreover, no testimony was presented. As reasoned by the court, Pacheco-Gonzalez v. SAIF, supra at 316, the post-reconsideration medical arbiter's report should have been considered at hearing. Under such circumstances, we find the record insufficiently developed. ORS 656.295(5). Consequently, we remand this matter to the Referee for further evidence taking.¹ See Nancy M. Buckles, 45 Van Natta 2077 (1993).

Accordingly, the Referee's order dated January 28, 1992 is vacated. The matter is remanded to Referee Holtan for further proceedings consistent with this order. Such proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7). Once these further proceedings are completed, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

¹ In light of ORS 656.268(7) and the court's ruling, the additional medical evidence will consist of the medical arbiter's report. Any lay testimony will consist of evidence concerning claimant's disability as of the date of issuance of the Order on Reconsideration. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160, 163 (1993).

December 2, 1993

Cite as 45 Van Natta 2277 (1993)

In the Matter of the Compensation of
CHARLES C. TAYLOR, Claimant
 WCB Case No. 91-16775
 ORDER ON REVIEW (REMANDING)
 Malagon, Moore, et al., Claimant Attorneys
 Employers Defense Counsel, Defense Attorneys
 Dennis Ulsted (Saif), Defense Attorney
 D. Kevin Carlson, Assistant Attorney General

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Gruber's order that dismissed claimant's hearing request regarding the Department's determination that Fred Jack and Charles McGlinchey were not subject employers at the time of claimant's alleged injury. On review, claimant argues that the Referee was authorized to consider claimant's contentions concerning the Department's subjectivity determination.¹ We remand.

¹ The Department has submitted an appellate brief on review. Noting that the Department did not seek a hearing, claimant challenges its standing to appear. Notwithstanding its failure to request a hearing, the Department has a stake in the outcome in that if the "subjectivity" determination is overturned, a noncomplying employer order may issue. Since the case has the potential of involving a noncomplying employer issue, we conclude that the Department has standing. See John A. Tallant, 42 Van Natta 939, 942 (1990). In any event, even if the Department lacked standing, we would still consider its brief on an amicus curiae basis. See Al S. Davis, 44 Van Natta 931 (1992).

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On March 15, 1991, the Department determined that claimant was not a subject worker for Fred Jack and Charles McGlinchey at the time of his alleged injury. In announcing its decision, the Department further advised claimant that if he objected to the determination he could seek a hearing with the Department's administrator. To secure such a hearing, claimant was notified that his written hearing request must be received by the Department within 30 days of the determination.

On April 23, 1991, the Department received claimant's hearing request. On November 12, 1991, the Department declined to grant the hearing because the request had not been received within 30 days of the March 19, 1991 determination. Thereafter, claimant requested a hearing with the Board contending that he was a subject worker.

The Department moved for dismissal of claimant's hearing request, contending that his failure to timely appeal its determination precluded further consideration of the "subject worker" question. The Referee granted the Department's motion. In reaching that decision, the Referee reasoned that the issue of subjectivity is not a matter concerning a claim because claimant's right to compensation was not directly in issue.

Subsequent to the Referee's order, we issued our decision in Douglas Fredinburg, 45 Van Natta 1619 (1993). In Fredinburg, we held that we retained appellate review authority to consider an appeal of a referee's order regarding the Department's "subjectivity" determination. Identifying the sole inquiry as whether the "subjectivity" determination involved a "matter concerning a claim" under ORS 656.283(1), we answered that question in the affirmative because the claimant's entitlement to compensation (i.e., the issuance of a noncomplying employer order and referral of the claim to the SAIF Corporation under ORS 656.054) was directly dependent on the "subjectivity" determination.

Here, claimant requested a hearing, contending that he was a subject worker for Fred Jack and Charles McGlinchey at the time of his alleged injury. Since such a request raises a question concerning a claim, claimant is entitled to present evidence at a hearing regarding his "subject worker" status. ORS 656.283(1), Douglas Fredinburg, *supra*. However, in doing so, each party must likewise be prepared to address the preclusive effect, if any, the Director's "subjectivity" determination has on this dispute. In other words, despite the opportunity to present evidence at the forthcoming hearing, the parties should address the question of whether the Director's determination has already resolved this issue.

In conclusion, we hold that the Referee was authorized to consider claimant's challenge to the Department's "subjectivity" determination. Inasmuch as claimant's hearing request was dismissed without the convening of a hearing, we vacate the Referee's August 6, 1992 order and remand to the Hearings Division.

Accordingly, we remand to the Presiding Referee with instructions to assign this case to another Referee. The designated Referee shall conduct further proceedings in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective position. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MANUEL ALTAMIRANO, Claimant
WCB Case No. 92-15408
ORDER ON REVIEW
Dye, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Referee Garaventa's order that awarded claimant 23 percent (73.6 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had not awarded any permanent disability. Claimant cross-requests review of that portion of the Referee's order which found he was not entitled to additional temporary disability benefits. On review, the issues are extent of permanent disability and temporary disability benefits.

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

The Referee relied on Dr. Poulson in finding that as a result of the compensable injury, claimant suffers from a chronic condition which limits repetitive use of his back. While we agree that claimant has a chronic condition, we do not rely on Dr. Poulson as he was not claimant's attending physician at the time of claim closure. ORS 656.245(3)(b)(B). Rather, we rely on Dr. Mitchell, who was claimant's attending physician at the time of claim closure.

While Dr. Mitchell indicated that the findings in the May 20, 1991 independent medical examination (reduced ranges of motion in flexion, extension and lateral bending) were more than adequate to define claimant's permanent disability, he also indicated that claimant suffered from chronic pain. (Exs. 41, 43A). Mitchell's opinion is consistent with his approval of modified work for claimant in March 1991. (Ex. 32). Finally, in a January 29, 1993 letter to claimant's counsel, Dr. Mitchell specifically stated that claimant "has a chronic back condition which precludes any repetitive motion related to his back. This chronic back injury is a result of an original accident that occurred on February 22, 1990." (Ex. 55).¹

Considering Dr. Mitchell's opinions as a whole, we find that as a result of the compensable injury, claimant suffers from a chronic condition which limits repetitive use of his back. Consequently, we agree with the Referee's award of permanent disability.

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

¹ The insurer contends that Exhibit 55 (a letter from Dr. Mitchell) cannot be considered because it was prepared after the reconsideration order. We disagree.

Subsequent to the Referee's order, 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, there is no other basis preventing the admission of Exhibit 55 inasmuch as Dr. Mitchell was the attending physician and was addressing claimant's condition prior to the time of the reconsideration order.

In addition, since a medical arbiter was not appointed, the evidentiary restrictions set forth in ORS 656.268(7) concerning no subsequent medical evidence after a medical arbiter's report are not applicable. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993)(ORS 656.268(7) prohibits the admission of medical evidence developed after the medical arbiter's report, not the medical arbiter's report). Therefore, pursuant to Smith and Luciani, the Referee had the authority to consider Dr. Mitchell's post-reconsideration report.

ORDER

The Referee's order dated March 22, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, payable by the insurer.

December 3, 1993

Cite as 45 Van Natta 2280 (1993)

In the Matter of the Compensation of

LUELLA M. BOSTICK, Claimant

WCB Case No. 92-15535

ORDER ON REVIEW

Hollander & Lebenbaum, Claimant Attorneys

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband:

Claimant requests review of those portions of Referee Peterson's order that found: (1) that claimant was precluded from litigating the compensability of her occupational disease claim for a right hand, arm and shoulder condition; and (2) that the insurer was not prevented by equitable estoppel from asserting the defense of res judicata. On review, the issues are scope of review, whether claimant is precluded from litigating the compensability of her occupational disease claim, and, if not, compensability.

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

In April 1990, claimant began work as a key punch operator for the insured. In September 1990, she sought treatment for right arm, hand and shoulder pain. Claimant was diagnosed with various conditions, including fibromyalgia, epicondylitis and tendonitis. (Exs. 1, 2A-3, 5). Eventually, based on a MRI and arthrogram, claimant was diagnosed with a torn right rotator cuff. (Ex. 10).

In February 1992, claimant signed an 801 form, claiming an injury to her right shoulder and arm. (Ex. 8A). On May 8, 1992, the insurer issued a denial stating that "the major cause of your current condition and need for treatment is not due to your employment, but rather to an underlying idiopathic condition diagnosed as a torn rotator cuff at the right shoulder." (Ex. 12-1). Claimant did not request a hearing or otherwise appeal the denial.

Claimant continued receiving treatment. In October 1992, she filed another 801 form for symptoms in her right wrist, arms, shoulder and neck. (Ex. 14). On November 19, 1992, the insurer issued another denial "for any treatment and/or disability in connection with your current condition." (Ex. 15). On December 4, 1992, claimant filed a request for hearing.

At hearing, claimant's attorney alleged that the May 8, 1992 denial was premature to the extent it applied to anything other than the specific injury claimed, and that the hearing request concerning the November 19, 1992 denial raised "compensability of [claimant's] occupational disease." (Tr. 4-5). In his opening statement, claimant's attorney stated that claimant had developed "arm, wrist and shoulder problems" and asserted that the November 1992 denial should be set aside. (*Id.* at 6-7). Finally, claimant's attorney stated that claimant's "occupational disease which regards her rotator cuff and shoulder condition is in fact compensable[.]" (*Id.* at 7).

The Referee found that the May 1992 denial was not premature and, moreover, because claimant did not appeal the denial, she was precluded from litigating compensability under any theory. Furthermore, the Referee found that claimant's condition had not worsened subsequent to the May 1992 denial.

On review, claimant asserts that she proved the compensability of a claim for tendonitis. The insurer moves to suppress those portions of claimant's brief regarding a tendonitis condition on the basis that claimant did not raise the issue at hearing. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991).

Although close, we find that the issue of the compensability of claimant's tendonitis was raised by claimant. In both of her 801 forms, claimant made a claim concerning her right arm, where she has been diagnosed with tendonitis. Furthermore, in both denials, the insurer denied compensability of claimant's "current condition". In view of the fact that claimant had been diagnosed with tendonitis and she sought treatment for the condition before either of the denials issued, and because the 801 forms referred to her right arm, we find that it is most reasonable to construe claimant's "current condition" as including tendonitis of the right arm.

Consequently, although claimant's attorney, when discussing the specifics of claimant's condition at hearing, referred only to the rotator cuff tear, we find that, because the denials included tendonitis and claimant sought to set aside such denials, she effectively raised the issue of the compensability of the tendonitis condition. Thus, we conclude that claimant may raise this issue on review. See Stevenson v. Blue Cross, supra.

The insurer asserts that, if compensability of claimant's tendonitis is properly before the Board, the May 1992 denial, from which claimant did not request a hearing, precludes claimant from seeking recovery for the condition. We agree.

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. Popoff v. J. I. Newberrys, 117 Or App 242 (1992); 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). Thus, claimant is barred from seeking recovery for a condition that was the subject of an unappealed denial, unless that condition has worsened.

Claimant asserts that her tendonitis was not included in the May 1992 denial and, because it was included in the November 1992 denial which she timely appealed, she may litigate compensability of her tendonitis. We disagree. As discussed above, the diagnosis of tendonitis was included in the insurer's May 1992 denial of claimant's "current condition." Consequently, claimant is barred from seeking recovery unless she can show that her tendonitis worsened following the May 1992 denial.

In reviewing the record, we find no such evidence. Although claimant's physicians referred to a diagnosis of tendonitis, (Exs. 2A-3, 5, 12C, 13A, 22), there is no suggestion that it worsened. Alternatively, even if we were to find that claimant was not precluded from litigating the compensability of her tendonitis, she has not shown that her work activities were the major contributing cause of the condition. At most, Dr. Switlyk, orthopedic surgeon, indicated that the tendonitis constituted an overuse condition brought on by a history of repetitive use. (Ex. 22-1). However, he did not state that any repetitive work activities caused the tendonitis. Consequently, even on the merits, claimant has not established compensability. See ORS 656.802(2).

ORDER

The Referee's order dated March 15, 1993 is affirmed.

In the Matter of the Compensation of

JOHNNY M. DAVIS, Claimant

WCB Case No. 92-13711

ORDER ON REVIEW

Francesconi & Busch, Claimant Attorneys

Neil W. Jones, Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Safeco Insurance Company requests review of Referee Peterson's order that awarded an insurer-paid attorney fee under ORS 656.386(1) when Safeco rescinded its denial of claimant's "new injury" claim prior to a hearing. On review, the issue is attorney fees.

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

Claimant has an accepted 1988 low back injury with the SAIF Corporation. While working for the same employer, claimant filed a claim with Safeco, the employer's current insurer.

In issuing its denial, Safeco stated that it was denying responsibility for claimant's low back condition. Suggesting that claimant file an aggravation claim with SAIF, Safeco also indicated that it would be requesting the designation of a paying agent under ORS 656.307.¹ Nevertheless, Safeco's denial further recited that it was not waiving other issues of compensability.² Moreover, the denial (which was identified as a denial of claimant's claim for benefits) contained a notice that not only disclaimed responsibility for the claim, but also represented a denial of compensation. See OAR 438-05-053(4).

Thereafter, claimant, through his attorney, filed a request for hearing from Safeco's denial. Safeco subsequently accepted the claim as a new injury prior to the scheduled hearing. Reasoning that claimant's attorney had been instrumental in obtaining compensation for claimant without a hearing, the Referee awarded an insurer-paid attorney fee under ORS 656.386(1).

Safeco challenges the Referee's attorney fee award, contending that it did not deny the compensability of claimant's "new injury" claim. Asserting that its denial was solely confined to responsibility, Safeco argues that claimant is not entitled to an insurer-paid attorney fee under ORS 656.386(1). See Multnomah County School Dist. v. Tigner, 113 Or App 405, 408, rev den 311 Or 150 (1991).² We disagree.

¹ Safeco did submit a copy of its letter to the Department, who issued a response seeking the "aggravation" carrier's (SAIF's) position regarding Safeco's request. Replying that further investigation would be necessary, SAIF stated that responsibility and compensability may be issues. In other words, no order designating a paying agent under ORS 656.307 issued. Since even the issuance of a "307" order does not preclude a carrier from subsequently denying compensability, we do not consider the submission of Safeco's letter to the Department in the absence of a "307" order (although probative evidence) to be conclusive evidence that Safeco was not contesting the compensability of claimant's low back claim. See Ronnie E. Taylor, 45 Van Natta 905 (1993).

² Safeco also relies on Joseph P. Grothe, 44 Van Natta 2132, 2133 (1992), which held that a claimant was not entitled to an attorney fee award under ORS 656.386(1) because a carrier had denied only responsibility, not compensability, for a condition. Submitting a copy of what it represents to be the carrier's denial in Grothe (which contains a "notice of hearing" provision consistent with a responsibility disclaimer and compensability denial under OAR 438-05-053(4)), Safeco argues that the Referee's conclusion that Safeco denied compensability is contrary to the Grothe holding. We disagree with Safeco's contention for several reasons.

To begin, the Grothe decision does not identify what "notice of hearing" provision was contained in the carrier's denial letter. Rather, the decision merely states that the carrier denied only responsibility and not compensability. Inasmuch as OAR 438-05-053(4) was not part of the reasoning leading to the Grothe holding, the Board's decision is not controlling on this case (regardless of what "notice of hearing" provision was actually contained in the carrier's denial).

In reaching our conclusion, we distinguish this case from the court's recent holding in Gamble v. Nelson International, 124 Or App 90 (1993). In Gamble, the court affirmed a Board order which concluded that a claimant was not entitled to an attorney fee award under ORS 656.386(1) when a carrier withdrew its responsibility disclaimer before a hearing. Reasoning that the disclaimer served only to notify the claimant that his claim may be compensable against another employer or insurer, the court concluded that the disclaimer was not a denial. Consequently, the court determined that the disclaimer neither triggered the provisions regarding the request for hearing under ORS 656.386(1) nor provided a basis for an attorney fee award under the statute because the disclaimer did not create an issue concerning the compensability of the claim.

Here, as was the case in Gamble, a carrier (Safeco) issued a responsibility disclaimer. In that disclaimer, Safeco further stated that claimant should file a claim with another carrier and that Safeco would be seeking a "307" order. Although Safeco submitted a copy of its "disclaimer" letter to the Department, no "307" order issued formally acknowledging Safeco's supposed concession of compensability and the designation of a paying agent under ORS 656.307. More importantly, unlike the responsibility disclaimer in Gamble, Safeco's "disclaimer" also stated that it was not waiving other issues of "compensability." Finally, again unlike the situation in Gamble, Safeco's letter included "notice of hearing" provisions consistent with a denial of compensation. See OAR 438-05-053(4). Specifically, the letter recited that "[t]his is a denial of your claim for benefits."

In light of such circumstances, we are persuaded that Safeco's "disclaimer" also created an issue concerning the compensability of claimant's low back claim. Inasmuch as we agree with the Referee's finding that claimant's attorney was instrumental in securing the rescission of that compensability denial and the acceptance of the claim without a hearing, we hold that claimant is entitled to an insurer-paid attorney fee award under ORS 656.386(1).

Since attorney fees are not compensation for the purposes of ORS 656.382(2), claimant is not entitled to an attorney fee award for services on Board review. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 5, 1993 is affirmed.

In any event, subsequent to Grothe, the court has issued its decision in Gamble. Inasmuch as the Gamble opinion includes a reference to the aforementioned administrative rule and an acknowledgment that the carrier did not also include a denial of the claim with its responsibility disclaimer, we consider the Gamble reasoning to be the major precedent in determining whether a "disclaimer" creates an issue concerning the compensability of a claim entitling claimant to a carrier-paid attorney fee award under ORS 656.386(1). In other words, even if we shared Safeco's interpretation of the Grothe holding, that decision would have been countermanded by the recent Gamble holding.

Finally, even were we to consider Safeco's "extra-record" submission of what it represents to be the carrier's denial in Grothe, we would find this case distinguishable. Although the Grothe denial includes a "notice of hearing" provision consistent with OAR 438-05-053(4), the denial consistently recites that the carrier is denying only responsibility. Here, Safeco's denial, unlike the Grothe denial, contains a provision stating that Safeco was issuing its denial "without waiving other issues of compensability." The inclusion of such a provision in conjunction with the "notice of hearing" statement consistent with a disclaimer/compensability denial leads us to conclude that, unlike the Grothe denial, Safeco's denial extended to compensability of the claim.

In the Matter of the Compensation of
RICHARD C. DOYLE, Claimant
 WCB Case No. 92-15209
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
 Reviewed by Board Members Haynes and Hall

Claimant requests review of Referee Barber's order that affirmed an Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for a cervical 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's highest job skill level is SVP 3, based on employment as a truss assembler.

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 April 9, 1992 Determination Order, OAR 438-10-010, 436-35-003(2). Those standards are provided in WCD Admin. Order 2-1991.

The Referee found that claimant is not entitled to values for age, education and adaptability factors under the standards, because claimant was released to return to his regular work after his compensable injury.

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). 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., supra.

Pursuant to the parties' agreement, we find that claimant is entitled to a 6 percent award for cervical impairment. Turning to the non-medical factors in rating claimant's permanent disability, claimant's age of 43 years is assigned a +1 value. See OAR 436-35-290(2). He has 10 years of schooling and no GED, for a +1 value. He has attained an SVP level of 3 as a truss assembler (DOT #762.684-062). There is no indication in the record that he has attained a higher SVP level. Therefore, claimant is assigned a value of 3 for the education factor. See OAR 436-35-300(3)(e). The sum of the age, education, and training factors equals 5.

Regarding the adaptability factor, we find that claimant's job at injury as a janitor required medium strength. 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). Claimant was released to perform his job-at-injury. Consequently, we assign a value of 1 for the adaptability factor. See OAR 436-35-310(3); 436-35-003.

Assembling the factors, we multiply the age, education, training factors total (5) and the adaptability value of 1 for a product of 5. That product is then added to the impairment value of 6 for a total of 11 percent. See OAR 436-35-280. Claimant is entitled to 11 percent unscheduled permanent disability for the compensable injury.

ORDER

The Referee's order dated March 15, 1993 is modified. In addition to the Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total of 11 percent (35.2 degrees) unscheduled permanent disability for a cervical 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, not to exceed \$3,800.

December 3, 1993

Cite as 45 Van Natta 2285 (1993)

In the Matter of the Compensation of
JUNE A. GONSHOROWSKI, Claimant
WCB Case Nos. 92-14022 & 92-14201
ORDER ON REVIEW
Welch, Bruun, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of that portion of Referee Galton's order that assessed an attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable denial. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his ultimate finding that SAIF's denial was unreasonable when issued.

CONCLUSIONS OF LAW AND OPINION

On review, SAIF contests only that portion of the Referee's order that awarded an attorney fee pursuant to ORS 656.382(1) for an allegedly unreasonable denial. SAIF denied the injury claim on the basis that there were no objective findings to substantiate a compensable injury. SAIF contends that at the time it issued its denial it had a legitimate doubt as to its liability for the claim. On this basis, SAIF contends that it did not unreasonably resist the payment of compensation and that no ORS 656.382(1) attorney fee should have been awarded.

The Referee concluded that at the time SAIF issued its denial, its file contained reports with numerous objective findings. On this basis, the Referee found SAIF's denial unreasonable. We disagree.

ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10). Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).¹ 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 Insurance Co., 93 Or App 588 (1988).

Here, several medical reports satisfied the "objective/findings" requirement.² Indeed, based on the findings made, Dr. Eusterman authorized time loss and prescribed physical therapy. (Ex. 5, 7, 9,

¹ Here, the Referee also assessed a penalty pursuant to ORS 656.262(10) for SAIF's unreasonable delay and resistance to the payment of temporary disability benefits and SAIF does not contest that portion of the Referee's order.

² See Suzanne Robertson, 44 Van Natta 1505 (1991); Georgia-Pacific Corp v. Ferrer, 114 Or App 471 (1992).

and 11). On the other hand, prior to issuance of SAIF's denial, Dr. Eusterman began to doubt that there was an objective basis for claimant's complaint. Specifically, in a chart note dated August 13, 1992, Dr. Eusterman indicated that he could not justify additional radiologic studies given the paucity of physical examination findings and normal x-rays. (Ex. 19). In that same note, Dr. Eusterman diagnoses "low back and leg pain - no objective basis." On August 19, 1993, Dr. Eusterman diagnoses "subjective low back and leg pain - cause undetermined - improved." (Ex. 21). In subsequent reports, Dr. Eusterman states that there are "no objective findings yet," and "symptoms do not fit findings". (Exs. 16 and 17). Because these expressions of doubt were voiced by the attending physician, we conclude that SAIF had a legitimate doubt as to its liability for the claim and that SAIF was not unreasonable in denying the claim on the basis that objective findings to support the claim were lacking. Therefore, an attorney fee pursuant to ORS 656.382(1) is not warranted.

ORDER

The Referee's order dated January 29, 1993 is reversed in part. That portion of the Referee's order that awarded a \$600 assessed attorney fee pursuant to ORS 656.382(1) is reversed. The remainder of the order is affirmed.

December 3, 1993

Cite as 45 Van Natta 2286 (1993)

In the Matter of the Compensation of

ALTA C. JANSON, Claimant

WCB Case No. 92-16309

ORDER ON REVIEW

Ransom, et al., Claimant Attorneys

Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Haynes.

Claimant requests review of Referee Barber's order which dismissed her request for hearing from the SAIF Corporation's alleged "de facto" denial of a left hip injury, cervical radiculopathy, and a herniated disc in the lumbar spine. On review, the issues are claim preclusion and, if the claim is not barred, compensability.

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

After our review of the record, we agree with the Referee's claim preclusion analysis. See also Derek J. Schwager, 44 Van Natta 1505 (1992), on recon 45 Van Natta 428 (1993), aff'd mem 124 Or App 681 (1993) (new diagnosis of previously denied condition does not overcome claim preclusion).

Moreover, were we to find the claim is not barred by claim preclusion, we would nevertheless find that claimant failed to carry her burden of establishing a causal relationship between her January 1990 fall at work and the L3-4 disc condition diagnosed by Dr. Bowman in February 1992.

It is claimant's burden to prove the compensability of her claim. ORS 656.266. Claimant must prove that the January 1990 fall at work was either a material or the major contributing cause of the claimed conditions. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We find the nature of the causal relationship between the herniated disc diagnosed in February 1992 and claimant's fall at work in January 1990 to be a complex medical question requiring expert medical evidence to resolve. See Uris v. Compensation Dept., 247 Or 420 (1967). Claimant must prove medical causation in terms of probability, not just possibility. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Only Dr. Bowman, who became claimant's treating orthopedist in February 1992, addresses causation. He diagnosed a disc bulge at L3-4. (See Exs. 14, 15, 17). However, regarding causation, he opined only that it is "possible" that claimant's symptoms were caused by her January 1990 fall at work. (Ex. 17-1). He also mentioned other potentially contributory factors unrelated to the January 1990 fall at work. (Ex. 17-2). We find that Dr. Bowman's opinion is not sufficient to carry claimant's burden of proving compensability, since it fails to establish with reasonable medical probability a causal relationship between the claimed conditions and the January 1990 work incident. See Gormley v. SAIF, supra. Accordingly, we conclude that, were we to address the merits of claimant's claim, we would find that claimant failed to establish the compensability of her claim.

ORDER

The Referee's order dated April 23, 1993 is affirmed.

December 3, 1993

Cite as 45 Van Natta 2287 (1993)

In the Matter of the Compensation of
JOB G. LOPEZ, Claimant
WCB Case No. 92-14335
ORDER ON REVIEW
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of that portion of Referee Howell's order that found that he had withdrawn from the work force at the time his compensable low back condition worsened. With his request for review, claimant submits additional documents. We treat such a submission as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and entitlement to temporary disability compensation. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONRemand

With his request for review, claimant submits additional documents. We treat such a submission as a motion to remand for the taking of further evidence. Judy A. Britton, supra. However, two of the documents submitted were admitted into evidence as Exhibits 29A and 62. Therefore, there is no need to include those documents in any discussion regarding remand.

Copies of the remaining documents were also submitted by claimant to the Referee after the hearing. The Referee received claimant's first ex parte submission four days after the hearing. The Referee placed that submission in the Hearings Division file but did not receive it into evidence and reopened the record to allow either party to submit a rebuttal. No rebuttal was received and the Referee closed the record and issued his order.

Subsequently, claimant submitted another ex parte communication to the Referee. In response to this submission, the Referee notified the respective attorneys that these ex parte communications from claimant would also be placed in the Hearings Division file but not received into evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that the material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem., 80 Or App 152 (1986).

Following our de novo review, including one additional document submitted by claimant post-hearing, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we are not convinced that this evidence was not obtainable with due diligence at the time of the hearing.

Here, the new evidence consists of documents dated from November 2, 1986 through March 22, 1991. It includes documents relating to claimant's job performance reviews in 1986, 1987, 1988 and 1989 and documents addressed to claimant and to and from claimant's former attorneys in July and September 1990 and February 1991. Finally, it includes a copy of a "physician's report of disability" dated November 27, 1990 from Dr. Schaub, one of claimant's treating physicians. We have evaluated this new evidence and conclude even if we were to remand for admission of this evidence, the evidence does not bear on the issue of whether claimant had withdrawn from the workforce in 1992 at the time of the aggravation.

Entitlement to Temporary Disability Benefits

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

ORDER

The Referee's order dated March 3, 1993 is affirmed.

December 3, 1993

Cite as 45 Van Natta 2288 (1993)

In the Matter of the Compensation of

GARY R. PEYTON, Claimant

WCB Case No. 92-14726

ORDER ON REVIEW

Bischoff & Strooband, Claimant Attorneys

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

The insurer requests review of Referee Brown's order which increased claimant's unscheduled permanent disability award for tinnitus to 5 percent (16 degrees), whereas the Order on Reconsideration awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact, except for finding (3).

CONCLUSIONS OF LAW AND OPINION

OAR 436-35-390(7)(b) allows a value of 5 percent unscheduled permanent disability for "[t]innitus which by a preponderance of medical opinion requires job modification." The Referee found that the hearing protection previously provided claimant would not be adequate. The Referee concluded that claimant's job would be modified to the extent that claimant would require more than normal hearing protection. Therefore, the Referee awarded 5 percent unscheduled permanent disability. We disagree.

Claimant suffers from sensorineural hearing loss with secondary tinnitus. The disability rating standards for calculating permanent disability for work-related hearing loss are provided in OAR 436-35-250. OAR 436-35-250(7) provides that tinnitus may be determined as an unscheduled loss under OAR 436-35-390. This rule provides that claimant's tinnitus must require job modification to entitle him to an award of permanent disability.

The doctors who have treated and examined claimant recommended that he wear more effective hearing protection at work. Claimant was wearing rubber-type ear plugs at the time of his injurious exposure. Wearing "more effective" hearing protection is a safety measure,¹ and affects neither claimant's work duties nor performance of his regular work. The medical evidence also establishes that claimant's tinnitus should not prevent him from performing his regular work. Thus, claimant is not required to modify his job duties due to his tinnitus. Therefore, he is not entitled to an award of permanent disability for his tinnitus.

ORDER

The Referee's order dated April 8, 1993 is reversed. The August 26, 1992 Order on Reconsideration is reinstated and affirmed.

¹ For example, this safety measure is no different than giving a gardener leather, rather than cloth, gloves to protect his hands; or giving a construction worker a hard hat. A position of employment is defined by its duties and responsibilities. It is not defined or altered by measures which protect employee safety while they perform their regular duties.

In the Matter of the Compensation of
DOUGLAS B. ROBBINS, Claimant
WCB Case No. 92-13962
ORDER ON REVIEW (REMANDING)
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

The self-insured employer requests review of that portion of Referee Hoguet's order which set aside its denial of claimant's current rhinitis condition. Claimant, pro se, cross-requests review of that portion of the Referee's order which upheld the employer's denial of his aggravation claim for his rhinitis condition. Claimant also contends that his claim should have been classified as disabling from the outset. Additionally, in their appellate briefs, the parties move to strike portions of the opposing briefs.

On review, the issues are compensability, aggravation, reclassification, motions to strike, and remand. We grant in part and deny in part the motions to strike, and we remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motions to Strike

The employer moves to strike those portions of claimant's brief which it contends: (1) raised an issue (reclassification) which was not raised at hearing; and (2) constitutes unsworn additional testimony which is not part of the evidentiary record. Claimant moves to strike those portions of the employer's briefs which rely on medical reports that claimant contends are based on an inadequate exposure history.

We interpret claimant's "motion to strike" to be argument regarding the proper weight to be given the medical reports, in light of his contention that the exposure history underlying the reports is incomplete. We do not, however, consider claimant's argument to be a basis for striking portions of the employer's briefs. Accordingly, we consider claimant's argument, but we deny his motion to strike.

Furthermore, we consider the parties' appellate briefs to the extent that they address the issues on review based on the record developed at the hearing. To the extent claimant's briefs diverge into testimony that was not presented at the hearing, those comments have not been considered.

The employer also moves to strike those portions of claimant's brief which challenge the classification of his claim as nondisabling, contending that the issue was not raised at hearing. We disagree.

Claimant appeared in this matter pro se. He filed his own hearing request, in which he identified the issue of entitlement to permanent disability, among others. (See Ex. C-20).¹ Since there is no Determination Order or Notice of Closure in this claim, we interpret claimant's contention regarding entitlement to permanent disability as tantamount to a request to reclassify his 1987 claim from nondisabling to disabling.

The employer contends that claimant specifically agreed that reclassification was not at issue in the hearing. Indeed, claimant agreed with the Referee's statement that the only issue in the case was "aggravation," and the Referee addressed only the "aggravation" issue. (Tr. 2, 19). However, in his opening statement, claimant immediately stated that he expected to prove that his claim should have been originally classified as disabling, not nondisabling. (Tr. 16). Claimant also explained the basis for his position regarding reclassification. (Tr. 16-18). Thus, we conclude that claimant raised the issue of reclassification at the hearing. Accordingly, we deny the employer's motion to strike those portions of claimant's brief that address the reclassification issue.

¹ Our references to the record conform to the Referee's. Claimant's exhibits 1 through 37, submitted January 19, 1993, are referred to by a "C" before the exhibit number. The employer's exhibits 1 through 32, submitted December 10, 1992, are referred to by an "E" before the exhibit number.

Reclassification/Remand

Having determined that claimant raised the issue of reclassification, we next consider whether the Hearings Division had jurisdiction to consider the reclassification request. We answer that question in the affirmative.

Because claimant's request to reclassify his 1987 injury claim was made more than one year after the date of injury, the Department does not have jurisdiction to consider the request. See ORS 656.262(6)(c), 656.268(11); Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993). However, in Donald R. Dodgin, 45 Van Natta 1642 (1993), we held that where a claim is initially classified as nondisabling more than one year after the date of injury, thereby precluding a claimant, through no fault of his own, from seeking reclassification by the Department, the Hearings Division has jurisdiction to consider the reclassification request. 45 Van Natta at 1645. If, on the other hand, claimant was notified within one year after the date of injury that his claim was initially classified as nondisabling, but he did not request reclassification within one year after the date of injury, then claimant's reclassification claim must be made as an aggravation claim, over which the Hearings Division has jurisdiction. See ORS 656.277(2); Charles B. Tyler, 45 Van Natta 972 (1993).

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

Here, the record is unclear regarding whether or when claimant was notified of the classification of his claim. Further, because the Referee limited the hearing to the "aggravation" issue, evidence concerning the appropriate classification of the claim may have been restricted. For example, claimant argued that he lost time from work as a result of his injury, but neither party presented evidence on that point. (See Tr. 16-19). Under such circumstances, we consider the record regarding classification of claimant's claim to be incompletely and insufficiently developed, and we find a compelling reason to remand this matter to the Referee for the taking of additional evidence concerning the classification issue. See Murray L. Johnson, 45 Van Natta 470 (1993).

On remand, we believe the following questions should be addressed to determine the proper disposition of claimant's reclassification request: (1) did claimant receive a notice of claim acceptance which advised him that his claim was classified as nondisabling and informed him of the procedure for objecting to that classification; (2) if so, when did he receive such notice; (3) was the claim disabling from the outset, or did it become disabling within one year; and (4) was claimant's injury one that required medical services only? See generally, SM Motor Co. v. Mather, 117 Or App 176, 180 (1992); Donald R. Dodgin, *supra*; Charles B. Tyler, *supra*; Ronda A. Carlson, 43 Van Natta 244 (1991).²

Because of our disposition of this case, we do not address the issues of aggravation or compensability of claimant's current rhinitis condition.

Accordingly, the Referee's order dated February 12, 1993 is vacated. This matter is remanded to Referee Hogue for further proceedings, at which time each party shall be permitted to present additional evidence regarding the issues and questions raised in this order. Such evidence may be presented in any manner that the Referee determines achieves substantial justice. Thereafter, the Referee shall issue a final, appealable order concerning all matters at issue in this case.

IT IS SO ORDERED.

² We recognize that these questions raise complex legal and factual issues. Thus, in accordance with OAR 438-06-100(2), claimant is encouraged to seek legal representation for the future hearing.

In the Matter of the Compensation of
LOIS J. SCHOCH, Claimant
WCB Case No. 92-09982
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Holtan's order that affirmed the Director's Proposed and Final Order Concerning a Bona Fide Medical Services Dispute. On review, the issue is jurisdiction. We remand.

We first note that, subsequent to the filing of briefs, claimant submitted a supplemental brief containing further argument based on Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993). It is permissible for any party to assist the Board in its review of a case. However, further argument is not considered. Betty L. Juneau, 38 Van Natta 553 (1986). Accordingly, we allow claimant's submission, but consider it only to the extent that it advises the Board of recent developments in the law.

Claimant has a compensable low back condition. Dr. Berkeley, claimant's neurosurgeon, requested authorization to perform right L4-5, L5-S1 microdecompression surgery. The insurer requested review of the proposed surgery by the Director pursuant to ORS 656.327(1). Jean Zink, R.N., on behalf of the Director, found that the proposed surgery was not appropriate and ordered that the insurer was not required to pay for the proposed surgery.

Claimant requested a hearing pursuant to ORS 656.327(2). The Referee, after reviewing the record, found that substantial evidence supported the Director's order and affirmed. On review, claimant asserts numerous objections to the order, including challenges to its procedural validity, constitutionality, and admissibility of evidence at hearing. We conclude that we need not address claimant's arguments inasmuch as we hold that the Director did not have jurisdiction to review the medical services dispute pursuant to ORS 656.327.

Claimant first asserts that, because ORS 656.327(1) refers to medical treatment that an injured worker "is receiving" and claimant has not "received" the proposed surgery, the statute is not applicable. The Court of Appeals recently considered claimant's contention in Jefferson v. Sam's Cafe, 123 Or App 464 (1993). Finding that the statute expressly applied only to treatment that the claimant "is receiving" at the time review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment, and that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 467.

Here, the dispute pertains to the propriety of proposed surgery. Based on Jefferson v. Sam's Cafe, supra, the insurer was not entitled to Director review of the proposed surgery under ORS 656.327. Rather, the Hearings Division has jurisdiction to resolve the dispute concerning the proposed surgery. Furthermore, the proceeding before the Referee consisted only of reviewing the Director's findings for substantial evidence. See ORS 656.327(2). Consequently, it is apparent that the parties were presenting their respective positions under a standard of review that does not apply at hearing on a matter concerning a claim. Accordingly, it is apparent that the evidence was limited to that developed before the Director (since no testimony was offered nor any additional evidence allowed into the record other than that developed before the Director). See Peter Britz, 45 Van Natta 2187 (1993).

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). Given the posture of this case, we find compelling reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Peter Britz, supra. Consequently, we conclude that the record is incompletely and insufficiently developed. See ORS 656.295(5). Therefore, we remand to the Hearings Division for further proceedings.

Accordingly, the Referee's order dated December 10, 1992 is vacated. This matter is remanded to Referee Holtan for further proceedings to be conducted in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective position regarding this dispute. Following these proceedings, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL K. BROWN, Claimant
WCB Case No. 92-11623
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Bethlahmy's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1988 low back strain, for which he received 3 percent permanent disability. On May 31, 1992, after taking a shower in his home, claimant hung up a towel and felt low back pain. The Referee concluded that claimant proved a claim for aggravation. On review, SAIF only disputes the Referee's conclusion that it failed to prove that an off-work incident was the major contributing cause of claimant's worsened condition.

If the major contributing cause of a worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable. See ORS 656.273(1). As the parties correctly note, if a carrier denies a claim for aggravation on the basis that an off-work injury is the major contributing cause of a worsening, the burden of proving that theory is on the carrier. Roger D. Hart, 44 Van Natta 2189 (1992); Fernandez v. M & M Reforestation, 124 Or App 38 (1993).

Claimant underwent an independent medical examination by Drs. Fuller, orthopedic surgeon, and Finseth, chiropractor. Although their report stated that the "major contributing cause of [claimant's] current need for treatment is the incident in the shower in May 1992," it further provided that "it is not possible to place the shower incident in perspective until reviewing his record prior to the 1988 industrial injury. After review of that record, we should be able to render an opinion as to the major contributing cause of the current condition and need for treatment." (Ex. 14-6). The record contains no evidence that the panel subsequently reviewed the requested medical information and rendered an opinion. Consequently, we consider the panel as not having provided an opinion as to whether the shower incident was the major contributing cause of claimant's need for treatment and disability.

Dr. Nelson, chiropractor, treated claimant shortly after the May 1992 shower incident and first reported to SAIF's claims adjuster that "the event of 5/31/92 when [claimant] slipped while exiting his shower (at home) was largely responsible" for the aggravation and that the "major contributing cause of the current disability and need for treatment was the event of 5/31/92." (Ex. 15-2).

Dr. Nelson then concurred with a letter drafted by claimant's attorney stating that "although the incident at home on May 31, 1992 where [claimant] reinjured himself while drying himself off after a shower precipitated the immediate need for treatment at that time, that incident did not then become the major contributing cause of [claimant's] overall worsened condition." (Ex. 18-1).

Although Dr. Nelson qualifies as claimant's treating physician, we decline to accord his opinions the usual deference because they are inconsistent and the inconsistency has not been explored to our satisfaction. See Weiland v. SAIF, 64 Or App 810 (1983).

Therefore, after reviewing the medical evidence, we conclude that SAIF failed to provide persuasive evidence that the major contributing cause of claimant's worsened condition was the off-work shower incident. Accordingly, it failed to carry its burden of proof under ORS 656.273(1).

Claimant's attorney is entitled to an assessed fee for services on 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. 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 interest involved.

ORDER

The Referee's order dated April 16, 1993 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the SAIF Corporation.

December 6, 1993

Cite as 45 Van Natta 2293 (1993)

In the Matter of the Compensation of
ANDREA M. GILDEA, Claimant
WCB Case No. 92-10168
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The self-insured employer requests review of Referee Gruber's order that: (1) found that claimant's claim had been prematurely closed; and (2) set aside a Notice of Closure and an Order on Reconsideration that awarded temporary partial disability from March 12, 1991 through December 19, 1991 and no permanent partial disability. In its brief, the employer contends that the Referee erred in relying on a post-closure medical report. In her brief, claimant contends that, if she is not medically stationary, she is procedurally entitled to temporary partial disability benefits from June 1992 through October 16, 1992; or, if she is medically stationary, she is entitled to a 14 percent unscheduled permanent disability award for a low back condition. On review, the issues are medical evidence, premature closure, temporary disability compensation, and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the sixth paragraph on page 3 and the ultimate finding of fact. We supplement as follows.

The July 13, 1992 Notice of Closure established claimant's medically stationary date as December 19, 1991. (Ex. 30). The Order on Reconsideration affirmed that date. (Ex. 34).

CONCLUSIONS OF LAW AND OPINIONMedical Evidence

Citing the limitation of medical evidence provided in ORS 656.268(5) and OAR 436-30-050(4)(f), the employer objects to the Referee's reliance on Dr. Matteri's post-closure chart notes in establishing claimant's medically stationary status.

The Court of Appeals recently held in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), that, whereas ORS 656.268(5) limits the evidence that may be submitted during the reconsideration process to that which corrects erroneous information and to medical evidence that should have been but was not submitted at the time of claim closure, that limitation does not apply to referees at hearing. See ORS 656.283(7). Although the issue on the merits before the court concerned a permanent disability award, we find the court's analysis of the applicability of ORS 656.268(5) and ORS 656.283(7) instructive in regard to the evidence that may be considered by a referee regarding the determination of medically stationary status. Moreover, ORS 656.283(7) expressly provides that if the referee finds that the claim has been closed prematurely, the referee shall issue an order rescinding the determination order or notice of closure. Finally, ORS 436-30-050(4)(f) is a Department rule that applies specifically to medical evidence that may accompany a reconsideration request. Accordingly, we conclude that the limitations on evidence provided in ORS 656.268(5) and OAR 436-30-050(4)(f) are inapplicable to the Referee's determination of claimant's medically stationary status under ORS 656.283(7). We now turn to the merits of the premature closure issue.

Premature Claim Closure

The Referee concluded that claimant was not medically stationary at the time of the July 13, 1992 closure. We disagree.

Claimant has the burden to establish that she was not medically stationary on the date of closure. Scheuning v. I.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). We accordingly evaluate claimant's condition and the reasonable expectation of improvement as of the July 13, 1992 date of closure.

Whether or not claimant was medically stationary is primarily a medical question. Harmon v. SAIF, 54 Or App 121, 125 (1985). Competent medical evidence is not limited to a physician's statement concerning the medically stationary date, but may include circumstantial and direct evidence. Austin v. SAIF, 48 Or App 7, 12 (1980). Claimant's condition and the prospect of any material improvement are evaluated as of the date of closure, without consideration of subsequent changes in her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Service, 72 Or App 524 (1985). Medical reports authored after closure may be considered if claimant has had no post-closure change in her condition. The only question is whether claimant was medically stationary at the time of closure. Id.; William K. Porter, 44 Van Natta 937, 943 (1992).

On July 23, 1991, Dr. Roy, claimant's then-treating physician, released claimant to modified work, which included a permanent lifting restriction of 60 pounds. He also recommended that claimant continue to do her exercises. (Ex. 16). On October 7, 1991, after her condition worsened, Dr. Roy also restricted claimant from bed making. (Ex. 18). The only medical evaluation following a prior referee's order that found claimant not to be medically stationary as of November 4, 1991, and prior to the July 13, 1992 closure, is a December 19, 1991 chart note by Dr. Roy, which states:

"Follow-up Back

[Claimant] is improving. She still has one area of discomfort over the right posterior superior iliac spine but otherwise is doing well. She has some days when she has no pain at all, other days when she has quite severe discomfort for no apparent reason.

"On Examination

"There is a good range of motion with no pain. There is no sign of facette or sacroiliac dysfunction and no sacral torsion. Straight leg raising is normal. Strength of the lower extremities is normal. No local tenderness is present.

"Plan

"1. It is felt that [claimant] should continue with the no lifting over 60 lbs. and no bed making limitation, and this should be in effect for an indefinite period of time. She will continue with her exercises on a long term basis, and continue working on her mechanics of motion and protect her back during her work as well as at other times. She will be seen again on an as-needed basis only.

"2. Copy to WC carrier" (Ex. 26) (emphasis added).

Dr. Roy effectively concluded medical treatment. The question is whether, when he stated that claimant was improving, he expected material improvement in claimant's condition with the passage of time.

Dr. Roy instructed claimant to exercise and to work on motion mechanics to protect her back. In addition, he continued her restrictions on weight-lifting and bed making indefinitely. We find that these instructions and restrictions were designed to prevent recurrence of her symptoms, rather than to effect a material improvement in claimant's condition. Furthermore, the permanent restrictions on lifting and bed making indicate that Dr. Roy did not expect claimant's condition to materially improve either through exercise or motion mechanics. We accordingly conclude that Dr. Roy did not expect claimant's condition to materially improve with the passage of time. Instead, he expected her symptoms to wax and wane, depending upon the extent and nature of her activities and her body mechanics.

Moreover, under OAR 436-30-035(7)(a) and (b), a worker is presumed to be medically stationary if the worker has not sought medical care for a period in excess of 28 days, and the insurer has notified

the worker that claim closure may be requested for failure to seek medical treatment. In this case, claimant did not seek medical treatment for seven and a half months. The insurer did not meet the requirements of subsection (b), and therefore claimant's medically stationary status cannot be presumed. However, such an extensive period without treatment is additional, albeit circumstantial, evidence that claimant had become medically stationary. Austin v. SAIF, supra.

Claimant sought medical treatment from Dr. Matteri for low back and right leg pain on July 30, 1992, after her claim had been closed. Although Dr. Matteri found that claimant's condition had deteriorated to the point that he prescribed physical therapy, his report did not indicate when claimant's condition had worsened or whether she was medically stationary at the time of closure. Accordingly, we do not consider Dr. Matteri's report in our analysis, nor do we consider the subsequent change in her condition. Sullivan v. Argonaut Ins. Co, supra; William K. Porter, supra.

We conclude that, at the time of the July 13, 1992 claim closure, no further material improvement was reasonably expected from either medical treatment or the passage of time. Thus, claimant has failed to establish that she was not medically stationary on the date of closure. Scheuning v. I.R. Simplot & Company, supra. We conclude that claimant was medically stationary on December 19, 1991 and reinstate that portion of the Order on Reconsideration and Notice of Closure.

Temporary Disability Compensation

Because we have concluded that claimant was medically stationary on the date established by the Notice of Closure and Order on Reconsideration, we need not address claimant's alternative argument on the issue of temporary disability compensation.

Extent of Unscheduled Permanent Disability

Because the Referee concluded that claimant was not medically stationary and set aside the Order on Reconsideration, he did not address the issue of unscheduled permanent disability. Since we find the record sufficiently developed to resolve the permanent disability issue, we proceed with our review.

Claimant contends that she is entitled to a 14 percent unscheduled permanent disability award. Claimant has the burden to prove the extent of disability resulting from her compensable injury or occupational disease. ORS 656.266. Unscheduled partial disability is rated based on the permanent loss of earning capacity. ORS 656.214(5).

Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f). This calculation is made by determining the appropriate values assigned by the standards to the worker's age, education (including skills), adaptability and impairment.

Claimant's claim was closed on July 13, 1992. Accordingly, we apply the standards effective March 13, 1992, as amended June 1, 1992, and June 17, 1993. OAR 436-35-003 (WCD Admin. Order 93-052) (Temp); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

Impairment--Chronic Condition

Claimant contends that she has a chronic and permanent medical condition in the low back/hips area, which would entitle her to a 5 percent award for an unscheduled chronic condition impairment.

OAR 436-35-320(5) provides:

"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. "Body area" means the cervical/upper thoracic spine (T1-T6)/shoulders area and the lower thoracic spine(T7-T12) lowback/hips area."

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).

In October 1991, Dr. Roy diagnosed claimant's condition as a recurrent low back strain with facet and sacroiliac dysfunction and sacral torsion. (Ex. 19). Although these symptoms resolved, Dr. Roy continued claimant's restrictions of lifting no more than 60 pounds and no bed making. (Ex. 26). Dr. Smith, who reviewed claimant's records in February 1992, noted that claimant was limited from repeated bending or working in a bent or stooped position as when making beds. (Ex. 27-2). We are more persuaded by these reports of permanent restrictions than by the report of Dr. Ayers, the medical arbiter, who found sacroiliac joint tenderness, which he hypothesized would subside with rehabilitation. (Ex. 33-5). Although he reported that Dr. Matteri told claimant that he found no reason why she could not return to work as a nurse's aide, there is no evidence that Dr. Ayers knew about the permanent restrictions ordered by Dr. Roy or the job analysis prepared as part of a vocational eligibility evaluation report. Accordingly, based on Dr. Roy's permanent restrictions on lifting and bending, we conclude that claimant is unable to repetitively use her low back/hips area due to a chronic and permanent condition. OAR 436-35-320(5); Donald E. Lowry, supra.

Age

For workers under 40 years old the standards assign a value of 0. Because claimant is under 40 years old, the appropriate value for age is 0. OAR 436-35-290(2).

Adaptability

Claimant contends that she was frequently required to lift patients weighing 100 pounds; therefore, her work at injury should have been classified as heavy.

The adaptability factor is based upon 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 Certified Nurse's Aide is classified as requiring medium strength. DOT # 355.674-014. The SCODDOT description of a nurse assistant (nurse 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 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, and making beds. The orderly job falls within the category of heavy work. DOT # 355.674-018.

A rehabilitation consultant completed a job analysis for medical evaluation of the physical demands of claimant's job for the purpose of possible vocational assistance. The job analysis states in pertinent part:

"5. Lifting

"The worker assists patients [to] stand or lie by providing an under the shoulder lift. Many geriatric patients are unable to assist in their own lifting. The worker may be required to lift a patient weighing up to 100 pounds. * * * Lifting patients occurs up to sixty or more times per day, as well as assisting patients to and from the dining room and to various activities within the facility. The maximum in this particular position, fifty out of seventy-two patients are in transfers to and from bed to chair. * * * [P]atients who are non-ambulatory are required to be turned in their beds every two hours. This requires lifting up to fifty pounds.

"6. Pushing/Pulling

"The worker pushes or pulls a wheelchair or cart of ice water. These carts may take five to twenty-five pounds of pressure to start, then pushing the cart or wheelchair between thirty-one to sixty times per shift. The worker may also be required to push the hooyer lift * * *. The worker may also push the patient in the wheelchair which requires up to twenty-five pounds of pressure to start. This pushing of wheelchairs may occur fifteen to thirty times per shift." (Ex. 23-3).

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 constitutes work in the "heavy" category. See Michele A. Montigue, 45 Van Natta 1681 (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, we find that "orderly" (DOT 355.674-018) most appropriately describes claimant's job at injury. See Michele A. Montigue, *supra*.

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.

Claimant's restriction to lifting 60 pounds maximum is medium-heavy work. For those workers determined to have a RFC between two categories and also have restrictions, the next lower classification shall be used. OAR 436-35-310(3). Thus, claimant's residual functional capacity is medium. Thus, claimant's adaptability factor is calculated as 3. OAR 436-35-310(2) and (3).

Education

The education factor is based upon formal education, skills, and certification. For workers who have a high school diploma or GED certificate, the standards assign a value of 0. Because claimant has more than 12 years of school, her formal education value is 0.

A value for a worker's skills is allowed based on the highest Specific Vocational Preparation (SVP) time for jobs performed during the ten years preceding the time of determination. OAR 436-35-300(3). Claimant was employed as an orderly (DOT # 355.674-018) long enough to meet the SVP time of three to six months. This employment has an SVP of 4. (Ex. 24-4). Thus, claimant's skill value is 3. OAR 436-35-300(3)(e). (We also note that the classification of her job as a nurse aide, DOT # 355.674-014, has an SVP of 4). Because claimant has a phlebotomy certification, she receives no additional value. OAR 436-35-300(4).

Having determined each of the values necessary under the standards, we calculate claimant's unscheduled permanent disability. The sum of the value (0) for claimant's age and the value (3) for education is (3). The product of that value and the value (3) for claimant's adaptability is (9). The sum of that product and the value (5) for claimant's impairment is (14). That value represents claimant's unscheduled disability. OAR 436-35-280.

ORDER

The Referee's order dated January 11, 1993 is reversed. The July 13, 1992 Notice of Closure and October 7, 1992 Order on Reconsideration are reinstated. The Order on Reconsideration, which awarded no permanent disability, is modified to award claimant 14 percent (44.8 degrees) unscheduled permanent disability for a low back condition. Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the increased compensation created by this order. However, claimant's attorney's total "out-of-compensation" attorney fee received from the Referee's order and this order shall not exceed \$3,800.

In the Matter of the Compensation of

CAROLYN J. HENGEL, Claimant

WCB Case No. 92-14806

ORDER ON REVIEW

Davis, Gilstrap, et al., Claimant Attorneys

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

The insurer requests review of Referee Brown's order which: (1) set aside its partial denial of claimant's injury claim for a headache condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings" with exception of the "Ultimate Finding of Fact" section of the order.

CONCLUSIONS OF LAW AND OPINION

The Referee found that this case did not present a complex medical question of causation and, thus, did not require expert medical opinion for its resolution. We disagree.

Expert medical evidence is required when the issue of causation presents a medically complex question. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The relevant factors for determining whether expert testimony is required are: (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. Barnett v. SAIF, 122 Or App 279, 283 (1993); Uris, supra.

In this case, claimant suffered headache pain immediately after she fell down stairs at work. Her employer was not on the premises at the time, but claimant reported the injury to her employer the same night, and sought medical treatment within 72 hours of the incident. Prior to the work incident, she had not experienced constant, severe headaches. However, Dr. Grant, claimant's treating physician, noted that after claimant's initial minimal headache complaints, his medical records show an absence of further headaches. Therefore, Dr. Grant opined that claimant's headache condition was not related to her September 1991 work injury. Finally, Dr. Grant and other physicians who examined claimant for her headache condition reported that claimant exhibited pain behavior and functional overlay.

On these facts, it is not clear whether claimant's headache condition is a continuation of her original injury or is attributable to noncompensable factors. See Susan L. Hall, 45 Van Natta 818, 819 (1993). Therefore, inasmuch as there is expert testimony suggesting that the fall at work might not be the cause of claimant's headache condition, we conclude that this case presents a complex medical question regarding causation. Accordingly, claimant is required to establish causation by expert testimony to meet her burden of proof. Barnett v. SAIF, supra.

The insurer argues that claimant must prove that her September 1991 compensable back injury is the major contributing cause of her headache symptoms. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992). However, as subsequently explained, we do not find evidence to support a conclusion that claimant's work injury is a material contributing cause of her headache complaints. Therefore, we need not address the insurer's contention that this matter should be analyzed as a consequential condition.

On September 9, 1991, claimant first treated with Dr. Brown, physician. Dr. Brown diagnosed "cervical dorsal and lumbar strain." Dr. Brown also reported that claimant's complaints included "much headaches" [sic]. Dr. Brown referred claimant to Dr. Peterson, orthopedic physician. Dr. Peterson's September 13, 1991 evaluation did not note any headache complaints.

On October 8, 1991 Dr. Lundquist became claimant's treating doctor. Dr. Lundquist noted that claimant complained of pain from her "neck to her tailbone." Dr. Lundquist's findings did not report any headache complaints.

On November 22, 1991, Dr. Grant became claimant's treating physician. Dr. Grant diagnosed claimant's condition as: "Chronic post-traumatic myofascial left greater than right neck, shoulder and upper extremity pain syndrome secondary to the injury of 9/6/91." (Ex. 11). Dr. Grant reported that claimant's complaints included intermittent pain radiating into the occipital region and headaches. Dr. Grant prescribed medication and physical therapy.

On November 26, 1991, physical therapist Duxbury reported that claimant's complaints included "constant mild headache" which increase in intensity associated with an increase in pain in the bilateral cervical through thoracic and right posterior shoulder areas. Subsequently, Ms. Duxbury noted that claimant's headache complaints had resolved the morning of December 23, 1991.

On January 15, 1992, Dr. Grant reexamined claimant. Dr. Grant's findings did not note any headache complaints.

On February 3, 1992, Drs. Fuller and Reimer, independent medical examiners (IME), noted claimant's complaints of pain "from neck to tail bone." (Ex. 18). Drs. Fuller and Reimer diagnosed: (1) "Severe psychogenic magnification of symptoms, with pain behavior" and (2) "Contusion/sprain, cervical, thoracic and lumbar spine, by history, related to her work experience of 9-6-91."

On March 18, 1992, Dr. Grant concurred with the IME report via a check-the-box letter. (Ex. 19). On March 24, 1992, Dr. Grant noted "an enormous amount of functional overlay and pain behavior in general." Dr. Grant found that claimant was medically stationary with the ability to do light/medium duty work activities.

On April 29, 1992, Dr. Conwell, neurologist, examined claimant for "pain in back and headaches." Dr. Conwell reported that claimant displayed a "moderate amount of pain behavior," and he opined that claimant was suffering from "chronic reactive depression with some functional component contributing to her symptoms."

On May 19, 1992, claimant was seen in the emergency room by Dr. Minser for a severe headache with right sided facial numbness. On May 23, 1992, claimant was again seen in the emergency room by Dr. Hewitt. He diagnosed "acute headache" and "possible psychiatric disorder."

After reviewing the medical record, we find that Dr. Grant provides the only medical opinion which addresses directly the question of whether claimant's headache condition is causally related to her September 1991 work injury. In February 1993, Dr. Grant opined that he could not attribute claimant's headache problem to her September 1991 work injury. Additionally, Drs. Grant, Fuller, Reimer, Conwell and Hewitt all reported pain behavior and functional overlay as causal factors concerning claimant's headache complaints.

Therefore, we conclude that there is insufficient medical evidence to support a finding that claimant's September 1991 work injury is a material contributing cause of her headache condition. Accordingly, claimant has failed to carry her burden of proof. Inasmuch as we have found that claimant did not prove compensability, we reverse the Referee's order.

As we have upheld the insurer's denial of compensability for claimant's headache condition, we reverse the Referee's award of a penalty and related attorney fee for an unreasonable denial. We also reverse the Referee's assessed attorney fee award for claimant's counsel's services in overcoming the denial.

ORDER

The Referee's order dated March 1, 1991 is reversed. The insurer's partial denial is reinstated and upheld. The Referee's penalty award and related attorney fee is reversed. The Referee's award of an assessed attorney fee of \$2,500 is also reversed.

Board Member Gunn dissenting.

Inasmuch as I am persuaded that claimant has established the compensability of her headaches, I would affirm the Referee's order. Consequently, I respectfully dissent.

There is no contention that claimant complained of constant, severe headaches prior to her September, 1991 fall at work. Moreover, the contemporaneous medical reports following her fall consistently refer to recurring headaches which she attributes to the incident. Since claimant reported her fall the same night that it occurred, her "headache" claim unquestionably satisfies the first four of the five Barnett factors for determining whether expert testimony is necessary to establish the compensability of a claim.

The remaining factor is whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. The majority relies on subsequent references to "pain behavior" and "functional overlay," as well as Dr. Grant's "pre-hearing" report that he was "not of the opinion that [the headaches] are related" to the September 1991 injury to conclude that this remaining factor has been satisfied and, thus, that this case presents a medically complex issue.

I disagree with the majority's reasoning. To begin, notwithstanding some references to claimant's pain behavior and functional overlay in subsequent medical reports, there is no medical opinion which expressly relates claimant's headache condition to such "diagnoses." Moreover, Dr. Grant's "pre-hearing" opinion is premised on an inaccurate history. Specifically, Dr. Grant assumed that when claimant was initially seen, she presented minimal complaints and never received treatment for her symptoms. Yet, most of the initial medical reports included references to recurring headache complaints (Dr. Brown mentioned "much headaches," physical therapists referred to "constant mild headache.") In fact, Dr. Grant himself prescribed medication and physical therapy for claimant's intermittent pain radiating into the occipital region and headaches.

In light of such circumstances, I am not persuaded that there was expert evidence attributing claimant's headaches to a cause other than her fall at work. Therefore, I would agree with the Referee's conclusion that medical evidence is not required to establish the compensability of this uncomplicated claim.

In any event, even if medical evidence was required, I would conclude that claimant has satisfied her requisite burden of proof, i.e. that her fall at work is a material contributing cause of her headache disability or need for medical treatment. See Albany General Hospital v. Gasperino, supra.

In reaching such a conclusion, I would rely on claimant's consistent representation of recurrent headaches since her September 1991 fall at work. Moreover, these complaints are documented in most of the ensuing medical reports (without suspicion of her complaints or a reference to an alternative cause of the problem). Finally, as I explained earlier, Dr. Grant's subsequent opinion that declined to attribute claimant's headaches to the September 1991 work injury is based on a premise that was inconsistent with claimant's actual medical history.

In conclusion, because I am persuaded by claimant's testimony, as supported by the contemporaneous medical reports (and in the absence of a persuasive contrary medical opinion), I would affirm the Referee's order which set aside the insurer's denial of claimant's headache condition. Consequently, I respectfully dissent from my fellow members' majority opinion.

In the Matter of the Compensation of
EVAN I. LYMAN, II, Claimant
WCB Case No. 92-08783
ORDER ON REVIEW
Estell & Bewley, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes¹ and Gunn.

Claimant requests review of Referee Quillinan's order that: (1) affirmed an Order on Reconsideration which awarded claimant 5 percent (16 degrees) unscheduled permanent disability for his low back condition; (2) found that the insurer had properly processed claimant's claim as an aggravation, rather than a new injury; and (3) declined to assess a penalty and related attorney fee for the insurer's allegedly unreasonable claims processing. In his brief, claimant also contends that the Referee should have admitted Exhibits 37, 38 and 39 into evidence. On review, the issues are evidence, extent of unscheduled permanent disability, claims processing and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee declined to admit Exhibits 37, 38 and 39 into evidence, as she found that the exhibits were not relevant. On review, claimant argues that the Referee should have admitted the exhibits as they were relevant evidence on the issue of whether claimant sustained an injury in March 1991.

ORS 656.283(7) provides that the referee is not bound by common law or statutory rules of evidence *** and may conduct a hearing in any manner that will achieve substantial justice. The statute has been interpreted as giving referees broad discretion with regard to the admissibility of evidence. See e.g. Brown v. SAIF, 51 Or App 389, 394 (1981). We review the Referee's evidentiary rulings for abuse of discretion. William J. Bos, 44 Van Natta 1691 (1992).

Here, claimant sought at hearing to establish that the insurer had improperly processed his claim as an aggravation, rather than a new injury which occurred on March 13, 1991. However, Exhibits 37, 38 and 39 are comprised of reports from a work hardening program undertaken by claimant in December 1992. After reviewing the exhibits, we do not find that the reports are relevant to the issue of whether the insurer properly processed claimant's March 1991 claim. Therefore, we do not find that the Referee abused her discretion by excluding the exhibits.

Extent of Unscheduled Permanent Disability

The Referee concluded that, because claimant returned to regular work, he was not entitled to a factor for adaptability. On review, the insurer argues that adaptability cannot be considered, as claimant only requested reconsideration on the issue of impairment. We disagree.

In Raymond L. Mackey, 45 Van Natta 776 (1993), we held that a party was 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. However, following our decision in Mackey, the court issued its opinion in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). In that case, the court held that the claimant's adaptability, for purposes of rating permanent disability, must be determined on the basis of work status as of the date of the reconsideration order, rather than the date of the prior determination order. The Smith court determined that, pursuant to ORS 656.268(5), a referee may consider evidence at hearing that was not submitted on reconsideration.

Given the court's determination that the reconsideration and hearing levels constitute two distinct proceedings, we concluded that Mackey should no longer be given effect. See Darlene K. Bentley, 45 Van Natta 1719 (1993). We reasoned that, to apply Mackey in light of the court's decision in Smith, would provide the anomalous result of limiting issues at hearing which were not similarly

¹ Although a signatory to this order, Board Member Haynes directs the parties to her special concurrence in Kelly R. Baker, 45 Van Natta 2097 (1993) concerning the admissibility of post-closure medical evidence.

limited at reconsideration. Consequently, we concluded that the parties may raise extent of disability issues at hearing, regardless of whether those issues were specifically raised at the reconsideration proceeding. Bentley, supra.

We conclude that our holding in Bentley is dispositive on the issue raised by the insurer. Although claimant requested reconsideration on the issue of impairment, he was not precluded from raising the issue of adaptability at the time of hearing.

The Referee declined to award a value for adaptability because claimant had returned to regular work. However, claimant contends that in a subsequent Supreme Court decision, the Court determined that a claimant's age, education and adaptability factors must be considered under the Director's "standards." England v. Thunderbird, 313 Or 633 (1993). We agree with claimant that, pursuant to the England case, claimant is entitled to a value for adaptability.

In response to the 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).

Amended OAR 436-35-310(1) provides that a worker's adaptability is based upon a comparison of the highest prior strength preceding the time of determination, as compared to the worker's maximum residual capacity at time of determination. Maximum residual functional capacity (RFC) is the greatest capacity evidenced by: (1) the attending physician's release; or (2) a preponderance of medical opinion; or (3) the strength of any job at which a worker has returned to work. OAR 436-35-270(3)(d).

Claimant worked as a tower builder since 1987. The Dictionary of Occupational Titles lists claimant's work as heavy work. (DOT# 869.664-014). On May 15, 1991, claimant received a full release for regular work.

After reviewing the record, we agree with the Referee's conclusion that claimant returned to substantially the same job as the one he held at the time of injury. Therefore, claimant's RFC is heavy, and he is entitled to an adaptability value of 1. OAR 436-35-310(2) (Temporary Rules, June 17, 1993, WCD Admin. Order 93-052).

In rating claimant's permanent disability, we find that claimant's age of 25 is assigned no value. OAR 436-35-290(1). Claimant has earned a high school diploma and attained an SVP level of 4 as a microwave tower builder/construction worker (DOT #869.664-014). Therefore, claimant is assigned a value of 4 for education factors.

On review, the parties do not contest the Order on Reconsideration impairment value of 5, for claimant's decreased range of motion in the lumbar area. We agree that the award is supported by the medical arbiter's opinion and claimant is entitled to an impairment value of 5.

Assembling the factors, we multiply the education value of 4 and the adaptability value of 1 for a product of 4. That product is then added to the impairment value of 5 for a total of 9 percent. Claimant is therefore entitled to 9 percent unscheduled permanent disability.

Claim Processing

We adopt the Referee's "Opinion" on the issue of the insurer's claims processing.

Penalties and Attorney Fees

We adopt the Referee's "Opinion" on the issue of penalties and attorney fees for the insurer's "de facto" denial.

ORDER

The Referee's order dated February 22, 1993 is affirmed in part and modified in part. That portion of the Referee's order that affirmed the Order on Reconsideration is modified. In addition to the Order on Reconsideration award of 5 percent (16 degrees), claimant is awarded 4 percent (12.8 degrees) for a total award to date of 9 percent (28.8 degrees) unscheduled permanent disability for his low back condition. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DANIEL R. POWERS, Claimant
WCB Case Nos. 93-01586 & 92-16338
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Industrial Indemnity requests review of those portions of Referee Baker's order that: (1) set aside its denial of responsibility for claimant's low back condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; (3) awarded claimant an assessed attorney fee for prevailing against Industrial Indemnity's denial of responsibility; and (4) awarded an assessed attorney fee for Industrial Indemnity's allegedly unreasonable failure to request a paying agent. On review, the issues are responsibility, compensability/responsibility and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

In 1988, claimant injured his low back while working for O&S Contractors, which was insured by Liberty Northwest. He underwent back surgery. Pursuant to litigation before the Hearings Division and the Board, Liberty was ordered to accept responsibility for the claim. Liberty then issued a "back-up" denial. The parties entered into a Disputed Claim Settlement (DCS) whereby claimant accepted consideration in exchange for allowing the "back-up" denial to become final.

In May 1990, claimant began working for Industrial Indemnity's insured, Speedy Auto Glass, and developed back symptoms. After initially denying a claim for a protruded disc, Industrial Indemnity accepted a "recurrent herniated intervertebral disc, L5-S1 left[.]" (Ex. 45A).

In May 1991, claimant was laid off from Speedy Auto Glass. In September 1991, claimant began working for the SAIF Corporation's insured, Tag Dental Co. On October 26, 1992, claimant experienced increased back symptoms after attempting to move a loaded trailer at work. Industrial Indemnity denied responsibility for claimant's need for treatment and disability; SAIF denied compensability and responsibility. The Referee, based on the opinion of claimant's treating neurosurgeon, Dr. Melgard, found that claimant proved compensability and that responsibility remained with Industrial Indemnity. On review, Industrial Indemnity asserts that claimant sustained a "new compensable injury" and, therefore, responsibility shifts to SAIF.

With regard to the cause of claimant's need for treatment following the October 1992 lifting incident, Dr. Melgard first reported that claimant had sustained a "new injury." (Ex. 66). However, after rendering additional treatment, Dr. Melgard stated that the October 1992 event represented an "aggravation" since claimant's symptoms were not related to a disc. (Exs. 69, 76, 77). Dr. Melgard subsequently explained that the October 1992 incident caused irritation of the facet and that such condition was related to claimant's 1988 injury and subsequent surgery. (Ex. 80).

In December 1992, claimant underwent an independent medical examination by Drs. Wilson, neurologist, and Neufeld, orthopedist. The panel concluded that claimant had sustained a low back strain as a result of the October 1992 lifting incident and that the injury was the major contributing cause of his need for treatment. (Ex. 70-8).

Dr. Thompson, orthopedic surgeon, first examined claimant in June 1991 for an independent medical examination. In March 1993, Dr. Thompson conducted a record review at the request of Industrial Indemnity's counsel. Dr. Thompson agreed with Drs. Wilson and Neufeld that claimant had a separate and new injury on October 26, 1992 since claimant was doing "fairly well" prior to the event and he had "a very definite incident" when he lifted a tongue of a heavy trailer. (Ex. 78-2). Dr. Thompson concluded that the incident was the major contributing cause of claimant's current need for treatment. (Id.)

Unless there are persuasive reasons not to do so, we generally defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810, 812 (1983). We find persuasive reasons not to defer to Dr. Melgard's opinion since we find that he provided inconsistent opinions regarding claimant's condition. First, prior to the October 1992 lifting incident, Dr. Melgard attributed claimant's symptoms to irritation of the facets. (Ex. 63). Regarding the "pathophysiology" of claimant's condition, Dr. Melgard explained that when a disc narrows and protrudes, the facet joints sublux or slide and become inflamed. (Ex. 64-1). Dr. Melgard believed that claimant's pain was "secondary to referred pain from the facets itself [sic]" as a result of the prior herniation. (Id.)

In the most recent report, however, Dr. Melgard stated that he had "no reason to believe that [claimant] had a previously irritated facet." (Ex. 80-1). Dr. Melgard further stated that it was not "uncommon for people who have had disc removal to have some settling of their facets and some overriding that makes them susceptible to irritation. In light of this and the fact that [claimant] did not ultimately have a new protruded disc I feel that is related to the original injury of 1988 which required surgery at L5-S1." (Id. at 1-2).

We interpret these statements as indicating that claimant had no facet irritation before the October 1992 event and that the October 1992 incident caused facet irritation, although the condition was related to the 1988 injury and subsequent surgery. Consequently, we find that he contradicted his earlier opinion that claimant had facet irritation as a result of the prior herniation. Therefore, we find Dr. Melgard's opinion to be unreliable and give it little or no weight. See Weiland v. SAIF, *supra*.

The remaining opinions show that the October 1992 lifting incident was the major contributing cause of claimant's need for treatment. Thus, we find that claimant sustained a "new compensable injury" and responsibility shifts to SAIF. See ORS 656.308(1); SAIF v. Drews, 308 Or 1 (1993).

Attorney Fees

At hearing, SAIF denied compensability and responsibility; Industrial Indemnity's denial was limited to responsibility. The Referee awarded an assessed attorney fee for prevailing against SAIF's denial of compensability, payable by SAIF, as well as a separate assessed attorney fee for prevailing against Industrial Indemnity's denial of responsibility at hearing, payable by Industrial Indemnity. Industrial Indemnity objects to the award of an attorney fee against it because it denied only responsibility.

Inasmuch as we are reinstating Industrial Indemnity's denial, this attorney fee issue has been rendered moot. Nevertheless, claimant is entitled to an assessed attorney fee under ORS 656.386(1) only if the carrier denies the claim for compensation. See Gamble v. Nelson International, 124 Or App 90 (1993); Multnomah County School District v. Tigner, 113 Or App 405, 408 (1992). Thus, even if we had agreed with the Referee that Industrial Indemnity was responsible for claimant's need for treatment, there was no entitlement to an assessed attorney fee under ORS 656.386(1) against Industrial Indemnity since Industrial Indemnity denied only responsibility and not compensability.

Industrial Indemnity also challenges the Referee's additional award of an attorney fee based on its "unreasonable failure to request a paying agent." Presumably, the Referee based the award on ORS 656.382(1), which provides for the assessment of an attorney fee for unreasonable resistance of the payment of compensation.

The Director designates which carrier pays a claim for disputes concerning responsibility between two or more insurers if the insurers "admit that the claim is otherwise compensable." ORS 656.307(1)(b). In this case, even if Industrial Indemnity had requested a paying agent, no order could issue under ORS 656.307(1) because SAIF denied compensability. Thus, even if Industrial Indemnity's failure to request a paying agent was unreasonable, its conduct did not result in a resistance to the payment of compensation because of SAIF's compensability denial (which parenthetically we note that the Referee found to have been unreasonable). See ORS 656.382(1).

Finally, because claimant's right to compensation was at risk on review due to our de novo authority and SAIF's denial of compensability, claimant is entitled to a carrier-paid fee for services rendered on review, payable by SAIF. See ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi,

115 Or App 248 (1992). After considering the factors set forth in OAR 438-15-010(4), 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), complexity of the issue, and value of interest involved. We have not considered claimant's counsel's efforts devoted to the attorney fee issues.

ORDER

The Referee's order dated April 9, 1993 is reversed. Those portions finding Industrial Indemnity responsible and awarding \$2,000 and \$400 assessed attorney fees, payable by Industrial Indemnity, for prevailing against Industrial Indemnity's denial of responsibility and failure to request a paying agent are reversed. Industrial Indemnity's denial of responsibility is reinstated and upheld. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$1,000, payable by SAIF.

December 6, 1993

Cite as 45 Van Natta 2305 (1993)

In the Matter of the Compensation of
PATRICIA D. SIMMONS, Claimant
WCB Case No. 92-09384
ORDER ON REVIEW (REMANDING)
Welch, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee Podnar's order that affirmed a Director's order under ORS 656.327(2) finding that proposed right foot surgery was not appropriate medical treatment. Contending that the Referee was not provided with the Director's entire record, claimant seeks remand. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Reviewing for substantial evidence under ORS 656.327(2), the Referee affirmed the Director's order which found that the proposed surgery for claimant's right foot was not appropriate medical treatment. Contending that the Referee was not provided with the entire record developed by the Director, claimant asserts that the Referee could not determine whether the Director's order was supported by substantial evidence. We need not address this issue because we conclude that the Director lacked statutory authority to issue an order under ORS 656.327.

Subsequent to the date of the Referee's order, the court issued its decision in Jefferson v. Sam's Cafe, 123 Or App 464 (1993). In Jefferson, the court held that ORS 656.327, which provides a procedure for Director review of medical services disputes, is inapplicable to disputes regarding proposed medical treatment. The Jefferson court concluded that since ORS 656.327 does not apply to future medical treatment, the Board and its Hearings Division have exclusive jurisdiction to resolve disputes concerning proposed medical treatment.

In light of Jefferson, we hold that the Director did not have jurisdiction to review the appropriateness of claimant's proposed medical treatment. Claimant is therefore entitled to a hearing before the Referee concerning the propriety of the proposed surgery. ORS 656.283(1).

We may remand to the Referee if we determine that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). This matter was litigated in the belief that the Director had original jurisdiction and that the Referee could only review the Director's order for substantial evidence under ORS 656.327(2). We have previously ruled that where the parties were presenting their respective positions under an inappropriate standard of review and it is likewise apparent that the evidence admitted at the hearing was limited to that developed before the Director, there is a compelling reason to remand. See Peter Britz, 45 Van Natta 2187 (1993).

Here, as in Britz, the parties and the Referee believed that the scope of the Referee's review was limited to the record developed by the Director. Under such circumstances, we conclude that the record is incompletely developed and that there is a compelling reason to remand. ORS 656.295(5); Peter Britz, supra. Accordingly, we remand to Referee Podnar for further proceedings consistent with this order. The Referee may proceed in any manner that will achieve substantial justice. ORS 656.283(7). At the further proceedings, the parties may present evidence concerning whether the proposed surgery is appropriate medical treatment. The Referee shall then issue a final appealable order.

ORDER

The Referee's order dated March 25, 1993 is vacated. This matter is remanded to Referee Podnar for further proceedings consistent with this order.

December 6, 1993

Cite as 45 Van Natta 2306 (1993)

In the Matter of the Compensation of
TAMERA L. STEVENSON-LECLAIRE, Claimant

WCB Case Nos. 92-08219 & 92-02879

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Rick Dawson (SAIF), Defense Attorney

Tooze, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

ITT Hartford Insurance Group requests review of those portions of Referee Barber's order that: (1) set aside its "back-up" denial of claimant's aggravation claim for a right arm condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Claimant cross-requests review of that portion of the order that declined to assess a penalty for Hartford's allegedly unreasonable denial of compensability at hearing. On review, the issues are responsibility and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Responsibility

Pursuant to amended ORS 656.262(6), the Referee found Hartford responsible for claimant's aggravation claim on the basis that it failed to sustain its burden to prove by clear and convincing evidence that the claim, which it had previously accepted, is the responsibility of SAIF. The Referee also found Hartford's disclaimer of responsibility untimely under the 30-day statutory time period mandated by ORS 656.308(2) and, therefore, invalid.

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."

On review, Hartford argues that because both its aggravation acceptance and disclaimer of responsibility were issued within the 90-day period permitted under amended ORS 656.262(6) for notifying claimant of acceptance or denial, the "clear and convincing" standard of proof does not apply. Instead, Hartford contends, that standard should apply only to revocations of acceptances occurring more than 90 days after knowledge of the claim and less than two years from the date of acceptance.

We addressed this issue in Brian W. Andrews, 45 Van Natta 1115 (1993). In that case, the insurer argued that the portion of amended ORS 656.262(6) which shifts the initial compensability burden of proof from a claimant to an insurer does not apply when an insurer accepts and then denies a claim within the 90-day period permitted under the statute. We concluded that, under the statute, a carrier 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. We found, therefore, that the carrier bore the burden of proving by clear and convincing evidence that that claim was not compensable.

Here, Hartford accepted claimant's aggravation claim on February 18, 1992. Then, on April 14, 1992, Hartford denied responsibility. Finally, on May 7, 1992, Hartford issued a disclaimer of responsibility. Consequently, under amended ORS 656.262(6), Hartford bears the burden of proving by clear and convincing evidence that it is not responsible for the claim. See Brian W. Andrews, supra. In this particular case, to meet its burden, Hartford must prove by clear and convincing evidence that claimant's work activities for SAIF's insured were the major contributing cause of a pathological worsening of her right arm condition. ORS 656.308(2); Donald C. Moon, 43 Van Natta 2595 (1991).

Drs. Button, Nye and Quaram all noted claimant's symptomatic complaints. However, all three physicians reported that there were no objective findings to support claimant's symptoms. In particular, none of the three physicians believed that claimant had an ulnar condition. Rather, the doctors opined that claimant's complaints were due to functional interference.

Dr. Berkeley, neurosurgeon, is the only physician to find that claimant is currently impaired. Berkeley reported that claimant's repetitive work activity for SAIF's insured caused swelling and inflammation in the elbow area. Dr. Berkeley, however, characterized these complaints as a symptomatic exacerbation of her underlying ulnar condition. Berkeley's reports do not document any pathological worsening.

Even if the medical evidence is viewed in a light most favorable to Hartford, the most it establishes is that claimant suffered an increase in symptoms. Thus, as did the Referee, we find that Hartford has failed to establish that claimant sustained a new occupational disease while working for SAIF's insured.

Our finding that Hartford has failed to prove that responsibility for claimant's right arm condition shifts to SAIF is dispositive of this claim. Therefore, we do not consider its alternative argument that its responsibility disclaimer, issued within 30 days of the date it discovered that a responsibility issue existed, complied with the spirit of ORS 656.308(2).

Penalties

The Referee found that both Hartford and SAIF had reasonable doubts as to the compensability and responsibility issues. Accordingly, the Referee declined to award a penalty.

On review, claimant seeks penalties for Hartford's allegedly unreasonable denial of compensability at hearing. We agree with claimant.

Prior to hearing, Hartford denied only responsibility. SAIF denied both compensability and responsibility; therefore, no .307 order issued designating a paying agent. Hartford concedes that it had no evidence to support its compensability denial at hearing. However, Hartford explains, in light of SAIF's continued compensability denial, it felt compelled to amend its denial to avoid being held responsible for the claim.

In Harold R. Borron, 44 Van Natta 1579 (1992), we found that a denial of compensability was unreasonable where the insurer did not have a legitimate doubt regarding the compensability of the claim, but still denied compensability solely for tactical reasons relating to litigation. Similarly, Hartford concedes that it had no evidence to support its compensability denial, but denied compensability solely for tactical reasons. Under these circumstances, we find that Hartford's compensability denial was unreasonable and a penalty is warranted. Id.

Accordingly, for Hartford's unreasonable denial, a penalty will be assessed equal to 25 percent of all compensation due as of the date of hearing as a result of the Referee's order. This penalty shall be equally shared by claimant and her attorney.

Attorney Fees/Board Review

Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See 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). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review, payable by Hartford. 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 \$1,400. 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. In reaching this conclusion, we note that claimant's counsel was awarded one-half of the penalty in lieu of an attorney fee. Therefore, we have not considered claimant's counsel efforts with regard to the penalty issue in awarding an attorney fee for services on review.

ORDER

The Referee's order dated October 26, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which declined to award a penalty for Hartford's unreasonable denial of compensability is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation owing at the date of the hearing as a result of the Referee's order, payable by ITT Hartford Insurance Group. Claimant's attorney shall receive one-half of the penalty in lieu of an attorney fee. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded a \$1,400 assessed fee, payable by ITT Hartford Insurance Group.

December 7, 1993

Cite as 45 Van Natta 2308 (1993)

In the Matter of the Compensation of

JIMMIE G. CLARK, Claimant

WCB Case No. 91-05860

ORDER ON REVIEW

Vick & Gutzler, Claimant Attorneys

Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerland, Neidig, and Gunn.

The self-insured employer requests review of Referee Thye's order that: (1) directed it to pay claimant benefits for temporary disability from February 20, 1991 to August 12, 1991; and (2) assessed a penalty for the employer's unreasonable resistance to the payment of compensation. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

Claimant injured his low back on October 2, 1989, while employed as a floor waxer in the employer's janitorial department. He sought medical treatment at a local hospital, where a left back contusion was diagnosed. He subsequently came under the care of Dr. Huff, a chiropractor, who diagnosed a lumbosacral contusion and took claimant off work.

Following a period of conservative treatment, claimant became medically stationary on January 25, 1990. This determination was rendered by the Western Medical Consultants, following completion of an independent medical examination. Claimant returned to work for another employer between December 1990 through February 1991 when he was laid off. (Tr. 81, 82, 119). Thereafter, he briefly worked for two other employers, performing custodial and groundskeeping duties. (Tr. 82, 83).

The employer denied compensability of the injury, asserting that claimant's need for treatment and resulting disability did not arise in the course and scope of his employment. The denial was set aside by a February 20, 1991 Opinion and Order, and the claim was remanded to the employer for acceptance and payment of appropriate benefits. The employer subsequently requested review of that order. On March 11, 1993, we affirmed that earlier referee's order.

On May 7, 1991, claimant initiated this proceeding, asserting that the employer had failed to pay temporary disability subsequent to the earlier referee's February 20, 1991 order. Claimant's claim was eventually closed by an August 12, 1991 Determination Order, which awarded temporary total disability benefits from October 2, 1989 through January 25, 1990, and benefits for 28 percent unscheduled permanent partial disability.

CONCLUSIONS OF LAW AND OPINION

In this enforcement action, the primary issue is whether claimant is entitled to temporary disability benefits pending Board review of the earlier Referee's decision ordering acceptance of the claim. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, the matter is properly analyzed under the law as amended by the 1990 legislature. See Or Laws 1990 (Special Session), ch. 2, §54; Diamond Fruit Growers v. Goss, 120 Or App 390 (1993); Bird v. Bohemia, Inc., 118 Or App 201 (1993); Raymond J. Seebach, 43 Van Natta 2687 (1991).

As amended, ORS 656.313 provides, in part:

"(1)(a) Filing by an employer or the insurer of a * * * request for board review or court appeal 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 is reversed, which ever event occurs first[.]"

Here, the employer timely requested Board review of the earlier referee's "compensability" decision. Therefore, all temporary disability benefits accruing prior to the earlier referee's February 20, 1991 order could be stayed. However, any benefits accruing on and after that date could not be stayed. ORS 656.313(1)(a)(A). Thus, claimant contends that he is entitled to temporary disability benefits from February 20, 1991, the date of the appealed order, through August 12, 1991, the date of claim closure. Therefore, the question is whether the employer was obligated to provide temporary disability benefits on or after February 20, 1991 prior to the August 12, 1991 Determination Order. After conducting our review of the record, we conclude that the answer to that question is no.

On issuance of the earlier referee's February 20, 1991 decision, the employer assumed responsibility for processing the claim. This obligation included providing temporary disability benefits to the extent to which claimant was entitled. Jean M. Bates, 45 Van Natta 152 (1993). Claimant seeks temporary disability benefits from the February 20, 1991 order until claim closure on August 12, 1991. The August 12, 1991 Determination Order awarded temporary disability benefits through January 25, 1990, the medically stationary date. Thus, claimant's substantive entitlement to temporary disability benefits ended on that date. Lebanon Plywood v. Seiber, 113 Or App 651, 653 (1992).¹

¹ The dissent contends that claimant's substantive and procedural entitlements to temporary disability benefits are now identical. The dissent reaches this conclusion based upon the 1990 amendments to ORS 656.268, in which subsection (1) was modified and paragraph (2)(c) was deleted, both in response to the court's decision in Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Thus, the dissent asserts that, because there is no longer a distinction between procedural and substantive temporary disability compensation, Lebanon Plywood v. Seiber, supra, does not apply. The dissent is wrong.

The employer, however, did not commence payment of temporary disability benefits following the February 20, 1991 Opinion and Order and, as a result did not pay benefits beyond the January 25, 1990 medically stationary date. Because payment of temporary disability benefits beyond the medically stationary date is a consequence of the administrative process of claim closure and is not an entitlement, we have no authority to impose an administrative overpayment. *Id.* at 654.

We need not, however, resolve the issue of whether claimant is entitled to temporary disability benefits beyond the medically stationary date by virtue of ORS 656.313(1)(a)(A). *But see John R. Heath*, 45 Van Natta 840 (1993) (the exception created by ORS 656.313(1)(a)(A) does not create a procedural overpayment). We reach this conclusion because, even assuming for the sake of argument that claimant may claim entitlement to temporary disability benefits beyond the medically stationary date and the February 20, 1991 appealed referee's order based on the ORS 656.313(1)(a)(A) exception, claimant has not established that he is entitled to such benefits on the facts.

Claimant testified that, between February 20, 1991 and August 12, 1991, he worked for other employers performing custodial duties, but was laid off "because of my back." During that time, claimant also received welfare and unemployment benefits. (Tr. 81, 82, 83, 119). Since his claim had not been closed at the time of these events, claimant was not required to prove a subsequent "worsening" to trigger the reinstatement of temporary disability. *Rodgers v. Weyerhaeuser Company*, 88 Or App 458, 460 (1987). Nevertheless, he must establish that his condition was no longer medically stationary. *Id.* at page 461.

In other words, claimant must prove that a material improvement in his condition could be expected from medical treatment or the passage of time. *Id.* Without further corroboration, we consider claimant's testimony concerning the circumstances surrounding his departure from his subsequent employments insufficient to establish that his compensable condition was no longer medically stationary, particularly in the absence of medical evidence rebutting the Western Medical Consultants' January 25, 1990 "medically stationary" opinion. Consequently, we are not persuaded that, either during or following these employments, claimant's compensable condition changed from its January 1990 "medically stationary" status.

In addition, the employer was authorized to terminate temporary total disability on claimant's return to work. ORS 656.268(3)(a); *Viking Industries v. Gilliam*, 118 Or App 183 (1993).

To begin, as previously noted, even if *Seiber* did not apply, claimant has not proven that his condition changed from its "medically stationary" status on January 25, 1990. Thus, claimant has not established entitlement to temporary disability pending the employer's appeal of the February 20, 1991 referee's order. Secondly, since *Seiber* is a decision from a higher appellate authority and remains good law, we are obliged to follow its holding. In other words, if the *Seiber* holding is contrary to the statutory scheme, that decision is for the appellate courts, not this forum. Finally, and most importantly, the dissent misconstrues the *Fazzolari* holding and the ensuing 1990 statutory amendments.

Fazzolari did not address a claimant's substantive entitlement to temporary disability benefits. Rather, the *Fazzolari* decision and the amendments to ORS 656.268 concern a claimant's procedural entitlement to temporary disability benefits prior to claim closure. The 1990 amendments reflect an intent to return to the state of the law before *Fazzolari* when a carrier could procedurally terminate temporary disability upon a return to regular work or a release to regular work without a claimant also being medically stationary. *See Soledad Flores*, 43 Van Natta 2504 (1991) (the 1990 Legislature intended to limit procedural payments of temporary disability benefits, but did not indicate an intent to extend a claimant's substantive entitlement to temporary disability benefits). Now, amended ORS 656.268(3) allows a carrier to unilaterally terminate procedural temporary disability compensation, if one of its enumerated events occurs, prior to a claimant's medically stationary date or prior to claim closure. Such a provision is not designed to address substantive entitlement to temporary disability benefits, which is a matter appropriately left for claim closure. Therefore, the distinction between a claimant's procedural and substantive entitlement to temporary disability benefits remains. *Soledad Flores, supra.*

Here, we have found that claimant returned to work by December 1990, some 11 months after he became medically stationary. Since there was no subsequent medical verification that his condition changed or that he was unable to perform his work duties, the employer was under no obligation to pay temporary disability pending its appeal of the referee's February 20, 1991 order.

Claimant testified that he was "laid off" from some of his subsequent employments, relating his lay offs to an inability to perform his work activities due to his back condition. For the reasons previously discussed, in the absence of corroborating medical evidence, we are not persuaded that claimant's departure from his subsequent employments was caused by his compensable condition. Therefore, we conclude that the employer was not obligated to reinstate temporary disability.

Because claimant is not entitled to temporary disability benefits, there are no "amounts then due" upon which to base a penalty and no compensation to have unreasonably resisted to warrant an attorney fee. ORS 656.262(10); 656.382(1).

ORDER

The Referee's order dated November 25, 1991 is reversed. The Referee's award of temporary disability and approved "out-of-compensation" attorney fee are reversed. The Referee's assessed penalty and penalty-related attorney fee are also reversed.

Board member Gunn dissenting.

Citing Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the majority opinion suggests that claimant's substantive entitlement to temporary disability compensation would end on his medically stationary date, and that the Board would lack authority to order the payment of temporary disability benefits beyond that date. Since I disagree with that reasoning, I respectfully disagree.

In Seiber, the claimant had an accepted nondisabling injury that became disabling as the result of a subsequent aggravation. At the time of the aggravation, the claimant was receiving unemployment compensation because he had been laid off from his regular work. In light of such circumstances, the insurer contended that it was not responsible for temporary disability benefits during the aggravation. A Determination Order did not close the aggravation claim for some 6 months after claimant became medically stationary. The insurer paid no temporary disability compensation until such an award was granted following review of the Determination Order.

The Board awarded temporary disability compensation through the date of closure on the theory that the insurer would have been obligated to pay that disability had it begun the payment of temporary disability at the time required by law. The Court of Appeals, citing Fazzolari v. United Beer Distributors, 91 Or App 592 (1988), found that the claimant's substantive entitlement to temporary disability compensation ended when the claimant became medically stationary. Holding that the Board was without authority to create a purely procedural overpayment, the Seiber court reasoned that "[i]f processing delay does not result in an overpayment, the Board has no authority to impose one" Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

In Fazzolari v. United Beer Distributors, *supra*, the court reached the conclusion that the claimant's substantive entitlement to temporary disability compensation ended on the medically stationary date based upon its reading of former ORS 656.268(1) & (2). Specifically, section (1) of the former statute provided that "[c]laims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary . . ." Section (2) of the former statute further stated that "[i]f the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section." The Fazzolari court specifically relied upon the aforementioned provisions to conclude that the claimant's substantive entitlement to time loss ended on the medically stationary date, (See former ORS 656.268(1)), but that the right to temporary disability compensation continued until closure unless the worker had also been released to regular work. See ORS 656.268(2).

Subsequent to the Fazzolari decision, ORS 656.268 was modified. The amended statute permits termination of temporary disability compensation when the worker has returned to regular work, even if the worker has not reached a medically stationary status. Those amendments appear at Oregon Laws, 1990, Special Session, Chapter 2, Section 16. Of particular note, the phrase "nor temporary disability compensation terminated" was deleted from subsection (1) of ORS 656.268. However, this is the very phrase relied on by the Fazzolari court to conclude that the substantive entitlement to temporary disability compensation ends when the claimant becomes medically stationary.

An examination of the legislative history reveals some evidence that the legislature was aware that it was affecting the reasoning used in Fazzolari when it amended ORS 656.268. In his description of the impact of Section 16, of SB 1197, at the beginning of the House floor debates, Representative Shiprack stated that "[w]e are going to revise the criteria for time loss benefits. Right now there is . . . this overturns a particular court case known as the Frazeler (sic) decision." Special Session, House Floor Debate, May 7, 1990, Tape 1, Side B.

Chapter 656 does not contain a statute that links the substantive entitlement to time loss to the claimant's medically stationary status. ORS 656.210 provides only that "[w]hen the worker's disability is only temporary, the worker shall receive during the period of that total disability compensation...." ORS 656.212, which provides the statutory basis for temporary partial disability, states that "[w]hen the disability is or becomes partial only and is temporary in character, the worker shall receive..." Finally, that portion of former ORS 656.268(2) which required the insurer to continue the payment of temporary disability compensation until termination was authorized by the Department has also been deleted.

The determination that the claimant's disability has become permanent is not made on the medically stationary date. While it cannot be made until the claimant is stationary, achieving a medically stationary status is only a necessary precondition of that determination, and not the determination itself, which is finally made at claim closure. Since the statute no longer ties the substantive entitlement to temporary disability compensation to the medically stationary date, ORS 656.210 and ORS 656.212 require the continuation of temporary disability compensation until it is determined that the claimant's disability has become permanent, unless the specific relief provisions of ORS 656.268(3) are met. The determination that the claimant's disability has become permanent is made at the time of closure. Consequently, the claimant is substantively entitled to temporary disability compensation through the time of claim closure, and the claimant's substantive and procedural entitlements are now identical.

In light of its reference to Lebanon Plywood v. Seiber, supra, the majority mistakenly continues in the belief that claimant's substantive entitlement to temporary disability compensation ends on the medically stationary date. Yet, because the distinction between substantive and procedural entitlement created by Fazzolari v. United Beer Distributors, supra, was specifically overturned by the legislature in 1990, there remains no such distinction in the law and Seiber cannot apply to any claim closed after July 1, 1990.

December 7, 1993 Cite as 45 Van Natta 2312 (1993)

In the Matter of the Compensation of

DAVE D. HOFF, Claimant

WCB Case No. 92-08774

ORDER ON REVIEW

Malagon, et al., Claimant Attorneys

Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Westerband, Neidig and Gunn.

The SAIF Corporation requests review of Referee Myers's order that: (1) excluded an out-of-state laboratory report; and (2) set aside SAIF's denial of claimant's claim for injuries sustained in a June 9, 1992 motor vehicle accident (MVA). On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

Claimant, a long-haul truck driver, had been on the road approximately four days at the time of the MVA. On June 6 and June 7, 1992, claimant was laid over at a truck stop in Billings, Montana. Periodically during the layover, claimant drank a "few beers" with other truck drivers. On June 8, claimant drove to Sheridan, Wyoming. Although claimant slept from about 8:30 p.m. to 5:00 a.m. that night, he testified that he did not sleep well in the truck sleeper.

At about 6:00 a.m. on June 9, 1992, claimant went to pick up a load of railroad ties. Wanting to get to the job site, claimant skipped breakfast. Because of a number of problems with loading the railroad ties, he did not leave Sheridan until midafternoon to drive to Salt Lake City, Utah. Claimant also did not have lunch. About an hour after leaving Sheridan, he learned that he had to deliver his load at two different locations. This made him frustrated and upset, so that he bought a six-pack of beer and began drinking around 5:00 p.m. He did not eat dinner. He was still drinking when the sun went down. Around 9:00 p.m., claimant's truck drifted off the road and overturned when he attempted to bring it back onto the highway. Claimant believes he fell asleep at the wheel. Claimant's blood alcohol level (BAL) measured about 1-1/2 hours after the MVA was .11 percent, which would approximate a BAL of .13 at the time of the accident.

Based on a "post-accident" CT scan, doctors discovered that claimant has a preexisting hydrocephalus. Hydrocephalus causes increased pressure in the brain and causes impairment of mental function. Dr. Randle, neurologist, and Dr. Hacker, neurosurgeon, performed neurological evaluations on July 6, 1992 and July 20, 1992, respectively. Both neurologic examinations were normal. Dr. Hacker felt that claimant had developmental hydrocephalus, which had reasonably been compensated for throughout his lifetime.

Dr. Kurlychek, psychologist, saw claimant for a neuropsychological assessment. He also felt that claimant's hydrocephalus was developmental rather than acute. Based on interview and test results, Dr. Kurlychek reported mild neuropsychological impairments consistent with claimant's neurological condition. These impairments included problems with concentration and attention, impaired higher cognitive processing, and difficulty with concept formation and problem solving.

Dr. Lorenz, claimant's treating physician, opined that claimant's hydrocephalus caused significant impairment of mental function and social behaviors. These impaired cognitive skills and stress on the day of the accident led claimant to drink. Dr. Lorenz, therefore, concluded that claimant's hydrocephalus condition caused the MVA.

Dr. Jacobsen reviewed claimant's medical records and opined that claimant's .13 blood alcohol level would cause significant impairment to claimant's judgment, motor coordination, and cause sleepiness. He concluded that claimant's alcohol consumption was the major contributing cause of the MVA.

CONCLUSIONS OF LAW AND OPINION

Evidentiary ruling

The Referee excluded Exhibit 11, an out-of-state laboratory report, on the ground that SAIF failed to timely comply with the notice requirements of ORS 656.310(2), and because it was not a report from an examining doctor. (Tr. 30). We review the Referee's evidentiary 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).

ORS 656.310(2) limits admission of reports of nonresident doctors to those of treating or examining doctors. Downey v. Halvorson-Mason, 20 Or App 593 (1975); Harold T. Bird, 43 Van Natta 1732 (1991). Exhibit 11 is neither a medical report containing a doctor's opinion, nor a report of a nonresident treating or examining doctor. It is merely a laboratory report prepared at an out-of-state doctor's request. Therefore, ORS 656.310(2) is inapplicable. Rather, the issue is whether the report was timely disclosed under OAR 438-07-015 and OAR 438-07-018.

OAR 438-07-015 requires the parties to disclose claims documents within 15 days of initial request and to disclose subsequently obtained documents within seven days of receipt. The record does not establish when SAIF received the June 9, 1992 laboratory report. SAIF contends that it received notification of claimant's counsel's representation on July 6, 1992 and that a copy of the laboratory report was sent to claimant's counsel on July 9, 1992. Claimant does not dispute SAIF's contentions. Therefore, the laboratory report was timely disclosed under OAR 438-07-015.

OAR 438-07-018(1) requires SAIF to submit its exhibits not later than 20 days before the hearing. On September 15, 1992, SAIF submitted the laboratory report as an exhibit (Exhibit 11) for the September 16, 1992 hearing. Thus, SAIF's submission of Exhibit 11 was untimely under OAR 438-07-018.

Nevertheless, we have previously ruled that OAR 438-07-018(4) does not provide sanctions for failure to submit exhibits timely nor does it give the Referee discretion to exclude timely-disclosed documents merely because the documents could have been submitted at an earlier time. Sabeth Sok, 42 Van Natta 2791, 2793 (1990); T.S. Nacoste, 42 Van Natta 1855 (1990).

Inasmuch as SAIF has timely disclosed the laboratory report under OAR 438-07-015, we conclude that the Referee abused his discretion in excluding Exhibit 11. Therefore, because the exhibit is already in the record, it has been considered on appeal. See Herbert D. Rustrum, 37 Van Natta 1291 (1985).

Compensability

The Referee found that SAIF failed to prove, by clear and convincing evidence, that claimant's consumption of alcohol was the major contributing cause of the MVA. We disagree.

In Grace L. Walker, 45 Van Natta 1273 (1993), we held that under ORS 656.005(7)(b)(C) the claimant must first establish a prima facie case of compensability. If so established, then to defeat a finding of compensability, the carrier must carry the burden of proving, by clear and convincing evidence, that the claimant's consumption of alcoholic beverages or the unlawful consumption of any controlled substance was the major contributing cause of the injury. We further stated that the carrier could not meet its burden by merely showing that the claimant consumed alcohol or a controlled substance. Rather, the carrier must clearly and convincingly establish that the claimant was impaired by the alcohol or controlled substance and that such impairment was the major contributing cause of the injury. To be clear and convincing, the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

SAIF does not contest that claimant's disability was materially related to the MVA, which occurred within the course and scope of employment. Therefore, it is SAIF's burden to prove by clear and convincing evidence that claimant's consumption of alcohol was the major contributing cause of the MVA. Grace L. Walker, supra.

Dr. Lorenz, internist, examined claimant shortly after the MVA. He opined that claimant's hydrocephalus caused significant impairment of mental function and social behaviors and that this impairment led to claimant's excessive alcohol consumption around the time of the accident. Dr. Lorenz concluded that claimant's preexisting hydrocephalus, and not his alcohol consumption, was the major contributing cause of the accident because the hydrocephalus caused claimant to abuse alcohol. Dr. Lorenz added that claimant's sleepiness was a consequence of the long hours of work and lack of food on that day and was a material contributing cause of the accident.

SAIF contends that Dr. Lorenz's opinion is unpersuasive because it is conclusory and based on incomplete information. We agree, to some extent. Dr. Lorenz formed his opinion on the basis that claimant was a nonalcohol user and that claimant's behavioral changes were of a recent onset. This was inaccurate. The histories obtained by Drs. Randle, Hacker, and Kurlychek¹ noted behavioral changes over the last couple of years. Furthermore, claimant admitted that he did not inform Dr. Lorenz of his use of alcohol.

However, the primary problem is that Dr. Lorenz's opinion provides no defense, even if accepted. Specifically, his opinion that claimant's hydrocephalus caused claimant to drink excessively on the date of the accident does not address the relevant legal question. ORS 656.005(7)(b)(C) does not allow exceptions for abuse of alcohol attributable to extenuating circumstances such as a preexisting disease which causes poor judgment. ORS 656.005(7)(b)(C) states that an injury is not compensable if its major contributing cause is the worker's consumption of alcoholic beverages.

¹ These doctors did not address the cause of the MVA.

SAIF relies on the opinion of Dr. Jacobsen, specialist in addiction medicine, who opined that at claimant's blood alcohol level at the time of the accident (.13), claimant would be impaired.² Jacobsen concluded that, because claimant's BAL was sufficient to cause significant impairment to claimant's judgment, motor coordination, and cause sleepiness, claimant's consumption of alcohol was the major contributing cause of the MVA.

We rely on Dr. Jacobsen's opinion that claimant's consumption of alcohol (as evidenced by his .13 BAL) caused significant impairment, as opposed to the hydrocephalus condition, and that impairment was the major contributing cause of the MVA.³ We are, thus, persuaded, by clear and convincing evidence, that the major contributing cause of the MVA was claimant's consumption of alcohol. ORS 656.005(7)(b)(C); see Grace L. Walker, 45 Van Natta at 1275. Therefore, SAIF has sustained its burden of proof that the accident is not compensable.

ORDER

The Referee's order dated October 22, 1992 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

² The types of impairment expected, when there is no tolerance to alcohol, included: emotional instability, loss of critical judgment; impairment of perception, memory and comprehension; decreased sensory response; increased reaction time; reduced visual acuity, peripheral vision and glare recovery; sensory/motor incoordination, impaired balance; and drowsiness.

³ Dr. Jacobsen's admission that he is not specially qualified to comment on the effects of hydrocephalus is no reason to discount his opinion, since as previously discussed, that claimant's hydrocephalus condition may have caused claimant to abuse alcohol, is immaterial to the question presented.

Board Member Gunn dissenting.

The majority holds that SAIF has proven, by clear and convincing evidence, that the major contributing cause of claimant's MVA resulting in injuries was claimant's consumption of alcoholic beverages. I disagree and dissent.

The majority bases its conclusion on the opinion of Dr. Jacobsen that claimant's alcohol consumption caused significant impairment and therefore was the major contributing cause of the MVA. However, after admitting that he was not a specialist in claimant's hydrocephalus condition to comment on the role it played in causing claimant to drink, Dr. Jacobsen opined that if claimant had a history of long-term, heavy use of alcohol, then that could be an alternative explanation for the neuropsychological impairment that Dr. Kurlychek attributed to the hydrocephalus. Dr. Jacobsen's speculation that claimant is a chronic alcohol user is not supported by the record or by claimant's testimony. Claimant testified that he occasionally drank a few beers. Because Dr. Jacobsen's opinion is based on incomplete and inaccurate information, his opinion is unpersuasive regarding the contribution of claimant's hydrocephalus condition to the MVA. See Somers v. SAIF, 77 Or App 259 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

With Dr. Lorenz's and Dr. Jacobsen's opinions discredited, there are no other medical opinions addressing the causation issue. The possibility of other contributing factors, such as claimant's lack of sleep and food, weigh against sustaining SAIF's burden of proof. Moreover, since each of the opinions that provide an explanation for the MVA contain deficiencies which render those opinions unpersuasive, SAIF has failed to establish, by clear and convincing evidence, that the major contributing cause of the MVA was claimant's consumption of alcohol. ORS 656.005(7)(b)(C); see Grace L. Walker, 45 Van Natta at 1275; Roger D. Hart, 44 Van Natta 2189, 2192 (1992) (employer failed to prove by clear and convincing evidence that the claimant's off-the-job injury was the major contributing cause of a worsening under ORS 656.273(1)). Therefore, SAIF has failed to establish that the accident is not compensable.

I would affirm the Referee's conclusion that SAIF failed to sustain its burden of proof.

In the Matter of the Compensation of

RONALD L. LEDBETTER, Claimant

WCB Case No. 92-04603

ORDER ON REVIEW

Jolles, Sokol, et al., Claimant Attorneys

Jermome Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of Referee Davis' order that upheld the SAIF Corporation's denial of his current right leg osteomyelitis condition. On review, the issue is compensability.

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

Regardless of whether claimant is required to establish that his accepted injury is causally related to his current right leg osteomyelitis condition under a material cause standard or the major cause standard, we would still conclude that claimant has not proven compensability.

Dr. Donahoo attributes claimant's current right leg osteomyelitis condition to a natural progression of the underlying condition and the 1989 off-work incident. Donahoo further opined that claimant's osteomyelitis condition had returned to the status it was at prior to the 1982 exacerbation and that claimant's current condition was a manifestation of the ongoing natural progression of the preexisting osteomyelitis condition. We interpret Dr. Donahoo's opinion to mean that the accepted exacerbation is no longer a contributing factor to claimant's current right leg condition.

For the reasons stated by the Referee, we find Dr. Donahoo's opinion persuasive. Consequently, we agree with the Referee that claimant's current right leg osteomyelitis condition is not compensable.

ORDER

The Referee's order dated February 26, 1993 is affirmed.

Board Member Gunn, dissenting:

The majority finds that claimant's current right leg condition is not causally related to his compensable injury and therefore concludes that claimant's current right thigh condition is not compensable. Because I believe that SAIF is precluded from denying claimant's current condition, I dissent.

Claimant sustained a compensable injury to his right arm and leg in August 1982. SAIF accepted the injury, but did not specifically indicate what conditions it was accepting. Following the injury, claimant experienced increasing symptoms in his right thigh. His condition was diagnosed as an exacerbation of the stable chronic osteomyelitis condition. In June 1983, claimant requested a hearing raising, among other issues, the compensability of his right thigh condition. By stipulation dated July 28, 1983, SAIF agreed to "accept the claim for claimant's right thigh condition as an exacerbation of a pre-existing injury."

Since 1983 claimant's right thigh osteomyelitis has remained symptomatic. As a result of these symptoms, claimant was placed on a maintenance program of antibiotics. That program has continued from 1983 to the present. Relying on Dr. Donahoo, the majority concludes that claimant's right thigh osteomyelitis condition has returned to pre-1982 status and his current symptoms are due to the underlying condition and the 1989 incident. However, prior to the 1982 injury, claimant's right thigh osteomyelitis condition was asymptomatic. Therefore, I cannot accept Dr. Donahoo's opinion.

Rather, I find that claimant's current condition is the same condition that SAIF accepted by virtue of the July 1983 stipulation. That is, claimant's current need for treatment is due to the same exacerbation of osteomyelitis symptoms that SAIF has previously accepted. Since this issue has been resolved by stipulation, SAIF is precluded from denying it at this late date. See Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993) (An agreement accepting a claim "has the finality and effect of a judgment." citing International Paper Co. v. Pearson, 106 Or App 121 (1991)).

Based on the above reasoning, I believe the Referee's order should be reversed and SAIF's denial of claimant's current right thigh osteomyelitis condition should be set aside.

In the Matter of the Compensation of
VERNON D. McCALL, Claimant
WCB Case Nos. 90-21654, 90-21650, 90-21651, 90-21652 & 90-21653
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Referee McWilliams' order which: (1) upheld the SAIF Corporation's denials of claimant's current mid and low back condition; and (2) declined to award a penalty and attorney fee for allegedly unreasonable denials. On review, the issues are compensability and penalties and attorney fees.

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

SAIF issued five denials, each denying the existence of a causal relationship between claimant's current need for treatment and five accepted claims. At hearing, and in his appellant's brief, claimant narrowed the issue to that of whether a causal relationship existed between his current need for treatment and, specifically, his October 30, 1981 lower thoracic and lumbar strain injury. (Tr. 5).

Claimant relies on the testimony of his treating physician, Dr. Becker. Becker's opinion is the only one in the record that supports a relationship between claimant's current need for treatment and the October 30, 1981 injury. For the following reasons, we do not rely on that opinion.

Dr. Becker first examined claimant on November 20, 1990, purportedly in relation to injuries sustained in an injury on February 11, 1983. (See Ex. 45-1). A letter to Dr. Becker from claimant's attorney, prior to the examination, related that claimant considered the February 11, 1983 injury to be the root of his problems. (Ex. 46-13).

In his deposition, Dr. Becker agreed that when he saw claimant for the first time, the 1981 injury was not the event about which claimant initially complained. (Ex. 46-17). Rather, the first history that claimant related to Dr. Becker dealt with an injury in 1987, which was described as the injury involving the altercation with a co-worker. (Ex. 46-6). Dr. Becker could not explain why claimant did not mention the 1983 injury, as claimant's attorney had done. (Ex. 46-13).

On June 5, 1991, Dr. Becker responded to a letter from claimant's attorney. (Ex. 44). In that letter, Dr. Becker stated that claimant's mid-thoracic pain is clearly related to the October 30, 1981 injury. (Ex. 44-1). Nevertheless, when asked why he picked the October 30, 1981 date as the one from which claimant's current problems stem, Dr. Becker replied:

"Why I would pick the '81 date? * * * That [June 5, 1991] letter was in response to a communication from claimant's attorney of May 3rd. * * * The only injury that really is mentioned in claimant's attorney's report is that of the October 30th, 1981 claim that deals with thoracic area of discomfort."

"I can't in any real world fashion remember what was going through my head June 5th, 1991. So I guess that's as good as I can come to a guess as to why I said that [date]." (Ex. 46-16).

It is clear, from Dr. Becker's testimony, that the only reason he related claimant's current need for treatment of his thoracic back to the October 30, 1981 injury is that the October 30, 1981 date is the only date mentioned in the letter from claimant's attorney to which Dr. Becker was responding in his June 5, 1991 letter. Since we do not consider such reasoning to be persuasive, we conclude that claimant has not met his burden of proving that his current need for treatment is related, in a material or major way, to his October 30, 1981 accepted injury.

ORDER

The Referee's order dated November 4, 1992, as amended by the February 5, 1993 order, is affirmed.

In the Matter of the Compensation of
ROGER L. PORTER, Claimant
Own Motion No. 93-0530M
OWN MOTION ORDER
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights expired on April 18, 1990. 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.

As of July 28, 1993, claimant's compensable left knee condition worsened requiring surgery. (July 28, 1993 chart note from Dr. Baldwin, treating physician). Claimant underwent that surgery in August 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). Here, the time of disability is July 1993, the time claimant's condition worsened requiring surgery. 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).

With a November 15, 1993 letter, claimant's attorney submitted the following documents in support of claimant's contention that he is not retired: (1) 1991 W-2 form; (2) 1992 W-2 form; (3) a direct deposit statement for part-time teaching at Mount Hood Community College (MHCC) for pay period ending 6/30/93; (4) a history of employment at MHCC; and (5) Article 22, Retirement Incentive for MHCC, part of the faculty contract pertaining to part-time teaching by retired faculty members.

Claimant's direct deposit stub clearly shows substantial earned income through the period ending June 30, 1993. In his "History of Employment," claimant noted that he worked 10 weeks in a part-time capacity for MHCC, and that he was scheduled to teach Fall term of 1993, but was unable to teach because of surgery. Claimant also submitted a recovery schedule from Dr. Baldwin for the surgery.

We note that claimant's worsening occurred during the summer months rather than during the school year. However, claimant need not prove actual loss of wages at the time of disability to be entitled to temporary disability benefits. Claimant only need prove that, because of the worsening, he was less able to work in that he was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452 (1991), citing Smith v. SAIF, 302 Or 396, 401 (1986); Michael Pickett, 45 Van Natta 255 (1993).

On this record, we find that claimant has met his burden of proof and has established that he was in the work force at the time of disability. Therefore, claimant is entitled to temporary disability benefits.

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 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
GLENN POTTER, Claimant
Own Motion No. 93-0570M
OWN MOTION ORDER ON RECONSIDERATION
Joel B. Reeder, Claimant Attorney

Claimant requested reconsideration of our September 23, 1993 Own Motion Order in which we declined to reopen his claim for own motion relief on the ground that he had not established he was in the work force at the time of his July 23, 1993 disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

On October 19, 1993, we withdrew our order for reconsideration and allowed the insurer time to respond to claimant's motion. The insurer's response has been received and we proceed with our reconsideration.

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 he was in the work force on July 27, 1993, when his condition worsened requiring surgery. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant contends he was in the work force at the time of his current disability and cites a January 9, 1993 Opinion and Order in support of that contention. In that order, the issue was which of two insurers were responsible for claimant's current left knee condition. Referee Spangler found that claimant's left knee condition worsened in April 1992 and concluded that the own motion insurer was responsible for claimant's current condition. Referee Spangler also found that claimant remained in the work force at the time of his April 1992 worsening. Referee Spangler concluded that claimant remained a permanent employee of a subsequent employer, although claimant had been laid off several times in 1992 by the employer due to a lack of business. The Referee also found that because "claimant expected the last lay-off to end in a few days (i.e., by May 1, 1992), he did not look for work during that brief period. Due to his disabling left knee condition, however, he was unable to return to work as expected on May 1, 1992."

Following Referee Spangler's order, the own motion insurer reopened claimant's claim. On April 12, 1993, the insurer closed the claim, declaring claimant medically stationary as of March 12, 1993. Claimant was awarded time loss payments from August 6, 1992 through March 30, 1993. The April 12, 1993 closure was not contested and has become final by operation of law.

Although claimant was found to have remained in the work force at the time of his April 1992 disability, the issue at hand is whether claimant remained in the work force at the time of his July 27, 1993 disability. Claimant has the burden of proof on this issue.

Claimant's current condition worsened requiring surgery on July 27, 1993, which is the time of disability and the relevant time frame during which claimant must prove he remained in the work force. The insurer contends that claimant is no longer in the work force because he has not been employed since he was declared medically stationary on March 12, 1993. The insurer also contends that claimant has not looked for employment since March 12, 1993, and that there is no medical evidence to show his compensable knee injury made it impossible for him to perform any kind of work for which he was qualified.

Claimant has not responded with any evidence that he was willing to work, looking for work, or that a reasonable employment search would have been futile because of the compensable knee injury. Claimant was found to have remained in the work force in April of 1992, and continued to remain in the work force due to his inability to work as evidenced by his award of temporary disability benefits. However, claimant became medically stationary on March 12, 1993 and his claim was last closed on April 12, 1993. Claimant submits no evidence that he was in the work force at the time of his current disability on July 27, 1993. Neither has claimant indicated that he was willing to work.

On this record, we conclude claimant has failed to establish he was in the work force at the time his compensable condition worsened on July 27, 1993. Consequently, we deny reopening of claimant's claim to provide temporary total disability compensation.

Accordingly, our September 23, 1993 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 23, 1993 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

December 7, 1993 Cite as 45 Van Natta 2320 (1993)

In the Matter of the Compensation of

BETSY A. PREECE, Claimant

WCB Case No. 92-12098

ORDER ON REVIEW

Craine & Love, Claimant Attorneys

Dávid Lillig (Sáif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral hand condition. On review, the issue is claims processing.

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

We agree with the Referee that claimant failed to prove that her most recent work activities with Blue Cross (SAIF's insured) were the major contributing cause of a worsening of her underlying condition and, therefore, the claim properly was processed as an aggravation of her 1985 claim. In particular, claimant's treating hand surgeon, Dr. Tongue, explained during a deposition that claimant's repetitive work in 1985 caused swelling in the ligament and tendons surrounding the median nerve and that pressure from this condition caused her symptoms. (Ex. 31-16). Furthermore, even though her symptoms subsequently subsided, according to Dr. Tongue, the episode left residual fluid and thickening of the tissue so that an underlying persistent swelling condition continued to be present. (*Id.*) Dr. Tongue additionally stated that claimant's work activities in 1990-92 caused additional swelling and pressure, resulting in another onset of symptoms. (*Id.* at 16-17).

Based on Dr. Tongue's opinion, we find that the condition causing claimant's carpal tunnel symptoms--swelling and pressure around the median nerve--preexisted claimant's 1990-92 work activities. Dr. Tongue also indicated that claimant's work activities in 1990-92 contributed to a worsening of this condition in that they caused increased swelling and pressure. However, Dr. Tongue did not quantify the extent of contribution from the 1990-92 work activities to the underlying condition and, therefore, did not show that such work activities were the major contributing cause of claimant's need for treatment. Although "magic words" are not required, we do not find Dr. Tongue's opinion to establish a compensable occupational disease claim. Consequently, we conclude that the claim properly was processed as an aggravation rather than a new occupational disease. See *Peggy Holmes*, 45 Van Natta 278, 279 (1993).

ORDER

The Referee's order dated March 10, 1993 is affirmed.

In the Matter of the Compensation of
JOANN SWEENEY, Claimant
WCB Case No. 92-04231
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

The self-insured employer requests review of Referee Michael V. Johnson's order that set aside its denial of claimant's aggravation claim for a current L5-S1 herniated disc condition. On review, the issue is aggravation.

We affirm and adopt the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 18, 1993 is affirmed. For services on review, claimant's counsel is awarded an \$800 attorney fee, payable by the self-insured employer.

Board Member Haynes, dissenting:

Claimant's aggravation claim is denied on causation grounds. She argues that her current herniated disc condition is compensable solely insofar as it is related to her accepted 1989 low back injury. However, because claimant had no clinically significant symptoms suggesting disc herniation until 1992, Dr. Rosenbaum, treating surgeon, believes that claimant's herniated disc is not related to her 1989 strain injury. Similarly, considering claimant's significant new symptoms in 1992, Dr. Longland (who has treated claimant since 1990) doubted "highly" that claimant's 1989 injury was the major contributing cause of her recent surgery for an L5-S1 disc herniation.

In this case, I find no persuasive reason to discount the opinions of claimant's treating physicians. Moreover, considering Dr. Rosenbaum's specialized expertise, his well-reasoned opinion, and his unique "hands on" opportunity to observe claimant's condition (as treating surgeon), I would find Rosenbaum's conclusions persuasive. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
GUSTAVO CANTU-RODRIGUEZ, Claimant
WCB Case No. 92-15963
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Referee Garaventa's order that declined to award an attorney fee pursuant to ORS 656.382(1). On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant has an accepted low back strain. On August 10, 1992, he underwent surgery. On August 27, 1992, SAIF issued a notice of ineligibility for vocational assistance, stating that claimant was not eligible "because it is not feasible to evaluate your eligibility at this time due to your current medical condition. When you are able to participate or when physical capacities are known, we will evaluate your eligibility." (Ex. 6).

Claimant's attorney sought review by the Director. The Director voided SAIF's determination and ordered SAIF to determine claimant's eligibility "when he is medically stationary or his permanent capacities are known, whichever occurs first." (Ex. 9-2).

CONCLUSIONS OF LAW AND OPINION

On review, claimant seeks an assessed attorney fee under ORS 656.382(1), alleging that SAIF unreasonably resisted the payment of compensation when it issued its determination that claimant was not eligible for vocational assistance. We agree that SAIF's determination (specifically, the procedure for reaching that determination) did not conform with the administrative rules. Before a worker may be found likely eligible for vocational assistance, the insurer must possess information "sufficient to indicate the worker will probably meet the eligibility criteria under OAR 436-120-040[.]" OAR 436-120-035(2). If such information is not available, the insurer must obtain it. OAR 436-120-035(3).

Here, SAIF's vocational coordinator, Sally Villwock, first reviewed claimant's likely eligibility status because he had at least 90 days of consecutive time loss. See OAR 436-35-035(1)(c). She then determined that claimant was not eligible for vocational assistance because, based only on evidence that claimant had recently undergone surgery, Villwock found that claimant had not shown a substantial handicap to employment and that he had physical problems which would materially interfere with his ability to participate in vocational assistance. See OAR 436-120-040(3)(c), 436-120-040(4).

A medical report showing only that claimant underwent surgery is not sufficient to show that claimant would probably satisfy the criteria provided in OAR 436-35-040. Lacking sufficient information, SAIF was required to first obtain such information before determining whether claimant was likely eligible or ineligible for vocational assistance. See OAR 436-120-035(3). Consequently, we find SAIF's determination did not conform with the administrative rules and we find its determination of ineligibility to be unreasonable.

Notwithstanding this conclusion, we find no authority for awarding an assessed attorney fee under ORS 656.382(1). SAIF's action, though unreasonable, did not result in the delay of compensation since no compensation (vocational services) was due. Absent a determination that claimant is, in fact, eligible for vocational assistance, we do not find an unreasonable resistance to compensation. See e.g. Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991).

ORDER

The Referee's order dated March 8, 1993 is affirmed.

In the Matter of the Compensation of
MICHAEL A. HAGGENSON, Claimant
WCB Case No. 92-08404
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Jacques P. Deplois, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Bay Area Dispatch/Bulletin Board, the alleged employer, requests review of Referee Brown's order which set aside a Director's order that found claimant was not a subject worker. On review, the issue is subjectivity.

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

All of the persons that the employer referred to as "working partners" were employees, at least during March and April 1992, the 30-day time period prior to claimant's injury. (Tr. 8-11). The total amount paid to all the employees, including claimant, was well over two hundred dollars. Id. Accordingly, we agree with the Referee that claimant was not a casual worker. See ORS 656.027(3)(a).

Claimant's counsel has submitted a statement of services seeking an attorney fee award for services at hearing and on review. We hold that claimant is not entitled to such an award. Attorney fees may only be awarded as specifically authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). An assessed attorney fee may be awarded pursuant to ORS 656.386(1) when a claimant finally prevails over a denial of the compensability of a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988); see also O'Neal v. Tewell, 119 Or App 329 (1993); Gloria J. Shelton, 44 Van Natta 2232 (1992).¹

Here, the hearing did not pertain to a compensability denial or address the merits of the compensability of the claim. Rather, the Referee was only authorized to consider the issue of whether claimant was a subject worker at the time of his injury. OAR 438-06-038. Accordingly, claimant is not entitled to an assessed attorney fee pursuant to ORS 656.386(1) for his counsel's services at the subjectivity hearing. See John A. Coffman, 45 Van Natta 869 (1993). Furthermore, inasmuch as the Referee's order did not award compensation, claimant is not entitled to an attorney fee for services on review concerning the employer's appeal of that order. See ORS 656.382(2).

ORDER

The Referee's order dated October 14, 1992 is affirmed.

¹ Member Gunn is required by stare decisis to follow the Court's rather confusing principles on awarding attorney fees. Although this is a subjectivity case, without the excellent efforts of this attorney, claimant would have gotten nothing. I hate to see good work on behalf of claimants which aid claimants position, not be rewarded with a reasonable attorney fee award.

In the Matter of the Compensation of
EUI B. KIM, Claimant
 WCB Case No. TP-92005
THIRD PARTY ORDER
 Churchill, et al., Claimant Attorneys
 William E. Brickley (Saif), Defense Attorney

Claimant has petitioned the Board to resolve a dispute concerning the proposed settlement of a third party action. Claimant contends that the SAIF Corporation, as a paying agency, did not have authority to enter into a third party settlement on claimant's behalf because claimant had previously elected to proceed against a third party. SAIF responds that claimant elected not to proceed against the third party. We hold that SAIF was not authorized to settle claimant's third party action.

FINDINGS OF FACT

On November 10, 1988, claimant was involved in a motor vehicle accident while driving a freight truck for his employer. As a result of the accident, claimant sustained injuries to his head, neck, back, left shoulder and left hand. On November 29, 1988, SAIF, the employer's insurer, accepted claimant's injury as a nondisabling left shoulder abrasion.

On January 5, 1989, Martha Blair, SAIF Third Party Examiner, sent claimant a letter encaptioned "DEMAND FOR THIRD PARTY ELECTION" which informed claimant of his rights with regard to pursuing an action against a third party. The letter informed claimant of the following three alternatives:

- (1) You may elect to recover damages against the third party yourself; (2) You may elect to assign your rights against a third party to SAIF to pursue; or (3) You may take no action on the election in which case your cause of action against the third party is deemed assigned to SAIF by operation of law.

The letter referenced an enclosed Election Form that claimant was directed to complete and return to SAIF. The letter also informed claimant that the workers' compensation law required him to make the election within 60 days of the demand for election.

Martha Blair sent the letter by certified mail, return receipt requested to claimant's correct address. Claimant signed the return receipt on January 7, 1989. Although claimant received the letter, he did not receive the Election Form that was referenced in the letter because the form was not enclosed. In SAIF's "Record of Telephone Conversation", there is a written notation, dated January 30, 1989, which states, "-letter but no form?-form to employer."

On January 19, 1989, claimant retained Mr. Brown, attorney. On January 30, 1989, Mr. Brown spoke to Bea Anderson, SAIF claims adjuster, concerning claimant's claim. Ms. Anderson's handwritten notes of the conversation indicate that Mr. Brown informed her that he was claimant's counsel. Her notes further indicate that Attorney Brown was not "schooled" in workers' compensation law, but rather concentrated on personal injury cases.

Attorney Brown informed Ms. Anderson that he had been retained by claimant to prosecute a personal injury action against the third party. Ms. Anderson advised Brown to contact SAIF's third party claims. Attorney Brown telephoned third party claims and advised the clerk who answered the phone that he represented claimant in connection with a personal injury claim and asked that all correspondence and communication be through him. Attorney Brown was informed by the clerk that this information would be placed in claimant's file.

Thereafter, claimant's counsel was occasionally contacted by Ms. Anderson and Dee Barton of SAIF with regard to claimant's injury. A February 1989 "Real Reserve Evaluation and Analysis of Loss" prepared by a SAIF claims examiner indicated that claimant was represented for "3rd party."

On September 21, 1989, Susan Woolsey, a SAIF claims adjuster, sent claimant a letter inquiring whether claimant was still receiving medical treatment for his compensable injury. On October 5, 1989,

Attorney Brown replied to SAIF advising that claimant was still treating for his injury. The letter also confirmed that Attorney Brown's firm represented claimant in connection with a personal injury claim arising from the compensable injury. On January 22, 1990, SAIF sent claimant a letter informing him that an independent medical examination had been scheduled for February 5, 1990. The report from the independent medical examination did not issue until March 20, 1990.

On February 13, 1990, Martha Blair wrote the third party insurer. The letter indicated that SAIF had assumed claimant's cause of action and was prepared to settle the matter for the sum of \$2,752.58. The letter was not copied to either claimant or his attorney.¹ At that time, claimant's outstanding medical bills were in excess of \$10,000. A settlement for \$2,752.58 was reached in late February 1990.

By letter dated March 9, 1990, Martha Blair wrote claimant informing him that his third party case had been settled. Blair enclosed a check for \$1,000 representing claimant's share of the proceeds. Claimant returned the check to SAIF.

In November 1990, claimant filed a civil action against the third party. The civil action was placed in an inactive status pending resolution of this matter.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damage from such third person. ORS 656.578. Assuming the worker elects to pursue a third party action, the proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

The paying agency may require the worker to exercise the right of election provided in ORS 656.578 by serving a written demand upon such worker. ORS 656.583(1). Unless such an election is made within 60 days from the receipt of service of such a demand and unless, after making such election, an action against a third party is instituted within such time as is granted by the paying agency, the worker is deemed to have assigned the cause of action to the paying agency. ORS 656.583(2).

The paying agency shall allow the worker, the beneficiaries, or legal representative at least 90 days from the making of such an election to institute such action. *Id.* Pursuant to ORS 656.591, an election not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker against the third person, and the paying agency may bring an action against such third person in the name of the injured worker. SAIF v. Meredith, 104 Or App 570 (1990).

Here, by letter dated January 5, 1989, SAIF sent claimant a written demand that he exercise his right of election. Based on Martha Blair's affidavit and claimant's signature on the return receipt, we conclude that claimant received the letter on January 7, 1989.

However, we also conclude that claimant did not receive the "election form" that is referenced by the January 5, 1989 letter. We base this conclusion on claimant's un rebutted affidavit which states that he did not receive the election form and the January 30, 1989 written notation in SAIF's "Record of Telephone Conversation" which states, "-letter but no form?-form to employer." In addition, we note that in her deposition, Martha Blair acknowledged that the only evidence that the election form was sent is the notation "enclosures" on SAIF's January 5, 1989 letter. Martha Blair could not confirm that the election form was included with the January 5, 1989 letter.

Although the January 5, 1989 demand letter listed claimant's options, it also advised him that in order to choose from the options listed, claimant needed to complete the allegedly enclosed "election

¹ Attorney Brown's letters and telephone messages involving Bea Anderson and Susan Woolsey remained in SAIF's "medical claim" file and were not routed to the "third party" file. Martha Blair acknowledged that had she been aware of claimant's representation, she would not have made a settlement demand without first contacting claimant's attorney.

form.² However, as we have found above, the election form was not sent to claimant. Moreover, the letter did not inform claimant how to elect in the absence of the election form. Finally, the letter did not indicate in what manner claimant was required to provide notice of his intentions to proceed with his cause of action on his own behalf.

In other words, SAIF's notice did not state whether claimant had to notify SAIF by personal service, registered/certified mail, or by telephone. (As conceded by Martha Blair, had she known of claimant's representation by legal counsel, she would not have proceeded with the settlement negotiations without first checking with claimant's attorney). Finally, while the letter advised claimant that his election must be made within 60 days, it did not notify him that his cause of action could pass to SAIF if he did not institute civil proceedings in a timely fashion as required by ORS 656.583(2).

In addition to the incomplete demand for election, SAIF became aware that claimant had obtained representation for a third party action on January 30, 1989, when SAIF was contacted by Attorney Brown. Bea Anderson's handwritten notes of the conversation establish that Mr. Brown informed her that he was claimant's counsel.

In conjunction with Ms. Anderson's notes, Attorney Brown's un rebutted affidavit establishes that he informed Ms. Anderson that he had been retained by claimant to prosecute a personal injury action against the third party. The affidavit also establishes that on Ms. Anderson's advice, Attorney Brown telephoned SAIF's third party claims and advised the clerk who answered the phone that he represented claimant in connection with a personal injury claim and asked that all correspondence and communication be through him. Attorney Brown was informed by the clerk that this information would be placed in claimant's file.²

Finally, SAIF continued to contact Attorney Brown for information concerning claimant's injury. On October 5, 1989, Attorney Brown wrote SAIF confirming that he was representing claimant with regard to a personal injury claim arising from the motor vehicle accident. In this regard, we note that the notices and correspondence from Attorney Brown were not placed in claimant's "third party" file. Rather, they were logged into claimant's "medical claim" file. Regardless of the particular claim file into which SAIF deposited the phone messages and correspondence, the fact remains that claimant's counsel was in contact with SAIF claims examiners and advised them of claimant's legal representation for the purpose of initiating a cause of action against the third party.

Under these circumstances, we conclude that, in the absence of the referenced election form, the January 5, 1989 letter is not an adequate written demand under ORS 656.583(1). Since we do not find that SAIF's demand was adequate, the 60-day time period for claimant to elect was not triggered. Consequently, there was no assignment "deemed" by claimant's failure to respond.

Alternatively, we further conclude that, as of January 30, 1989, SAIF was aware that claimant had elected to pursue a third party action through its contacts with Attorney Brown. This representation was further documented through Attorney Brown's letter of October 5, 1989 to SAIF. Thus, despite SAIF's inadequate notice, claimant elected to pursue his cause of action within 60 days.³

² The original affidavit submitted by Attorney Brown was unsigned. SAIF noted this fact and requested that the affidavit be fully executed. Thereafter, Attorney Brown submitted a signed copy of his affidavit. Since SAIF has neither contested the assertions contained in Brown's affidavit nor objected to this recent execution version of the affidavit, we have considered it during our review. Nevertheless, the facts contained in Attorney Brown's affidavit are consistent with Bea Anderson's handwritten notes which are already in the record. Therefore, we would reach the same conclusions regarding SAIF's knowledge of claimant's legal representation and his intentions regarding his third party claim even without considering Attorney Brown's affidavit.

³ In addition to requiring that a worker make an election within 60 days of written demand by the paying agency, ORS 656.593(1) provides that the paying agency shall allow the work at least 90 days from the making of such election to institute a cause of action. The provision does not set a time limit or provide for any consequences if the worker does not institute a cause of action within 90 days.

We have found herein that claimant elected to pursue a cause of action as of January 30, 1989. However, claimant did not institute that cause of action until November 1990. As noted above, claimant is not required to institute his cause of action within a prescribed time limit. Rather, a paying agency is required to allow at least 90 days for a worker to institute a cause of action. In this regard, we note that SAIF did not advise claimant or his attorney of its intended settlement nor did it provide claimant or his attorney with a copy of the settlement letter to the third party insurer. Under such circumstances, we conclude that claimant's failure to institute a third party cause of action until some 22 months after SAIF's notice of election, does not preclude him from prosecuting his third party claim.

We find this situation analogous to EBI Companies v. Cooper, 100 Or App 246 (1990). In Cooper, the court affirmed the Board's order which invalidated an assignment of third party rights, from the claimant to the paying agency, on the basis that the election form provided by the paying agency was misleading. Here, claimant was not even provided with an election form. Therefore, as is in Cooper, there was no valid assignment of third party rights.

We find therefore, that SAIF was without authority to enter into a settlement agreement with the third party's insurer. Accordingly, we hold that claimant is entitled to proceed with his cause of action against the third party.

IT IS SO ORDERED.

December 8, 1993

Cite as 45 Van Natta 2327 (1993)

In the Matter of the Compensation of
MONTY L. LEWIS, Claimant
WCB Case No. C3-02908
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Robert E. Nelson, Claimant Attorney
Lundeen, et al., Defense Attorney

On November 8, 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 right to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On November 15, 1993, the Board requested that the parties submit an addendum clarifying the footnote on page 4 of the CDA which referenced "Bills to Be Paid" to certain hospitals. Specifically, we stated that the footnote could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245. See Marilyn London, 43 Van Natta 1689 (1991). In London, the agreement provided that claimant would pay outstanding medical bills from settlement proceeds. We disapproved that agreement, holding that, by agreeing to pay the bills from settlement proceeds, claimant was effectively relinquishing her claim for medical benefits. Marilyn London, 43 Van Natta at 1690.

On November 26, 1993, the Board received the parties' Addendum to Claim Disposition Agreement. The addendum did not state that the above-noted footnote should be removed from the CDA. Rather, the addendum stated that the note concerning payment of hospital bills did not affect claimant's right to medical services under ORS 656.245, nor did the addendum alter the total amount of the CDA, specifically \$18,500, \$15,500 of which will be paid to claimant and \$3,000 to claimant's attorney. The addendum did, however, state that said bills were to be paid through claimant's attorney's trust account "from the sums received." (P. 1, line 23-25).

In light of the fact that the addendum provides that the hospital bills will be paid from the sums received, we continue to hold (notwithstanding the parties' assertions to the contrary) that claimant is effectively relinquishing his right to have bills for his medical services paid by his insurer. As such, the CDA has the effect of limiting claimant's right to medical services under ORS 656.245. Accordingly, for that reason, we conclude that the portion of the CDA referring to payment of hospital bills is unreasonable as a matter of law.

We note, however, that although a CDA is not a proper method of disposition under the circumstances, if these medical bills are actually disputed, the parties are not precluded from entering into a separate Disputed Claim Settlement/stipulation addressing those disputed matters. See William L. Durbin, 45 Van Natta 397 (1993); see Frederick M. Peterson, 43 Van Natta 1067 (1991).

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 (1990). Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

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

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

IT IS SO ORDERED.

December 8, 1993

Cite as 45 Van Natta 2328 (1993)

In the Matter of the Compensation of
VICKIE S. MOORE, Claimant

WCB Case No. 92-10262

ORDER ON REVIEW

David C. Force, Claimant Attorney

Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of Referee Black's order that dismissed her request for hearing regarding a Director's order under ORS 656.327(2) on the ground that the request was premature. On review, the issue is the propriety of the Referee's Order of Dismissal.

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

We acknowledge that prior Board and court decisions have held that parties may proceed to a hearing on cases involving a premature hearing request when a party fails to object or request a continuance. See Thomas v. SAIF, 64 Or App 193 (1983); Jeffrey K. Stafford, 42 Van Natta 251 (1990). In the present case, however, the insurer's October 30, 1992 correspondence to the Referee specifically objected to claimant's proceeding to hearing concerning the Director's August 4, 1992 order. In its letter, the insurer stated that the basis for its Motion to Dismiss was that, "claimant's (August 6, 1992) Request for Hearing was premature and therefore insufficient to vest jurisdiction within the Hearings Division" because the Director's order did not become final until 10 days after its issuance (assuming that the Director did not abate, reconsider, or otherwise modify the decision within that 10-day period).

Under the circumstances, we find this case to be distinguishable from Thomas, supra, and Stafford, supra. In those cases, it was proper for the parties to have proceeded to hearing as there was no objection based upon a premature request for hearing. In the present case, however, the insurer has opposed proceeding to hearing and, from the outset, has contended that claimant's request for hearing was premature. Therefore, we find no "waiver" of procedural errors which would have permitted claimant to proceed to hearing over the insurer's objections. Thomas v. SAIF, supra.

Finally, we note that amendments and supplements to hearing requests are freely allowed up to the time of hearing. OAR 438-06-031. In this case, however, we find no evidence that claimant's attorney sought to amend or supplement the original request for hearing once the Proposed Order became final. Rather, claimant's attorney based his contention regarding jurisdiction upon an argument that ORS 656.327(2) provides that an "order" may be appealed. In other words, claimant's attorney argued that the statute did not specifically require the "order" to be a "final" order.

Under such circumstances, we are unable to find evidence that claimant sought to amend or supplement her request for hearing once the Proposed Order became final; i.e. 10 days after its issuance. In reaching this conclusion, we note that the parties have apparently operated under an assumption that a hearing request must be filed within 30 days of a Director's order issued under ORS 656.327(2). However, the 30-day appeal period pertains to Director's orders finding no bona fide dispute under ORS 656.327(1)(b). Unlike Section (1)(b), Section (2) pertaining to bona fide orders contains no specific time period within which a party must seek a hearing. Since claimant did not amend or supplement her hearing request to include an appeal of the Director's order subsequent to the expiration of the 10-day period, we need not address the question of whether a supplemented hearing request would be "timely" filed under ORS 656.327(2).

ORDER

The Referee's order dated January 13, 1993 is affirmed.

December 8, 1993

Cite as 45 Van Natta 2329 (1993)

In the Matter of the Compensation of
ROBERT C. TRAIN, Claimant
WCB Case No. 92-11666
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of those portions of Referee Quillinan's order that: (1) upheld the self-insured employer's partial denial of his current right knee condition; (2) upheld the employer's "de facto" denial of his left shoulder condition; (3) declined to assess a penalty for the employer's allegedly unreasonable denial of the right knee condition; and (4) declined to assess a penalty for the employer's allegedly unreasonable denial of his left shoulder condition. The employer cross-requests review of those portions of the Referee's order that: (1) assessed a penalty for its unreasonable delay in denying the right knee condition; and (2) assessed a penalty-related attorney fee for its unreasonable failure to accept or deny the left shoulder condition. On review, the issues are compensability, penalties and attorney fees.

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

Contrary to the Referee's opinion, ORS 656.005(7)(a)(B) does not require a claimant to prove that the compensable injury is the major contributing cause of a pathological worsening of the preexisting condition. ORS 656.005(7)(a)(B) applies where a compensable injury combines with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment. In order to obtain further compensation for disability or a need for treatment resulting from a combination of the injury and the preexisting condition, the claimant must show that the injury is the major contributing cause of the resultant disability or need for treatment. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594 (1993).

Here, we agree with the Referee's finding that claimant's compensable injury in February 1992 combined with his preexisting degenerative knee condition (chondromalacia) to cause his current need for treatment of the right knee. Therefore, claimant has the burden of proving that the compensable injury is the major contributing cause of his resultant need for treatment. See id. Like the Referee, we find that Dr. Woolpert's opinion is more persuasive than that of Dr. Warren and, hence, conclude that claimant has not sustained his burden of proof.

Finally, claimant requests an assessed attorney fee for his counsel's services in defending against the employer's cross-appeal on the penalty and attorney fee issues. However, inasmuch as penalties and attorney fees are not compensation, claimant's counsel is not entitled to an attorney fee under ORS 656.382(2) for defending on those issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated January 28, 1993 is affirmed.

In the Matter of the Compensation of
FRANK L. TAYLOR, Claimant
WCB Case No. MS-93001
ORDER ON RECONSIDERATION
Francesconi, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Claimant requests reconsideration of our November 23, 1993 order which: (1) set aside the Director's order under ORS 656.327(1)(b) that found no bona fide medical services dispute; and (2) remanded the case to the Director for further proceedings. Claimant contends that in initially requesting Director review of this medical treatment dispute he actually did not "wish" such a review, but instead desired to have the dispute resolved before the Board's Hearings Division. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). Consequently, claimant asks that we remand this case to the Hearings Division.

As noted in our prior order, our review authority is set forth in ORS 656.327(1)(b). We are authorized to set aside or remand the Director's order only if we find that the order is not supported by substantial evidence. Id. The statute does not contain a provision such as that in ORS 656.295(5), which allows the Board to "remand" the case to a referee if the case has been improperly, incompletely, or insufficiently developed. Rather, our "remand" authority under ORS 656.295(5) is expressly confined to our review of a referee's order issued pursuant to ORS 656.289(3). Since we are conducting our review pursuant to ORS 656.327(1)(b), our authority is limited to either affirming the Director's order or setting the order aside and remanding the case to the Director. Thus, we are not empowered to grant claimant's request to remand this case to the Hearings Division. Because this case is being remanded to the Director, claimant may wish to direct his arguments to that forum or, in the event that the Director subsequently issues an order under ORS 656.327(2), to a referee should claimant request a hearing from that later Director's order.

Accordingly, we withdraw our November 23, 1993 order. On reconsideration, as supplemented herein, we republish our November 23, 1993 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHERRY A. YOUNG, Claimant
WCB Case No. 91-12999
ORDER ON RECONSIDERATION
Callahan & Stevens, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

On October 29, 1993, we withdrew our September 30, 1993 order that affirmed a Director's order under ORS 656.327 which found that claimant's proposed surgery (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1) was not appropriate. We took this action to consider claimant's motion for reconsideration and to seek the parties' respective positions regarding the effect several recent court decisions had on this dispute. Having received the parties' responses, we proceed with our reconsideration.

We briefly summarize the relevant facts. In April 1991, the SAIF Corporation referred claimant's authorization request for low back surgery to the Director under ORS 656.327. In August 1991, the Director held that the proposed surgery (bilateral laminotomies with excision of the L4-5 disc and interbody fusion of L4-5 and L5-S1) was not appropriate.

Claimant requested a hearing regarding the Director's order. In addition to seeking the overturning of the Director's order, claimant asserted that the proposed surgery was reasonable and necessary. Reasoning that the Director lacked authority under ORS 656.327 for proposed treatments, the Referee set aside the Director's order. Finding that the proposed surgery was reasonable and necessary treatment, the Referee directed SAIF to authorize the proposed surgery. Finally, the Referee awarded claimant an insurer-paid attorney fee.

SAIF requested Board review of the Referee's order. While that appeal was pending, the Director issued a second order under ORS 656.327. Based on additional medical evidence supporting claimant's need for low back surgery, the Director found the proposed surgery (discectomy with interbody fusion of L4-5) to be appropriate. SAIF was directed to provide reimbursement for the expenses from the proposed surgery. The Director's second order was not appealed and the surgery was performed.

On review of the Referee's order, we held that our jurisdiction over the first proposed surgery dispute was limited to a "substantial evidence" review of the first Director's order under ORS 656.327. We relied on Kevin S. Keller, 44 Van Natta 225 (1993), which held that the Director review procedures in ORS 656.327 were applicable to disputes concerning proposed medical treatment. Reviewing for substantial evidence, we affirmed the Director's order which found that the first proposed surgery was inappropriate.

In reaching our conclusion, we declined to address SAIF's contention that the Referee had erred in admitting additional medical reports not considered by the Director. Even if these reports were considered, we reasoned that the Director's decision was supported by substantial evidence.

Finally, we emphasized that our decision had no effect on the second Director's order finding that the subsequent surgery request was appropriate. Since our review was limited to a review of the Director's order pertaining to the first surgery request, we concluded that we were obligated to perform that review.

Thereafter, claimant requested reconsideration of our decision. Asserting that the Director's order was not supported by substantial evidence, claimant contended that the Director's order must be set aside. Also, subsequent to our order, the court issued its opinion in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), which held that the process of Director review under ORS 656.327 does not apply to requests for future medical treatment and that the Hearings Division and the Board have jurisdiction to resolve disputes concerning proposed medical treatment.

In light of claimant's motion and the Jefferson holding, we withdrew our order and granted each party an opportunity to submit a supplemental brief. In addition, we asked the parties to respond to the following inquiry. In light of claimant's subsequent low back surgery, does the proposed surgery request remain pending? In other words, would a determination that the proposed surgery is appropriate result in further surgery? Having received the parties' respective responses, we proceed with our reconsideration.

As previously noted, the Jefferson court has considered the Director's jurisdiction to review proposed medical treatment disputes under ORS 656.327. Reasoning that the statute expressly applies only to treatment that the claimant "is receiving" at the time Director review is requested, the court has held that Director review under ORS 656.327(1) does not apply to requests for future medical treatment. Moreover, the Jefferson court has determined that the Hearings Division and Board have jurisdiction to resolve such disputes. Id. at 466-67.

Here, the dispute at hearing pertained to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, supra, SAIF was not entitled to Director review of the proposed surgery under ORS 656.327. Rather, the Referee had jurisdiction to resolve the dispute. Consequently, neither the Referee's nor our review is limited to "substantial evidence."

When it is apparent that parties were presenting their respective positions regarding a proposed medical treatment dispute under a "substantial evidence" standard of review, we have previously held that it is appropriate to remand for further development of the record. See Lynda M. England, 45 Van Natta 2191 (1993); Peter Britz, 45 Van Natta 2187 (1993). However, in the England and Britz decisions, neither testimony nor written evidence other than that presented to the Director was submitted at the hearing.

Here, in contrast, additional testimonial and documentary evidence was offered by claimant and admitted by the Referee. In light of its position that the record was confined to that developed before the Director, SAIF did not present further evidence. Considering such circumstances, we would generally find it appropriate to remand for additional evidence taking. England, supra; Britz, supra. Nevertheless, such an action is unnecessary because the surgery dispute which was previously viable before the Referee no longer exists.

As previously discussed, following the Referee's order, SAIF submitted another low back surgery request to the Director. Finding the proposed surgery appropriate, the Director ordered SAIF to provide reimbursement for claimant's surgery expenses. That Director decision was not appealed and the surgery was performed.

In response to our abatement order, claimant concedes that her need for surgery following the Referee's order has been resolved. Specifically, she acknowledges that "[a] determination by the Board that the proposed surgery is appropriate should not result in further surgery since the surgery has already been performed." Yet, contending that the Director's subsequent decision should have no bearing on this case, claimant asserts that our review should continue.

We agree with claimant that we retain authority to conduct our review of the Referee's order. Nonetheless, when a justiciable controversy no longer remains for our resolution, that review is significantly altered. In other words, our review extends to a conclusion that the issue submitted for our determination has become moot as a result of subsequent events.

In reaching this conclusion, we acknowledge that, in our prior order, we reasoned that we were obligated to conduct our review notwithstanding the second Director's order. However, we based our prior reasoning on the premise that we were reviewing the Director's first order for "substantial evidence" and that the record was limited to that pertaining to the first surgery request. In light of Jefferson, since this dispute pertains to a proposed surgery, it is apparent that our review is not subject to such restrictions. Likewise, it has been further clarified that additional surgery (other than that which was conducted following the second Director's order) will not be performed regardless of our decision.

Based on such circumstances, we hold that the Director's second order finding the proposed low back surgery to be appropriate and the ensuing events (no appeal from that order, the performance of that surgery, and the parties' acknowledgment that further surgery will not result from our decision) have rendered the "issue" presently before us moot.

Finally, even if we were to consider the merits of the "moot" surgery dispute and even if we found the surgery to be appropriate, claimant would not be entitled to an attorney fee award under ORS 656.386(1). In SAIF v. Allen, 124 Or App 183 (1993), the court held that a claimant is entitled to an attorney fee award under ORS 656.386(1) if the compensability of the claimant's injury is at issue and the claimant finally prevails from an order or decision denying that claim for compensation.¹

¹ Member Gunn is bound by stare decisis to follow the Court's holding in Allen supra. However, I believe that holding to be incorrect because medical services are compensation under the Act.

In Allen, the dispute pertained to unpaid medical bills. Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute." Inasmuch as the compensability of the claimant's injury was never disputed, the Allen court concluded that her attorney was not entitled to an attorney fee award under ORS 656.386(1).

This case involves the propriety of a proposed surgery, whereas Allen pertained to unpaid medical bills. Nevertheless, as in Allen, there is no dispute concerning whether the proposed surgery is causally related to claimant's compensable injury. Since the "compensability" of the proposed surgery is not the subject of the hearing, claimant would not be entitled to a carrier-paid attorney fee award under 656.386(1) even if we were to conclude that the surgery was appropriate.

Accordingly, based on the aforementioned reasoning, we hold that the proposed surgery dispute in this case has been rendered moot. Therefore, in lieu of our September 30, 1993 order, we vacate the Referee's November 14, 1991 order, as well as the Director's August 14, 1991 order.

IT IS SO ORDERED.

December 10, 1993

Cite as 45 Van Natta 2333 (1993)

In the Matter of the Compensation of
KENNETH W. DEVANEY, Claimant
WCB Case No. 92-03155
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Haynes.

Claimant requests review of Referee Nichols' order that upheld the self-insured employer's denial of claimant's injury claim for a left wrist condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's October 1991 left wrist strain injury at work was the major contributing cause of his subsequent need for medical services for his left wrist.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusion of Law and Opinion," except for the last paragraph, with the following supplementation.

In late October 1991, claimant was flipping sixty foot metal bars at work when he experienced the onset of pain in his left wrist. Thereafter, claimant sought medical treatment. His condition was diagnosed as a wrist strain or tendonitis. X-rays revealed that he had a gap between the scaphoid and lunate bones of his left wrist.

Claimant filed a claim for a left wrist injury, which the employer denied. A hearing was held.

The Referee found the opinion of Dr. Hales, treating physician, unpersuasive for three reasons. First, the Referee reasoned that Hales failed to adequately explain why he believes the injury caused claimant's left wrist problems, when claimant has a similar, but asymptomatic, scapholunate dissociation condition in his uninjured right wrist. Second, the Referee found that Hales failed to adequately explain why he changed his opinion concerning the significance of the injury. Third, because claimant's underlying dissociation condition is probably a congenital defect, the Referee concluded that Hales' ruling out of systemic causes is not sufficient to establish compensability. We disagree and conclude that Hales' opinion is persuasive, based on the following reasoning:

Hales initially stated that claimant's work "aggravated probably an underlying condition, the etiology of which and duration of which cannot be determined." (Ex. 54-1). Later, after claimant had undergone a "fairly exhaustive workup," and other potential causal factors had been ruled out, Hales opined that claimant's work injury accounted for his chronic left wrist problems. (Exs 57, 58). To the extent that Hales changed his opinion, we find such change reasonably explained by his ruling out previously suspected alternative causes. This had not been accomplished at the time of the initial opinion. (See Exs. 59, 61-19)).

In this regard, we acknowledge the employer's argument that claimant may not prove compensability by simply ruling out causes other than the work injury. See ORS 656.266. It is true that Hales believed that non-work causes have been ruled out. However, his conclusion that the problem is work related is also based on an accurate history regarding claimant's work and the onset of his symptoms, as well as the doctor's diagnostic expertise. Under these circumstances, we conclude that Hales did more than simply rule out noncompensable causes.

Moreover, we find Hales' opinion to be well-reasoned, particularly his explanation that claimant's left wrist is symptomatic, while his right wrist is not, precisely because only the left wrist was injured. Thus, according to Hales, only the left became "dynamically unstable" and chronically painful. (Ex. 61-21). Considering the mechanism of the injury, the immediate onset of symptoms, and the elimination of other potential causes, Hales concluded that claimant's work injury was the "major contributing factor to his wrist being symptomatic at this time." (Ex. 61-28-29). Under these circumstances, we find no persuasive reason to discount Hales' opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

Accordingly, based on Hales' essentially uncontroverted opinion (see, e.g., Exs. 54A, 60-5) that claimant's work injury caused his left wrist symptoms and need for treatment, we conclude that claimant has established that his left wrist condition is compensable. 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 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 appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 7, 1993 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's attorney is awarded an attorney fee of \$3,500, payable by the employer.

Board Member Haynes dissenting.

Dr. Hales' initial opinion that the etiology of claimant's left wrist condition "cannot be determined" is inconsistent with his subsequent theories. For example, Hales later opined that claimant's work injury caused a ligamentous injury which in turn caused the left wrist dissociation condition. This theory ignores the fact that claimant has an identical, but asymptomatic, dissociation condition in his right wrist. Moreover, Hales' eventual statement that claimant's work caused his left wrist symptoms is inconsistent with the doctor's prior statement that causation cannot be determined and the theory that the injury caused the dissociation condition. Hales never addressed or explained these inconsistencies. Under these circumstances, I would conclude, as did the Referee, that Dr. Hales' reasoning is inadequate and unpersuasive. Accordingly, I respectfully dissent.

December 10, 1993

Cite as 45 Van Natta 2335 (1993)

In the Matter of the Compensation of
ROLLAND R. DUBY, Claimant
WCB Case No. 92-04831
ORDER ON REVIEW
Francis & Martin, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial of his October 24, 1991 injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant lived in Hereford, Oregon (between John Day & Baker) at the time of hire. The employer, Patrick Kelley, has an office in La Pine, Oregon. He hired claimant to pile brush with a "cat" at several locations in the woods about 25 miles west of Sisters, Oregon.

Claimant moved to a motel in Sisters. The employer agreed to pay half of claimant's motel and gas, in addition to an hourly salary for his work operating the "cat." Claimant had to use his own pickup to get to the jobsites, where he would be working alone. Claimant was free to eat lunch where and when he chose. Claimant did not have time to buy gas after getting settled in his motel room.

On his first day of work, claimant left at daylight and returned after dark, when the gas station was closed. Claimant left at daylight the second day. After he finished at jobsite 1, he drove the cat where it was closest to jobsite 2 and left it. He planned to drive his truck to Sisters to buy gas and get his forgotten sack lunch, then return to jobsite 2, leave his truck, and walk through the woods to get the "cat" and drive it back to jobsite 2, where he would resume work. On his way to town, he skidded off the road and was injured when his truck rolled.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's motor vehicle accident did not arise out of the course and scope of his employment and was, therefore, not compensable. Claimant contends that he was a traveling employee and was not on a distinct departure on a personal errand at the time of injury. We agree and reverse.

Subsequent to the Referee's opinion, the Court of Appeals issued Proctor v. SAIF, 123 Or App 326 (1993), in which the court addressed the compensability of an injury to a traveling employee. The court held that where travel is a part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of injury. Furthermore, employees whose work entails travel away from the employer's premises are within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Proctor v. SAIF, *supra*, citing 1A Larson, Workmen's Compensation Law 5-275, §25.00

(1990). Whether a traveling employee's injury occurred during a distinct departure on a personal errand depends on whether the activity that resulted in injury was reasonably related to the travel status. The test of a reasonable relation to the travel status is whether a claimant's presence at the place of injury had a work connection, or whether it violated employer directives or was so inconsistent with the purpose of the worker's trip, or such a deviation therefrom, as to constitute an abandonment of employment. Id.

Here, the first question is whether travel was a necessary incident of claimant's employment. We conclude that it was. Claimant's home was in Hereford, Oregon. He temporarily relocated in Sisters, the nearest town to the jobsites, and had to use his own truck to travel from town to the jobsites and back again. In addition, the employer, whose office was in La Pine, Oregon, agreed to pay half of claimant's gas and motel, in addition to wages.

The next question is whether claimant's trip from the jobsites back to Sisters was a distinct departure on a personal errand. We conclude that it was not. Claimant, who was working alone and who was required to use his own truck to get to and from the jobsites, intended to go to Sisters to buy gas and to get his lunch. Claimant, who was unable to buy gas the previous night after work or in the morning before he left for the jobsites, testified to the dangers of working alone in the woods without having enough gas to get to the nearest doctor, whose office was in Bend. Furthermore, the employer expected claimant to eat lunch, either onsite or at a restaurant in Sisters. He did not tell claimant not to leave the jobsites. Thus, claimant's use of his truck to go to Sisters was reasonably related to his travel status. There is no evidence that claimant abandoned his employment or deviated from it in such a way that one could conclude that he was no longer in the course of his employment. Consequently, we conclude that claimant's injury claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$2,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 2, 1993 is reversed. The SAIF Corporation's compensability denial is set aside. The claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded \$2,500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
SEAN W. MILLER, Claimant
WCB Case No. 92-13759
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Referee Nichols' order that: (1) set aside its denial of claimant's claim for a cervical injury; and (2) awarded claimant a penalty and related attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

On review, the insurer contends for the first time that claimant's cervical condition should be analyzed pursuant to ORS 656.005(7)(a)(B). However, in her Opinion and Order, the Referee found that the "insurer conceded at hearing that if the injury occurred as claimant stated, it was within his employment." Having found claimant credible and concluding that his claim was supported by objective findings, the Referee held that claimant established compensability of his cervical injury.

We conclude that the insurer has now raised a new defense which would prejudice claimant if we resolved the case on that basis. At hearing, the insurer clarified the denial to deny "that the injury occurred as alleged or that it resulted in a compensable condition." Additionally, the insurer attempted to show at hearing that claimant was not credible and that the injury did not occur as claimed. Accordingly, we conclude that, to now decide this case on a completely different basis would be fundamentally unfair. See Greg S. Meier, 45 Van Natta 922 (1993), on recon 45 Van Natta 1015 (1993) (Board declined to consider a carrier's challenge to a claim based on insufficiency of medical evidence when the carrier had only contested the claim on "not arising out of employment" grounds at the hearing); Linda R. Burrow, 44 Van Natta 71 (1992) (Where hearing was based on denial of causal relationship, Board declined to consider a new "course and scope" defense on review). See also Mavis v. SAIF, 45 Or App 1059 (1980); Karen K. Malsom, 42 Van Natta 503 (1990).

Finally, even if we were to address this issue, we would find the insurer's contention to be without merit. Following the June 30 incident, Dr. Perlman examined claimant and diagnosed: "1. Old fracture. 2. Cervical strain." Dr. Sinnott, M.D., subsequently reported that claimant's prior cervical injury did not appear to be disrupted or altered. Additionally, in a September 28, 1992 independent medical examination report, Dr. Dickerman, M.D., reported that claimant's history, symptoms and treatment had been well described, and his specific need for treatment "was the incident of June 30, 1992."

Under the circumstances, we disagree with the insurer's contention that claimant's preexisting cervical problems combined with the injury to cause his current need for treatment. Accordingly, claimant's claim does not fall under the "preexisting" statute. We, therefore, affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of compensability, to be paid by the insurer. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) 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 claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated February 4, 1993 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$750, to be paid by the insurer.

In the Matter of the Compensation of
JOEL R. NELSON, Claimant
 WCB Case Nos. 92-07772, 92-01661, 92-01662 & 92-07589
ORDER ON REVIEW

Vick & Gutzler, Claimant Attorneys

Lundeen, et al., Defense Attorneys

Tooze, Shenker, et al., Defense Attorneys

Snarskis, Yager, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Crumme's order that: (1) upheld Hartford Insurance Company's denial of compensability and responsibility for claimant's low back and right leg condition, to include a L5-S1 disc herniation; (2) upheld Industrial Indemnity's denial of compensability and responsibility for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's denial of compensability and responsibility for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

It is claimant's position that his current low back and right leg condition, to include the L5-S1 disc herniation, is compensable. Claimant proceeds under two theories of compensability. More specifically, it is claimant's contention that his condition is compensable as an occupational disease claim for which the last insurer on the risk, here, Liberty Northwest, is responsible. ORS 656.802(2). In the alternative, claimant argues that his current low back condition is compensable as either an aggravation or as a consequential condition of claimant's compensable 1984 and/or 1986 low back claims for which Hartford Insurance Company is responsible. ORS 656.005(7)(a)(A); 656.273(1).

Occupational disease claim

We first consider whether or not claimant has a compensable occupational disease claim. In order to establish compensability of an occupational disease claim, claimant must show that work activities, i.e., a series of traumatic events or occurrences arising out of and in the course of employment, were the major contributing cause of his current condition or worsening of his underlying condition. ORS 656.802(1)(c). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See *Dethlefs v. Hyster, Co.*, 295 Or 298 (1983). Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

Claimant has experienced low back pain since 1973. In the past symptoms have been persistent, but have required no more than conservative care. In 1984 and 1986 claimant suffered two compensable low back claims. The 1986 claim aggravated in 1987. Since 1988 there has been no need for treatment or disability due to the back, with the exception of occasional chiropractic manipulation for pain. Claimant continued to perform work requiring heavy lifting and carrying.

Then, on or about October 12, 1991, claimant experienced severe right leg pain with give-way after attempting to hammer in a nail at home. He sought medical services from Dr. Rasor on October 14, 1991. (Ex. 42). A subsequent October 24, 1991 CAT scan revealed a herniated disc at the L5-S1 level. Claimant was referred to Dr. Hoppert for care, whom he saw one time on November 26, 1991.

On December 11, 1991, Western Medical Consultants opined that the major contributing cause of claimant's current condition was degenerative disc disease. In their view claimant's work activities were no more of a causal factor to his condition than the aging process. (Ex. 43). The attending physician, Dr. Rasor, agreed with this opinion. (Ex. 47).

Dr. Rosenbaum, also agreed with Western Medical Consultants insofar as work activities were not a causal factor in development of claimant's current condition. However, Dr. Rosenbaum disagreed that degenerative disc disease was the cause. It was his opinion that the need for treatment was related to the herniated disc. (Ex. 55).

Consulting physician, Dr. Hoppert, first opined that the disc herniation was a result of the 1973 injury. (Ex. 44). However, later in response to a hypothetical question by claimant's counsel, he opined that work activities in early October 1991 were the major contributing cause of claimant's current condition. (Ex. 51).

The weight of the medical evidence does not support the finding that claimant's work activities were the major contributing cause of the need for treatment in October 1991. In this regard we agree with the Referee's discussion and analysis of Dr. Hoppert's opinion and find that the other medical opinions are better reasoned and based upon a more accurate history. To conclude, we find that claimant has failed to prove a compensable occupational disease claim.

Aggravation/current condition claim

We next consider whether or not claimant has a compensable aggravation and/or current condition claim. In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273. A claim for aggravation has two components: causation and worsening. Both must be established in order for the claim to be compensable. We determine whether the current condition is compensable, and if it is, whether that condition has worsened. See Charles S. Karam, 45 Van Natta 1021 (1993).

When a condition or need for treatment is caused by the compensable industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. Whereas, when a condition or need from treatment is caused by the compensable injury, a worker must prove that the compensable injury was the major contributing cause of the consequential condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 112 Or App 411 (1992).

There is no evidence claimant's current condition arose directly from either the 1984 or 1986 compensable accidents. Nor is there evidence that the herniated disc was an indirect result or consequence of the compensable injuries. (Exs. 43, 47, 50, 57). Although Dr Hoppert opined that the 1984 and 1986 injuries "predisposed" claimant to additional injuries, this is insufficient to establish a causal relationship. (Ex. 51).

The medical record shows the 1984 and 1986 injuries resolved without permanent impairment or significant need for further treatment. Thereafter, claimant required no treatment except for an occasional chiropractic manipulation. We find claimant did not establish that either the 1984 or 1986 compensable injury was the major contributing cause of his current need for treatment and disability. See ORS 656.005(7)(a)(A).

The medical record establishes that claimant's current low back and right leg condition is due to a herniated disc at L5-S1. (Ex. 55). The lay and medical evidence further shows that the disc herniation resulted from an off-the-job incident that occurred on or about October 12, 1991 at claimant's home. Claimant's testimony supports this view. (Tr. 14-20). This was the persuasive opinion of Dr. Rosenbaum. (Ex. 57).

To the extent the record establishes that claimant's current condition resulted from an off-the-job injury, claimant also argues the aggravation claim is compensable, citing Roger D. Hart, 44 Van Natta 2189 (1992). See Fernandez v. M & M Reforestation, 124 Or App 38 (1993). In that regard, claimant has the burden of proving that the compensable 1984 and/or 1986 injury is a material contributing cause of the worsened condition. If, pursuant to ORS 656.273(1), the insurer denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the insurer has the burden of proving it. See Roger D. Hart, supra.

It is not altogether clear that Hartford denied the claim on the basis of an off-the-job injury. (Ex. 48). Assuming, however, the claim was denied on that basis, we find claimant has failed to carry his

burden of proving that either of the compensable injuries was a material contributing cause of the worsened condition. As noted above, there is no medical evidence that supports a causal connection between claimant's current condition and the compensable claims. Even assuming claimant carried this burden of showing material contributing cause, we would find that Hartford has carried its burden of proof in establishing that the off-the-job injury was the major contributing cause of the current need for treatment. (Exs. 55, 57).

Accordingly, because claimant failed to prove a sufficient causal relationship between the compensable injury and the current need for treatment, regardless of the standard, we need not further address the merits of the aggravation claim.

Responsibility

Because claimant's current condition is not compensable, the responsibility issue is not reached.

ORDER

The Referee's order dated March 1, 1993, is affirmed.

December 10, 1993 Cite as 45 Van Natta 2340 (1993)

In the Matter of the Compensation of
PATRICK H. SMITH, Claimant

WCB Case No. 91-11029

ORDER ON REVIEW

Ackerman, et al., Claimant Attorneys

Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of those portions of Referee Spangler's order that assessed it three separate 25 percent penalties based on all compensation owing under claimant's aggravation claim. Claimant seeks attorney fees under ORS 656.382(1) if the penalty assessments are reversed. 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" and "Ultimate Findings of Fact," with the following supplementation.

The insurer unreasonably resisted the payment of compensation by delaying its denial and refusing to pay interim compensation.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion," with the following modification and supplementation on pages 7 and 8.

The Referee found the insurer's delay in denying claimant's aggravation claim and its failure to pay interim compensation to be unreasonable. We agree.

In addition, the Referee awarded three penalties for three separate and distinct instances of unreasonable conduct, based on claimant's unpaid compensation. We disagree. Subsequent to the Referee's order, we held that under amended ORS 656.262(10), only one penalty may be assessed on a single amount "then due." Laurie A. Bennion, 45 Van Natta 829 (1993); see Conagra, Inc., v. Jeffries, 118 Or App 373, 376 (1993); Kim L. Haragan, 42 Van Natta 311, 313 (1990).

However, the insurer's unreasonable delay in denying claimant's aggravation claim and its unreasonable refusal to pay interim compensation constitute unreasonable conduct separate and distinct from its unreasonable denial. In addition, because we find that the delay and refusal to pay delayed claimant's compensation unreasonably, we conclude that the delay and refusal constitute an unreasonable resistance to the payment of compensation under ORS 656.382(1). Under these circumstances, claimant is entitled to an attorney fee award under that statute. See Oliver v. Nortar, Inc., 116 Or App 333 (1992); Laurie A. Bennion, *supra*.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services concerning the insurer's unreasonable resistance to the payment of compensation (untimely denial and refusal to pay interim compensation) is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and the hearing record), the complexity of the issues, and the value of the interest involved.

Claimant is not entitled to an attorney fee award for services on review concerning his successful defense of the Referee's penalty assessment regarding the unreasonable denial issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 22, 1993 is reversed in part and affirmed in part. In lieu of the Referee's penalty assessments for the insurer's delay in denying claimant's aggravation claim and its unreasonable refusal to pay interim compensation, claimant's attorney is awarded an attorney fee of \$500, to be paid by the insurer. The remainder of the order is affirmed.

December 10, 1993

Cite as 45 Van Natta 2341 (1993)

In the Matter of the Compensation of
FRANK E. STONER, Claimant
WCB Case No. 92-07883
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerland.

The insurer requests review of that portion of Referee Podnar's order that set aside its partial denial of claimant's claim for a cervical condition at C3-4. Claimant cross-requests review of that portion of the order that upheld the insurer's partial denial of his cervical conditions at C2-3 and C4-5. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured his back in a fall in August 1978. The claim was accepted and closed by Determination Order in October 1979 with no permanent disability award. By stipulation in July 1980, claimant was awarded 10 percent unscheduled permanent disability for the back condition.

Thereafter, claimant sought treatment for neck pain with radiating symptoms in the left arm. X-rays in February 1981 revealed degenerative disc disease at C3-4 and C6-7. There was considerable narrowing with osteophyte formation at C6-7, which was determined to be the cause of claimant's radiating symptoms. (Exs. 9, 10). A cervical myelogram in April 1981 confirmed nerve root compression at C6-7 due to osteophyte formation. (Ex. 13). On April 21, 1981, Dr. Miller performed disc removal and anterior fusion at C6-7. (Ex. 15).

On August 6, 1981, the insurer issued a denial letter which stated, in relevant part:

"[Y]ou have undergone surgery due to degenerative cervical disc disease. Based on medical information now available to us, we do not feel that your cervical problems are related to your work injury of August 11, 1978, and therefore we will not pay for medical treatment or time-loss benefits due to the cervical condition." (Ex. 18).

Claimant timely requested a hearing concerning the denial. By Stipulated Settlement Order dated May 17, 1982, the insurer agreed to "withdraw its notice of partial denial dated August 6, 1981 and provide benefits for Claimant's cervical condition as required by law." (Ex. 23).

Claimant continued to have cervical symptoms, including headaches and left shoulder pain. He underwent two additional surgeries at the C6-7 level. A myelogram and CT scan in March 1992 revealed abnormalities at C2-3, C3-4 and C4-5 due to degenerative disc disease, with the greatest abnormality at C3-4 (Exs. 79, 80). In April 1992 Dr. Miller requested authorization for decompression surgery at all three cervical levels. (Ex. 81). On June 8, 1992, the insurer issued a letter denying the compensability of claimant's cervical condition and need for surgery. (Ex. 83).

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the June 8, 1992 partial denial insofar as it denied the C3-4 condition, but concluded that claimant had not proved the compensability of the C2-3 and C4-5 conditions. On review, claimant argues that the May 17, 1982 stipulation bars the insurer from denying any portion of his cervical condition. We disagree.

By the May 17, 1982 stipulation, the insurer agreed to "provide benefits for Claimant's cervical condition as required by law." However, that phrase must be read in its proper context; it follows the insurer's express agreement to "withdraw its notice of partial denial dated August 6, 1981." When the stipulation is read as a whole, it is clear that the "cervical condition" for which the insurer agreed to pay benefits was the same condition which it had previously denied on August 6, 1981. Therefore, we turn to the August 6, 1981 denial to determine what "cervical condition" the insurer had agreed to accept.

The August 6, 1981 denial letter stated that claimant had undergone surgery for degenerative cervical disc disease but that his "cervical problems" are not related to the compensable injury; therefore, the insurer declined to pay for treatment and disability due to the "cervical condition." (Ex. 18). At the time the denial issued, the only "cervical condition" for which claimant had undergone surgery was the degenerative disc disease at C6-7 only. (Ex. 15). No treatment was required for any other cervical condition. Although x-rays had revealed degenerative disc disease at C3-4, there is no indication that the disc disease at C3-4 was symptomatic or required treatment. Indeed, the contemporaneous medical evidence attributed the cervical symptoms solely to the disc disease at C6-7. (Exs. 10, 12, 16, 17).

Accordingly, we find that the "cervical condition" for which the insurer had agreed to provide benefits was the degenerative disc disease at C6-7. Therefore, we conclude that the May 17, 1982 stipulation did not bar the insurer from denying the compensability of claimant's cervical conditions at C2-3, C3-4 and C4-5.

On the merits of the June 8, 1992 denial, we agree with and adopt the Referee's conclusion that claimant has proved the compensability of his current condition at C3-4. However, we disagree with the Referee's reasoning that, because the insurer had accepted claimant's degenerative disc disease at C3-4 in the May 17, 1982 stipulation, the "material contributing cause" test applies. As we concluded above, the insurer accepted only the C6-7 condition.

We do not find that claimant's current cervical conditions were directly caused by the industrial accident in August 1978. Following the accident, claimant was diagnosed with a lumbosacral strain. (Ex. 1). Cervical x-rays in March 1979 were normal. (Ex. 4-4). At that time, claimant was diagnosed with a chronic thoracic strain. (*Id.*) Claimant was first diagnosed with a cervical condition in February 1981, when x-rays revealed degenerative cervical disc disease. (Ex. 10).

On this record, we find that claimant's cervical conditions developed sometime after the 1978 injury. We conclude, therefore, that claimant must prove that his current cervical conditions are a compensable consequence of the 1978 injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Under ORS 656.005(7)(a)(A), claimant has the burden of proving that his 1978 injury was the major contributing cause of his cervical conditions.

Claimant has sustained his burden of proof concerning the C3-4 condition. Dr. Miller, the treating neurosurgeon, opined that the C3-4 condition is related to the 1978 injury. (Exs. 88, 89-8, 89-9). He based his opinion on his finding that claimant already had an abnormality at that level at the time of the first surgery in 1981. (Ex. 89-9). Dr. Kadwell, treating osteopath, agreed with Dr. Miller's opinion. (Ex. 86, 86A-22). Dr. Rosenbaum, examining neurosurgeon, opined that there was no relationship between the current cervical condition and the 1978 injury, reasoning that the the current condition is located in the upper cervical spine, whereas claimant's previous pathology and surgery (fusion) was directed toward the C6-7 level. (Ex. 82-5). However, Dr. Rosenbaum later conceded that a fusion at one area of the spine could put additional stresses on other areas of the spine, thus accelerating the degenerative process. (Ex. 87-7).

When medical evidence is divided, we generally accord greater weight to the treating physician's opinion, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We do not find any persuasive reason not to defer to Dr. Miller's opinion. As claimant's treating neurosurgeon, he had a better opportunity to evaluate claimant's condition than Dr. Rosenbaum, who saw claimant only once. Moreover, although Dr. Miller did not use the words "major contributing cause," such "magic words" are not required. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Based on Dr. Miller's opinion, we are persuaded that the 1978 injury was the major contributing cause of claimant's C3-4 condition.

We are not persuaded, however, that claimant has sustained his burden of proving that the 1978 injury was the major contributing cause of his C2-3 and C4-5 conditions. In this regard, we again rely on the opinion of Dr. Miller, who stated that the C2-3 and C4-5 degenerative conditions did not result from the injury. (Ex. 89-10). Accordingly, those conditions are not 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 compensability of the C3-4 condition issue is \$1,200, 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 February 18, 1993 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
JULIE STURTEVANT, Claimant
 WCB Case No. 92-12203
 ORDER ON REVIEW
 Hollis Ransom, Claimant Attorney
 Jeff Gerner (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Crumme's order which affirmed a Director's order finding that claimant's AZT drug treatment was not appropriate. On review, claimant contends that: (1) the Referee erred in finding that the Director's order was supported by substantial evidence; (2) the Referee erred in excluding evidence submitted by claimant at the hearing, including claimant's testimony; and (3) the Director's order was defective because it was made upon the recommendation of a registered nurse, rather than a physician. On review, the issues are evidence and review of a Director's order in a medical treatment dispute. We affirm.

FINDINGS OF FACT

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

Based on evidence presented at the hearing before the Referee, we make the following additional findings.

8. It was the policy of the employer, Eastern Oregon State Hospital-Training Center, not to determine the HIV status of previously untested patients in cases like this one, and the source patient was unable to consent to HIV testing. (Ex. 3-2; Tr. 23).

9. In Dr. Marier's opinion, the source patient's blood should be treated as HIV positive. (Ex. 3-1).

10. Dr. Marier relied on the assessment of claimant, a registered nurse, that she had a significant parenteral exposure to contaminated blood as a result of the December 1991 work incident, in his decision to begin AZT therapy. (Ex. 3-1).

11. In Dr. Marier's opinion, the prophylactic effectiveness of AZT treatment has not been proven, nor has any AZT treatment protocol been proven more effective than another. (Ex. 3-1).

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

At hearing, SAIF moved to strike claimant's testimony and to exclude a September 30, 1992 report by Dr. Marier, claimant's treating physician, on the ground that any evidence submitted at the hearing was not part of the record considered by the Director and, therefore, was not relevant to the Referee's review. The Referee granted SAIF's motion, relying on our decision in Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993). Claimant contends that our decision in Payne-Carr was erroneous, and that the Referee erred in excluding the evidence she offered at hearing. We agree with claimant.

In Payne-Carr, we considered the appropriate scope of review by a referee when a party requests a hearing from a Director's order regarding a medical services dispute, pursuant to ORS 656.327(2). We interpreted the provisions of ORS 656.327(2) as limiting review of the Director's order to the record developed before the Director. Iola W. Payne-Carr, supra, 45 Van Natta at 336. In doing so, we found the statutory language "plain and unambiguous" regarding the meaning of "the record" for the purpose of substantial evidence review. Id. at 335. Accordingly, in Payne-Carr, we concluded that "the record" under ORS 656.327(2) consists only of the record developed before the Director, and we affirmed the Referee's order excluding evidence offered at the hearing on review of the Director's order.

However, in light of the Supreme Court's recent decision in Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993), we believe it is appropriate to reexamine our decision in Payne-Carr. In Colclasure, the court construed ORS 656.283(2) and considered the proper scope of a referee's review of a Director's order regarding entitlement to vocational services. Reversing the Court of Appeals' decision which affirmed our order in Colclasure v. Wash. County School Dist. No. 48-J, 117 Or App 128 (1992), the Supreme Court held that when a party requests a hearing to review a Director's vocational assistance order under ORS 656.283(2), a referee is entitled to independently find facts based upon a hearing at which the parties develop a record. Noting that the Director's procedure did not provide the claimant a quasi-judicial hearing, nor did it result in a reviewable record, the Court concluded that the procedure before the referee comported with the hearing and decisional process required in a contested case, while the Director's procedure did not. The Court explained that whenever a general rule or policy is being applied to a specific individual interest in eligibility, "a more substantial hearing and decisional process" is required, including a quasi-judicial hearing, a reviewable record, and findings of fact made upon the record. Colclasure, supra, 317 Or at 535. Accordingly, the court concluded that when reviewing a Director's order under ORS 656.283(2), a referee conducts a hearing, develops a record and finds facts from which he or she determines whether the Director's order survives review, while the Board reviews the record developed by the Referee. Id. at 537.

The Court noted that although the contested case procedures of the Oregon Administrative Procedures Act (APA) do not directly apply to proceedings under ORS chapter 656, nevertheless general legal and constitutional principles require that proceedings where individual rights are decided are to be conducted substantially in the manner prescribed by the APA. Id. at 533 n.3. The Court further noted that its ruling in Colclasure followed the procedure actually used in that case, while a "different result would have been obtained had the director conducted a contested case hearing, made a record, and entered findings of fact thereon." Id. at 535 n.4.

Here, the Director's and referee's review procedures regarding a medical services dispute are set forth in ORS 656.327. In construing the statute, we follow the "usual trail" by beginning with an examination of the text and context of the statute. If the text and context are ambiguous, we look to legislative history. Finally, if those avenues do not resolve the question, we look to "other aids." See Colclasure, supra, 317 Or at 533. ORS 656.327(2) provides, in relevant part:

"The director shall review medical information and records regarding the [medical] treatment [in dispute]. * * * Review of the medical treatment shall be completed and the findings of the director shall be submitted to the parties within 30 days of the request for review. The findings of the director regarding the treatment in question shall be prepared in such form and manner and shall contain such information as the director may prescribe. Within 10 days of making the findings, the director shall issue an order based upon the findings. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a hearing on the order. * * * Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record."

First, we examine the text of the statute to determine whether a referee, upon review of a Director's order under ORS 656.327(2), may receive and consider evidence not contained in the record developed by the Director.

The statute provides that any party dissatisfied with the Director's order may request "a hearing" on the order. In Payne-Carr we dismissed the legislature's use of the term "hearing" as "grammatically incorrect." That judgment appears questionable, however, given the provision in ORS 656.327 that "[r]eview of the [Director's] order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board..." ORS 656.283(6) and (7) authorize the Board's referees to conduct a recorded hearing "in any manner that will achieve substantial justice." Inasmuch as the statute specifically refers to the hearing procedures set forth in ORS 656.283, the legislature's use of the term "hearing" in ORS 656.327 persuades us that the legislature intended referees to independently find facts based on evidence submitted at hearing.

ORS 656.327(2) also provides that the Director's order may be modified on review only if it is not supported by substantial evidence "in the record." The legislature's reference to "the record" is ambiguous; it could mean only "the record" before the Director, as we held in Payne-Carr, or it could mean "the record" developed by the referee in conducting a hearing under ORS 656.283. The text of ORS 656.327(2) provides us with no guidance in resolving this ambiguity.

We now turn to the context of the statute. The Director's and referee's review procedures under ORS 656.327(2) apply only if a party, or the Director, requests Director review of medical treatment that an injured worker is receiving, and the Director finds that a bona fide medical services dispute exists. ORS 656.327(1)(a), (b); see also Jefferson v. Sam's Cafe, 123 Or App 464 (1993); Meyers v. Darigold, Inc., 123 Or App 217 (1993). Under ORS 656.327(1)(b), appeal of a Director's order finding no bona fide medical services dispute is made directly to the Board which reviews the order based on the record developed before the Director. By contrast, under ORS 656.327(2), appeal of a Director's order in a bona fide medical services dispute is made by requesting a hearing before a referee. In both instances, however, the standard of review is substantial evidence.

The legislature could have directed appeals of Director's orders in bona fide medical services disputes to the Board, just as it did for appeals of Director's orders finding no bona fide medical services dispute. Instead, the legislature has provided a "hearing" for parties appealing Director's orders in bona fide medical services disputes. This statutory scheme persuades us that the legislature intended the "hearing" before the referee to include a full evidentiary hearing, rather than merely a review of the record developed before the Director, as is conducted by the Board in reviewing Director's orders finding no bona fide medical services dispute.¹

Finally, we turn to the legislative history of the statute. In Payne-Carr, we noted that the legislature's purpose in enacting the 1990 amendments to ORS 656.327 was to have medical treatment disputes decided by physicians rather than referees and the Board. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75. However, inasmuch as the review procedures enacted by the legislature in ORS 656.327 provide for Director, rather than physician, review, we find the legislative history unhelpful with respect to the question presented here. Further, insofar as the legislature intended to have medical treatment disputes decided by the Director, we find that such intent is largely served by the less rigorous standard of "substantial evidence" review applied to the Director's order. That is, because ORS 656.327(2) allows modification of the Director's order only if the order is not supported by substantial evidence in the record, it would appear that the vast majority of the Director's orders will not be disturbed on review.

Hence, based on the text and context of ORS 656.327(2), we conclude that the legislature intended referees to independently find facts based upon an evidentiary record developed at hearing. Even if we were to conclude that the text, context and legislative history of ORS 656.327 are ambiguous, we would apply to our construction of ORS 656.327 the general administrative law principles set forth in Colclasure.

Here, the Director developed a record consisting of medical information and records concerning the effectiveness of AZT treatment prescribed by claimant's treating physician. The Director entered findings based on that record and issued an order. However, the Director did not conduct a quasi-judicial hearing, in which the parties had the opportunity to be heard, and to present and rebut evidence, before an impartial tribunal. See Colclasure, *supra*, 317 Or at 535; OAR 436-10-046.

¹ Our conclusion in this regard is supported by other language in ORS 656.327. Section (1)(b) provides, in part: "The board shall set aside or remand the [Director's] order [finding no bona fide medical services dispute] only if the board finds that the order is not supported by substantial evidence in the record." (Emphasis supplied.) By contrast, in a bona fide medical services dispute, "the order of the director may be modified only if the order is not supported by substantial evidence in the record." ORS 656.327(2) (Emphasis supplied.) The Board is authorized only to set aside or remand a "no bona fide dispute" order, whereas the referee may modify a "bona fide dispute" order. Thus, if the Board were to receive additional evidence not considered by the Director, it would appear that the Board is authorized only to remand the "no bona fide dispute" order to the Director. The referee, on the other hand, has not been granted remand authority. Instead, the referee is authorized to modify the "bona fide dispute" order. The absence of remand authority, coupled with the authority to modify the Director's order, persuades us that the legislature contemplated that referees would consider evidence submitted at hearing, which was not previously considered by the Director.

A hearing was conducted by the Referee pursuant to ORS 656.283, upon claimant's request for a hearing under ORS 656.327(2). At the hearing, the Referee received evidence under an offer of proof, but granted SAIF's motion to exclude the evidence. However, consistent with the Supreme Court's decision in Colclasure, we find that the hearing envisioned under ORS 656.327(2) supplements the procedure before the Director, thereby affording the parties the full "contested case" procedure required by the Colclasure decision. Accordingly, we conclude that the evidence offered at the hearing should have been received. Therefore, we reverse the Referee's evidentiary ruling and admit into the record claimant's hearing testimony, as well as Dr. Marier's September 30, 1992 report, identified as Exhibit 3.

We recognize, as the dissent points out, that the medical dispute resolution procedure before the Director, as set forth in ORS 656.327, differs considerably from the Director's review of entitlement to vocational services under ORS 656.283(2). Nevertheless, under both statutes, there is no opportunity for a hearing before the Director. Under both statutes, that opportunity only exists when a party requests a hearing on the Director's order. Particularly in light of the Colclasure decision by the Supreme Court, we have construed the term "hearing" in ORS 656.327(2) to mean the opportunity to present and rebut evidence, including testimonial evidence, before an impartial tribunal, and the term "record" to include evidence submitted before the referee. In doing so, we believe that an individual's interest in eligibility for medical services requires no less than as substantial a hearing and decisional process as a determination of eligibility for vocational services. Indeed, we believe the proceeding under ORS 656.327, in which an individual's entitlement to medical services is at stake, presents an even more compelling basis for the development of a hearing record.

Accordingly, we disavow our contrary holding in Iola W. Payne-Carr, supra. Instead, we conclude that when a party requests a hearing under ORS 656.327(2) to contest a Director's order in a medical services dispute, the referee is to conduct a hearing under ORS 656.283 at which the parties may present evidence, including testimony, and the referee finds facts from which to conclude whether the Director's order is supported by substantial evidence in the whole record. See ORS 656.327; Colclasure, supra, 317 Or at 537. If a party requests Board review, we review the record developed by the Referee and determine whether substantial evidence supports the Director's order. Id. Accordingly, we proceed with our review.

Substantial Evidence Review

Pursuant to ORS 656.327(2), 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. Astén-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).

In addition to the evidence considered by the Referee, which consisted of the record developed by the Director, we also consider the testimony and evidence offered by claimant at the hearing.

The Referee concluded that the Director's order finding that AZT drug treatment was not appropriate in this case was supported by substantial evidence, based on the following facts:

1. In the December 5, 1991 work incident, the clothing on claimant's forearm was soaked with the blood of a patient who had risk factors for being infected with HIV virus; however, the source patient was never tested to determine if he was actually infected. (See Ex. 1-14, 1-19).
2. At the time of exposure, claimant had numerous healing cuts on her forearm, but none was likely open and bleeding. (Ex. 1-14).
3. Tests of claimant on December 11, 1991 and March 12, 1992 were negative for the HIV virus. (Ex. 1-15).
4. Dr. Loveless, an expert in HIV virus treatment, opined: (1) AZT therapy should only be used where there is a definable risk of HIV exposure, due to the toxicity of AZT; (2) the source of potential HIV exposure should be tested and AZT therapy begun only if the source is positive; (3) the risk of claimant contracting HIV virus under the circumstances of the December 5, 1991 incident were less than 0.01 percent; (4) the prophylactic efficacy of AZT therapy is reduced and speculative where the treatment is begun more than one hour after exposure; and (5) prophylactic AZT therapy should be discontinued after four weeks. (Ex. 1-17 to 1-18).

5. Dr. Marier conceded that he probably would not have instituted AZT therapy had he been aware at the time of the information related in Dr. Loveless' opinion. (Ex. 1-25).

After our review of the record, including the evidence developed at hearing, we agree that the Director's order is supported by substantial evidence in the record. Considering both supporting and countervailing evidence, we conclude that the record as a whole would permit a reasonable person to make a finding that the AZT therapy was not appropriate in this case. In this regard, we note that Dr. Marier's September 30, 1992 report does not directly contradict Dr. Loveless' opinion. For example, Dr. Marier explained why the source patient's blood will not be tested and opined that it should be treated as if it were HIV positive, while Dr. Loveless recommended AZT therapy only if the source is actually tested positive for HIV. (Exs. 1-17 to 1-18, 3). However, Dr. Loveless assumed the source patient tested positive for HIV and nevertheless recommended against AZT therapy in this case. (Ex. 1-17). Thus, although there is both medical and lay evidence supporting the reasonableness of Dr. Marier's decision to begin AZT therapy in December 1991, there is also medical evidence from Dr. Loveless supporting the Director's conclusion that AZT treatment was not appropriate in this case. Accordingly, we affirm the Director's September 10, 1992 order.²

Validity of the Director's Order

Claimant also contends that the Director's order is "fatally flawed" and inconsistent with ORS 656.327, because the review was not performed by a physician. The Director's "Proposed and Final Order Concerning a Bona Fide Medical Services Dispute" was prepared by a registered nurse, who is a medical reviewer for the Medical Review Unit of the Workers' Compensation Division of the Department, and issued under the Director's name. (See Ex. 2). We find no error in the Director's order.

ORS 656.327 establishes a procedure for director review of medical services. When the director finds that a bona fide medical services dispute exists, ORS 656.327(2) provides that the director shall review medical information and records and make findings regarding the treatment in question. In addition, the director may "cause an appropriate medical service provider to perform reasonable and appropriate tests . . . upon the worker and may examine the worker." ORS 656.327(2).

Under ORS 656.327(2), the plain language of the statute authorizes the director to conduct the review and make findings. The "director" is the Director of the Department of Insurance and Finance. ORS 656.005(11). The director need not be a physician, and typically is not. Nothing in the plain language of the statute limits the Director's inherent authority to delegate the actual review function to appropriate personnel in the agency. In addition, under ORS 656.327(2), the Director has the discretion to direct "an appropriate medical service provider" to perform tests upon the worker and examine the worker, but the Director is not required to do so. See also OAR 436-10-046.

Under ORS 656.327(3), however, either party may request the Director to delegate review of the medical treatment dispute to a panel of physicians. There is no evidence that either party requested review by a panel of physicians in this case. Accordingly, we find no error in the Director's order in this case being prepared by a registered nurse medical reviewer in the Medical Review Unit of the Department.

ORDER

The Referee's order dated December 30, 1992 is affirmed.

² We note that ORS 656.327(2) provides that when the director finds medical treatment is not compensable, the worker is not obligated to pay for such treatment.

Board Member Gunn specially concurring.

I agree that a referee must conduct a full evidentiary hearing when reviewing a Director's medical treatment order under ORS 656.327(2). I write separately, however, to explain that my decision to disavow Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993), is based entirely on the Supreme Court's holding in Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993).

Board Member Hall specially concurring.

While Colclasure v. Wash. County School Dist. No. 48-I, 317 Or 526 (1993) may give the Board (with two new members, including this one) reason or occasion to revisit and rethink Iola W. Payne-Carr, 44 Van Natta 2306 (1992), on recon 45 Van Natta 335 (1993), the majority's evidentiary ruling in the instant case (with which I concur and whereby we disavow the prior holding in Payne-Carr) need not depend upon an application or expansion of Colclasure. After all, ORS 656.327(2) dictates: "Review of the [Director's] order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board...."

The right to a full evidentiary hearing (with development of a record) is more explicit under ORS 656.327(2) than that provided for vocational assistance disputes under ORS 656.283(2). While Colclasure required a search down the "usual trail" and a study of the broader administrative law context, the instant case under ORS 656.327(2) does not. The right to a full evidentiary hearing (with development of a record) is required by the unambiguous terms of the statute. I agree with the dissent that the inquiry begins and ends with the statute; it is the statute which compels ("shall be") an evidentiary hearing.

Board Chair Neidig dissenting.

I disagree with the majority's application of Colclasure v. Wash. County School Dist. No. 48-I, 317 Or 526 (1993), and its conclusion that the Referee erred in failing to admit evidence that was not part of the record considered by the Director during a proceeding under ORS 656.327. My review of Colclasure, as well as the statutory scheme prescribed in ORS 656.327, convinces me that the Referee did not commit error. Consequently, I dissent.

To begin, it is important to emphasize that Colclasure addressed a different statute and procedure than at issue here. The issue in Colclasure was 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 that review authority. The Court stated that, in answering that question, it followed the "usual trail;" that is, it first examined the text and context of the pertinent statute, then if the text and context were ambiguous, it looked to legislative history and, if those avenues of inquiry did not resolve the issue, it looked to "other aids." 317 at 533. Finding that neither the text, context, nor legislative history of ORS 656.283(2) decided the question, the Court resorted to the "broader administrative law context" for guidance. Id.

The Court then reasoned that, because entitlement to vocational assistance was an "individual decision that depends on the facts of each individual case," it constituted a contested case, which in turn required a "more substantial hearing and decisional process, a process with which the director's procedure did not comply but the referee's hearing did." Id. at 535. In particular, the Court found the proceeding before the director inadequate because there was no "real" hearing before the director or reviewable record. Id. at 536-37.

Finally, the Court stated that it was "unwilling to assume that the legislature would make such a departure from normal practice [of contested case procedures] 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." Id. at 537. The Court then set out the process for reviewing vocational assistance determinations as provided in the majority's order.

The majority begins with an analysis of the text, context and legislative history of ORS 656.327(2), then turns to the "broad administrative law context" to resolve the dispute. After reviewing the pertinent statute, I believe that the inquiry begins and ends with the statute's text.

After a request for director review of disputed medical treatment, and a determination by the director that there is a bona fide medical services dispute, the director reviews as provided by ORS 656.327(2). That statute provides in relevant part:

"The director shall review medical information and records regarding the [medical] treatment [in dispute]. * * * Review of the medical treatment shall be completed and the findings of the director shall be submitted to the parties within 30 days of the request for review. The findings of the director regarding the treatment in question shall be prepared in such form and manner and shall contain such information as the director may prescribe. Within 10 days of making the findings, the director shall issue an order based upon the findings. * * * If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a hearing on the order. * * * Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except that the order of the director may be modified only if the order is not supported by substantial evidence in the record."

Unlike ORS 656.283(2), I think that the text of ORS 656.327(2) answers the question in this case regarding the admissibility of evidence at hearing that was not submitted to the director. First, the statute explicitly sets forth the decisional process required for director review of bona fide medical services disputes. For instance, the director must "review medical information and records regarding the treatment", make findings, and "issue an order based upon the findings."

Furthermore, a dissatisfied party may request a hearing "on the order" and review "of the order" is for substantial evidence. Inasmuch as the statute indicates that review is limited to the director's order and that order is based on the director's findings, I would continue to adhere to our prior holding that the "record" at hearing is limited to that developed before the director. See also ORS 656.327(1)(b) (defining "substantial evidence" as existing "to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding").

Even if I agreed with the majority that resort to "other aids" is necessary, I would find that the process provided in ORS 656.327(2) satisfies contested case procedures. Consistent with the statute's provision that the director make findings "in such form and manner and shall contain such information as the director may prescribe," the director has promulgated rules for gathering medical information and records. In submitting a request for Director review under ORS 656.327, the carrier is required to present all relevant and pertinent medical information. OAR 436-10-046(7). Such information also includes the medical service provider's response to the carrier's notice of its intention to seek Director review, as well as a statement explaining the parties' differences. *Id.* Copies of this information must also be provided to the other parties. *Id.*

The medical service provider has 7 days within which to submit additional information. OAR 436-10-046(9). Moreover, if any party believes relevant and pertinent information has not been provided, that party may notify the Director, who has the discretion to obtain the complete medical record. OAR 436-10-046(11). Also, after issuance of the Director's order, the parties have 10 days to submit written comments challenging the order. OAR 436-10-046(16). Finally, a party may also seek reopening of the record, abatement or reconsideration of the Director's order within 30 days of its issuance and prior to the filing of a hearing request. OAR 436-10-046(18).

Consequently, during the review procedure under ORS 656.327(2), although a formal hearing is not held, parties have an opportunity to be heard and present and rebut evidence. Furthermore, a reviewable record is made and the director issues an order containing findings of fact forming the basis of the decision. This procedure differs markedly from the one at issue in Colclasure, which did not develop a record or provide factual findings.

Finally, I note that our order in Iola Payne-Carr, *supra*, is presently before the Court of Appeals. That court also will have benefit of the Supreme Court's decision in Colclasure and can consider any argument regarding its application to ORS 656.327(2). I believe that the more prudent course is to await that decision rather than engage in the analysis rendered by the majority.

In the Matter of the Compensation of
DANIEL L. HAKES, Claimant
WCB Case No. 93-00718
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Scott Terrall & Associates, Claimant Attorneys

Reviewed by Board Members Haynes and Westerband.

The self-insured employer requests review of Referee Brown's order which set aside its denial of claimant's claim for blood exposure. In its brief, the employer contends that the Referee improperly admitted hearsay statements. On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

Claimant is a pilot for an air ambulance company. Claimant claims that on September 9, 1992, while unloading a trauma patient, he got blood on his hands. Because he had abrasions on his hands, claimant was concerned about exposure to HIV and sought HIV testing. Claimant saw Dr. Nagle, on October 9, 1992, for complaints of extreme fatigue, low back pain, swollen glands, constipation, and urinary frequency. Dr. Nagle reported that these complaints were unrelated to claimant's blood exposure.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that blood was an objective finding, because it is "red and wet," and that "[w]hen blood belongs to a high risk individual, blood contact warrants treatment." Because the exposure was supported by objective findings and required medical treatment, the Referee concluded that claimant's exposure to blood was compensable. We disagree.

The presence of another person's blood on claimant is not an objective finding. Claimant was not bleeding from an injury he sustained. Although claimant had been exposed to blood, there is no evidence that claimant has been injured by the exposure, or has HIV or any other disease. Brown v. SAIF, 79 Or App 205 (1986).

In Brown, the claimant had been exposed to asbestos at work and sought medical treatment when he became concerned that this exposure might have damaged his health. The doctors advised the claimant that he was healthy, but recommended regular testing. The claim was found not compensable because claimant failed to prove that he presently had a disease or had been injured.

Here, the Referee determined that Brown, supra, was inapplicable because former ORS 656.005 has been amended and that the current law emphasized verifiability, not physical or mental damage. We disagree. The amendments to ORS 656.005(7) added requirements to establish a compensable injury, but did not eliminate the requirement that an "injury" occur. Here, claimant was exposed to blood, but was not injured nor had a disease. As such, his claim is not compensable.

Given our finding on the merits,¹ we need not reach the evidentiary issue raised in the employer's brief.

ORDER

The Referee's order dated May 3, 1993 is reversed. The employer's November 17, 1992 denial is reinstated and upheld. The Referee's \$2,800 assessed attorney fee is reversed.

¹ Our holding does not turn on the Referee's finding that claimant came into contact with blood from a high risk individual. The employer did not dispute that claimant was exposed to blood. Therefore, we conclude that any error in admitting the hearsay statement was harmless.

In the Matter of the Compensation of
MICHAEL IVANOV, Claimant
WCB Case No. 92-12754
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Baker's order upholding the SAIF Corporation's denial, on behalf of the Inmate Injury Fund, of claimant's right leg injury claim. On review, the issue is timeliness. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On July 26, 1991, claimant was injured while working at the Farm Annex as an inmate. Claimant did not file a claim with the Department of Justice under the Inmate Injury Fund within 90 days of his injury. SAIF, on behalf of the Fund, denied the claim on the basis that claimant had not timely filed his claim and no "good and sufficient reason" existed as to why the claim could not have been timely filed.

ORS 655.520(3) provides that rights to benefits under the Inmate Injury Fund "shall be barred" unless the claim is filed with the Department of Justice within 90 days after the date of injury, or unless the Department waives the time limit on the ground that, "for good and sufficient reason, the claim could not be filed on time." The Department has adopted a written policy that "only physical and mental incapacity will be recognized as good and sufficient reason for failing to file a claim in a timely manner." Oregon Department of Justice, Special Compensation Programs, Inmate Injury Fund, Policy and Procedures Manual at 2.

In reviewing the Department's decision that an inmate did not show "good and sufficient reason" for failing to timely file a claim, the Board does not have de novo review authority and may not substitute its judgment for that of the department. Dept. of Justice v. Bryant, 101 Or App 226, 229 (1990). Instead, assuming that we have the authority to review such a decision, it is limited to determining if the department abused its discretion. Id. at 229-30.

Here, claimant argues that he showed "mental incapacity" because he has "very limited ability to read or communicate in English" and, therefore, did not "understand his right to file a claim or the time limit within which he must do so." We have serious reservations as to whether claimant's literacy and language limitations constitute "mental incapacity." Nevertheless, assuming that such limitations do rise to the "mental incapacity" level, we find no abuse of discretion by the Department in the application of its policy and its finding that there was not a "good and sufficient reason" why the claim could not be timely filed. Therefore, its denial of the claim was proper. See ORS 656.520(3).

ORDER

The Referee's order dated March 19, 1993 is affirmed.

In the Matter of the Compensation of
FRANK W. JUSTICE, Claimant
WCB Case No. 92-13463
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Gunn.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for asbestosis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the Referee's finding that claimant has the disease of asbestosis.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had asbestosis, the disease. However, the Referee further concluded that, because claimant had not established a disability or a need for medical services as a result of the disease, his claim was not compensable. We agree that claimant's occupational disease claim is not compensable. However, we base our conclusion on the following reasoning.

We ordinarily defer to the attending physician's opinion, unless there are persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810 (1983). We do so because attending physicians generally have had the best opportunity to evaluate workers' conditions. Id.

In the present case, however, claimant's treating doctor, Dr. Schlippert, did not offer an opinion on the causation of claimant's condition. Moreover, Dr. Schlippert referred claimant to Dr. Dreisin who saw claimant on only one occasion. Accordingly, we find no reason to defer to the opinion of Dr. Dreisin.

The remaining medical evidence is provided by Dr. Hansen, an Independent Medical Examiner who also specializes in pulmonary medicine. Dr. Hansen testified that claimant had "pathological," rather than "clinical" asbestosis. Dr. Hansen stated that a patient might have small areas (within the lungs) reflecting asbestos exposure, but that did not give them the "clinical" disease. Dr. Hansen further stated that pleural plaquing and thickening (i.e., "pathological asbestosis"), such as claimant demonstrated, was not viewed as a disease by the medical community. Dr. Hansen testified that such thickening was an abnormality, and was only a disease if it progressed or caused the patient disability or major problems. In claimant's case, Dr. Hansen opined that, because the pleural markings had not caused claimant any pain or problems, claimant would not even have known of their existence without undergoing an x-ray. Ex. 49.

After reviewing the medical evidence, we find Dr. Hansen's report to be thorough and well-reasoned. Accordingly, we rely on Dr. Hansen's opinion and conclude that claimant has failed to establish a compensable occupational disease which requires medical services or has resulted in disability. We, therefore, affirm the Referee on the issue of compensability.

ORDER

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

Board Member Gunn dissenting.

I agree with the portion of the Referee's order which found that claimant has asbestosis. However, unlike the Referee (and the the majority), I would go one step further and would find this claim compensable.

The majority has found that claimant has "pathological," rather than "clinical" asbestosis. Certainly, this distinction cannot be comforting to claimant, who has been diagnosed with asbestosis, regardless of the distinction provided by Dr. Hansen, the IME in this case.

Here, there is no dispute that claimant has been exposed to asbestos during the course of his employment. Claimant currently has trouble breathing and has a chronic cough. Dr. Dreisin opined that claimant's chronic bronchitis was contributed to by his asbestosis. Dr. Zbinden of the Good Samaritan Hospital Pulmonary Function Laboratory found that claimant's air flows were moderately reduced at all levels of lung volume. Dr. Zbinden diagnosed restrictive lung disease of mild severity, with a clinical diagnosis of asbestos (sic). Dr. Zbinden also diagnosed obstructive lung disease of mild severity.

Finally, even Dr. Hansen has agreed that claimant has impairment. Dr. Hansen has also stated that claimant "clearly has pleural changes related to remote asbestos exposure." Dr. Hansen agreed that in certain cases regarding asbestos-related abnormality, he would recommend periodic medical surveillance, even if a patient was asymptomatic.

After reviewing the medical evidence, I disagree with the majority's conclusion. I would find that claimant has established a compensable occupational disease which requires medical services and has resulted in disability. Although the Referee found that claimant has no disability or impairment, that finding is contrary to the medical evidence which establishes that claimant was treated for his chronic cough or bronchitis. Furthermore, I would alternatively conclude that, even if claimant is not disabled at the present time, the record establishes that asbestosis requires medical services in the form of annual examinations. Accordingly, claimant will require medical services for his asbestosis condition. Under such circumstances, I would reverse the Referee and find this claim to be compensable.

December 13, 1993

Cite as 45 Van Natta 2354 (1993)

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 92-12157
ORDER ON REVIEW
Ransom, et al., Claimant Attorneys
Carrol Smith (Saif), Defense Attorney

Reviewed by Board Members Westerband, Neidig and Gunn.

The SAIF Corporation requests review of Referee Thye's order that set aside its partial denial of claimant's current need for medical treatment. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 50, had coronary artery disease (CAD) prior to 1977. He has the following risk factors for CAD: a family history of the disease, smoking and hypertension. The disease is naturally progressive unless its course is retarded or reversed by risk factor reduction, medical intervention and treatment.

In 1977, claimant suffered a myocardial infarction (heart attack) at work, resulting in double bypass surgery. SAIF denied the compensability of the heart attack. A January 9, 1978 Opinion and Order found the heart attack compensable as an injury, and stated: "The underlying [CAD] is of course not in issue." (Ex. A-3). The claim was closed by an August 9, 1978 Determination Order.

Claimant continued to have symptoms, including dizziness, shortness of breath and fatigue, which worsened in late 1987 and culminated in another heart attack in February 1988.

SAIF issued a denial, stating:

"We have received information that you have recently suffered another myocardial infarction. Information in your file indicates that your current condition and need for treatment is unrelated to your myocardial infarction of March 19, 1977, and that this incident of March 19, 1977 did not materially contribute to your current disability or need for medical treatment. We further find that the incident of March 19, 1977, did not materially worsen your pre-existing, underlying coronary artery disease. Therefore, without waiving further questions of compensability we must issue this partial denial for your recent condition and need for medical treatment, as well as your pre-existing coronary artery disease." (Ex. 1A).

In his December 9, 1988 Opinion & Order, Referee Schultz framed the issue as follows:

"Claimant protests the June 8, 1988 denial of a heart attack (myocardial infarction) suffered on or about February 26, 1988. At issue is whether or not the 1988 heart attack is related, in a material way, to a heart attack suffered by claimant on March 19, 1977 which was found compensable." (Ex. 1B-1).

He also identified the issue at the beginning of his opinion as follows:

"This is an injury case. Claimant has the burden of proving by a preponderance of the evidence that the heart attack he sustained on March 26, 1988 (sic) is related, in a material way, to his compensable heart attack of March 19, 1977 and its sequela, including the bypass surgery performed in October of 1977."

Referee Schultz concluded that claimant's 1977 heart attack and subsequent surgery were a material contributing cause of his 1988 heart attack, based upon Dr. Semler's opinion that the most significant factors leading to the 1988 heart attack included claimant's compensable 1977 heart attack and compensable bypass surgery.

Referee Schultz set aside SAIF's denial "in its entirety," and remanded the claim to SAIF for further processing under the Workers' Compensation Laws. (Ex. 1B-6). This order was not appealed by SAIF.

From June 1990, claimant received treatment from Dr. Semler, the purpose of which was, in relevant part, to stop or slow the progression of claimant's underlying CAD. On September 1, 1992, SAIF denied the treatment, asserting that it was necessitated by claimant's underlying CAD, which was not compensable.

FINDINGS OF ULTIMATE FACT

SAIF accepted claimant's 1988 heart attack and any medical services flowing therefrom.

The progression of claimant's preexisting, underlying CAD is the major contributing cause of his current need for treatment.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee concluded that, under the res judicata doctrine of claim preclusion, SAIF was barred from denying the compensability of claimant's preexisting, underlying CAD condition and the current treatment for that condition. He based his opinion on the language of SAIF's June 8, 1988 denial, which partially denied claimant's underlying disease condition, and the order language of Referee Schultz's December 9, 1988 Opinion and Order, which set aside SAIF's 1988 denial "in its entirety." Referee Schultz's order was not appealed and has become final by operation of law.

SAIF maintains that the Referee erred for two reasons: (1) the 1988 denial letter not only denied claimant's 1988 myocardial infarction, but also his preexisting CAD, which claimant chose not to litigate; and (2) the Referee addressed claimant's injury claim for the 1988 myocardial infarction only. Alternatively, SAIF maintains that the 1988 and 1992 hearings did not concern the same issues or operative facts.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Under the doctrine of claim preclusion, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). A "claim" is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating, supra. Claim preclusion does not require actual litigation of an issue of fact or law; however, the opportunity to litigate is required, whether or not it is used, and there must be a final judgment. Drews v. EBI Companies, 310 Or 134, 140 (1990).

In applying claim preclusion, the first issue is whether the second action is on the "same cause of action" as the first. Carr v. Allied Plating, *supra*. Claimant relied on the prior referee's order language and the denial to establish that SAIF is barred from now denying the compensability of claimant's underlying CAD. (Tr. 3 and 4). However, the only claim identified in the 1988 Opinion and Order is that of the compensability of a heart attack that was allegedly a consequence of either a preexisting disease or a prior compensable heart attack. Claimant has provided no evidence that he made a new claim for the preexisting, underlying CAD, nor any evidence that he claimed that the preexisting CAD condition was worsened by the 1977 heart attack. Furthermore, the sole reference in the prior referee's order to claimant's underlying CAD is in a sentence rejecting Dr. Girod's opinion that the 1988 heart attack was caused by the underlying coronary artery disease. The referee's rejection of Dr. Girod's opinion on causation supports our conclusion that the compensability of the underlying heart disease was not claimed by claimant or litigated.

In short, when Referee Schultz's Opinion and Order is read as a whole, it is clear that SAIF was ordered to accept claimant's 1988 myocardial infarction and not the underlying CAD. To reach any other conclusion would require that we enforce one sentence of the Referee's order, rather than the order as a whole. We decline to read the single sentence claimant relies on without looking at the context of the order as a whole. For these reasons, we conclude that Referee Schultz's order resolved the parties' dispute over the compensability of the 1988 myocardial infarction, and that it did not address any claim for the underlying CAD, since no claim for that condition had been made.

Furthermore, although the issue of the compensability of the underlying CAD was raised by the 1988 denial, the denial may have been overbroad. The order merely sets aside the denial. It does not, in and of itself, answer the question of the scope of the claim made by claimant. The denial is some evidence that a claim may have been made for the underlying CAD, but that evidence is heavily outweighed by the Opinion and Order itself, which clearly indicates that the only condition litigated by claimant at the prior hearing was the compensability of the 1988 heart attack, the sole question being whether it was related to the accepted 1977 heart attack and bypass surgery.

We thus conclude that the cause of action raised in 1992, namely the compensability of claimant's current need for medical services as related to his preexisting, underlying CAD, is not the same as the cause of action in 1988, namely the compensability of claimant's 1988 heart attack. Accordingly, the doctrine of claim preclusion does not bar SAIF from now denying claimant's current claim for medical services allegedly related to his underlying CAD condition. North Clackamas School District v. White, *supra*; Drews v. EBI Companies, *supra*; Carr v. Allied Plating, *supra*.

We next turn to issue preclusion. Issue preclusion acts as a bar only when: (1) the same parties (2) actually litigate an issue of law or fact (3) which is necessary to (4) a valid and final judgment. North Clackamas School District v. White, *supra*.

Although the order language in the 1988 Opinion and Order set aside SAIF's denial in its entirety, the sole issue before the prior referee was whether claimant's 1988 heart attack was materially caused by his 1977 heart attack and ensuing surgery. (See Ex. 1B). As noted above, the sole reference in the prior referee's order to claimant's underlying CAD is in a sentence rejecting Dr. Girod's opinion that the 1988 heart attack was caused by the underlying CAD. Indeed, the narrow question of fact that the prior referee's order expressly decided was whether the 1988 heart attack was the result of the natural progression of the underlying heart disease (in which case it would not be compensable), or whether it was materially related to the 1977 heart attack and subsequent bypass surgery (if so, it would be compensable).

Consequently, since compensability of the preexisting CAD was never actually litigated, issue preclusion does not bar either party from now raising that issue. North Clackamas School District v. White, *supra*.

Medical Services

We now turn to the merits of SAIF's denial. The issue before us is whether claimant's need for medical services after August 2, 1991 is causally related to his prior compensable injury or its sequela. See Buddy J. Willis, Jr., 44 Van Natta 910 (1992).

A carrier is required to provide medical services for conditions resulting from the compensable injury for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability. ORS 656.245(1). The employer's denial is based on the ground that the major contributing cause of claimant's current need for medical services is due to the natural progression of his preexisting CAD.

Inasmuch as the medical evidence indicates that claimant's myocardial infarctions combined with his preexisting CAD, claimant must prove that his compensable injuries, i.e., his 1977 and 1988 heart attacks, remain the major contributing cause of his disability or need for treatment. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992).

Claimant has received ongoing treatment since 1988 for a number of heart-related conditions, including a myocardial infarction, angina, a stroke, and CAD. Consequently, the issue of whether claimant's compensable injuries are the major contributing cause of his current need for medical treatment is a complex medical question, requiring extensive medical analysis. Thus, although claimant's testimony is probative, the resolution of this issue turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant had been diagnosed with preexisting, underlying CAD at the time of his 1977 heart attack. (Ex. A). In 1988, claimant experienced a second myocardial infarction. In June 1990, Dr. Semler, claimant's treating physician, reported that claimant was "still having ongoing angina pectoris associated with ischemic heart disease and coronary insufficiency." (Ex. 1D). A month later, claimant developed a clot in his left ventricle and in December, 1990, he sought treatment for a stroke. (Exs. 1C and 1G).

Claimant continued to have angina "secondary to his coronary artery heart condition." (Ex. 1F). On January 31, 1991, Dr. Semler reported that claimant had recovered from the stroke but his heart condition was still present. He concluded that claimant was not yet medically stationary because of coronary insufficiency related to his heart attack. (Ex. 1H).

On August 1, 1991, Dr. Semler stated that claimant's condition had stabilized, that he was no longer suffering from a thrombus and that the major contributing cause of his current need for treatment is CAD and the prevention, if possible, of its further progression. (Ex. 4). SAIF closed claimant's heart attack claim on September 20, 1991, with no permanent disability. (Ex. 5).

Claimant continued to be treated by Dr. Semler, who continued to prescribe nitroglycerin to relieve claimant's angina pectoris and aspirin for the prevention of cerebral emboli. (Exs. 1F, 4, 7 and 8A).

Three doctors provided opinions regarding the causation of claimant's current need for treatment: Dr. Semler; Dr. Toren, cardiologist; and Dr. DeMots, Head, Division of Cardiology, University of Oregon Health Sciences Center.

As noted above, Dr. Semler initially indicated that the current treatment was due to claimant's underlying CAD. However, on February 6, 1992, he changed his opinion, saying that the current treatment was directed to the total care of claimant's heart condition that resulted from the 1977 heart attack. (Ex. 8-2).

In contrast, Dr. Toren explained that claimant's underlying CAD is a progressive disease and that claimant's angina is related to that progressive condition. He concluded: "[Claimant] had pre-existing coronary artery disease, and the treatment of the symptoms related to the disease as well as treatment directed at preventing future coronary events would be necessary whether or not [claimant] had had a prior myocardial infarction." (Ex. 9-4).

Dr. DeMots agreed with Dr. Toren's analysis and concluded that Dr. Semler's current medical management is to prevent future events that might be caused by the progression of CAD. He also opined that the angina is not due to claimant's work, his myocardial infarction, or to the bypass surgery.

We are more persuaded by Dr. Toren's and Dr. DeMots' extensive and well-reasoned opinions than by Dr. Semler's unexplained change of opinion. Accordingly, we conclude that claimant has failed to prove that his current need for medical treatment is related, in major part, to his 1977 and 1988 myocardial infarctions.

ORDER

The Referee's order dated February 3, 1993 is reversed. The SAIF Corporation's partial denial is reinstated and upheld.

Board Member Gunn dissenting.

The majority holds that claimant's current need for treatment is not compensable on the basis that claimant's preexisting, underlying coronary artery disease (CAD) is not compensable. Because I disagree with their conclusion regarding the compensability of the CAD, I respectfully dissent.

The majority concluded that claimant had made no claim for the underlying CAD as a part of his claim for the 1988 heart attack. Nevertheless, SAIF's 1988 denial had partially denied claimant's underlying CAD, and Referee Schultz's order set aside that denial "in its entirety." Thus, if claimant had failed to appeal that denial which had purported to deny the CAD, he probably would have been precluded from raising a claim for it later, except under circumstances where there was a change in his condition. Furthermore, if Referee Schultz had set aside only the heart attack injury portion of the denial, claimant would also probably have been precluded from raising a claim for the CAD later. Under either circumstance, once the time for appealing the claim passed, SAIF would have attempted to bar a claim for the CAD on the basis of res judicata, even if evidence arose directly linking the CAD to the injury.

Thus, if claimant would have been barred by res judicata from making a claim for the CAD, then res judicata should also apply to bar SAIF from challenging the compensability of the CAD, when the denial was set aside in its entirety.

In order to do substantial justice to both parties, we should hold both parties to the same standard for a failure to appeal. Here, SAIF failed to appeal an order that required it to accept claimant's claim "in its entirety," when SAIF itself knew that it had denied claimant's underlying CAD. To allow SAIF to deny this claim two years after it was required to accept it amounts to legal theft. Therefore, I would affirm the Referee's order barring SAIF from denying claimant's CAD condition.

December 13, 1993

Cite as 45 Van Natta 2358 (1993)

In the Matter of the Compensation of
NORMAN L. SELTHON, Claimant
 WCB Case Nos. 92-12805 & 92-10219
ORDER ON REVIEW

Stebbins & Coffey, Claimant Attorneys
 Dennis Ulsted (Saif), Defense Attorney
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The SAIF Corporation requests review of Referee Baker's order that: (1) set aside its denial of claimant's occupational disease claim for a hearing loss condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the last sentence in the last paragraph of his findings of fact.

CONCLUSIONS OF LAW AND OPINIONCompensability

We affirm and adopt the Referee's findings and conclusions that claimant's hearing loss is compensable.

Responsibility

Claimant has worked for the same employer since 1962. Claimant has no previously accepted hearing loss claims. Liberty's workers' compensation insurance coverage became effective July 1, 1990. Finding that there was no causally significant exposure during Liberty's coverage, the Referee assigned responsibility to SAIF. SAIF contends that the Referee applied an incorrect legal standard. We agree.

The parties agree that the last injurious exposure rule applies to determine responsibility for claimant's hearing loss condition. Fred A. Nutter, 44 Van Natta 854 (1992). The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If the claimant has not become disabled, the onset of disability is the date he first seeks medical treatment for the condition. Progress Quarries v. Vandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

Liberty contends that claimant first sought treatment in 1971 when he underwent a periodic hearing test, which showed some hearing loss, and a physician recommended he wear hearing protection. We do not construe obtaining audiometric tests, pursuant to OSHA requirements, as seeking medical treatment for purposes of determining the onset of disability. Such a position would be contrary to the purposes of the OSHA requirements. Rather, Dr. Hurbis' March 13, 1992 examination to evaluate claimant's hearing loss is the triggering event for the onset of disability. See Gregory A. Wilson, 45 Van Natta 235 (1993). Accordingly, responsibility is initially assigned to Liberty.

Liberty may shift responsibility to SAIF (an earlier carrier) by showing that claimant's work exposure while SAIF was on the risk was the sole cause of claimant's hearing loss or that it was impossible for claimant's exposure while Liberty was on the risk to have caused claimant's hearing loss.¹ FMC Corporation v. Mutual Ins. Co., 70 Or App 370 (1984).

Liberty asserts the "impossibility" defense and contends that it is not responsible because there is no evidence that claimant was exposed to injurious noise levels while it was on the risk. To be injurious, there must have been some exposure of a kind contributing to the condition or of a kind which could have caused the condition. Fossum v. SAIF, 293 Or 252 (1982); Inkley v. Forest Fiber Products Co., 288 Or 337, 342 (1980). Minimal exposure is sufficient. Wayne A. Hawke, 38 Van Natta 1538, 1540 (1986). Whether or not claimant's noise exposure is injurious is a complex question requiring competent expert opinion. Gregory A. Wilson, supra at 236. Thus, claimant's testimony regarding his work exposure is probative, but not dispositive.

Claimant testified that he was exposed to noise (from power saws, generators, cranes, and loaders), while Liberty was on the risk, but that the noise was not as intense as in his former job. However, there was no expert opinion that the noise level was capable of producing hearing loss or that the noise exposure was or was not injurious. Mr. Ediger, audiologist, was not provided the noise level studies nor did he have claimant's 1990 hearing test records in order to determine whether claimant's hearing loss occurred prior to 1990. Dr. Hurbis, claimant's treating physician, also did not have the benefit of the noise level studies nor could he determine which exposure caused claimant's hearing loss. Therefore, from this record, we conclude that Liberty has failed to meet its burden of proof. Consequently, Liberty remains responsible for claimant's hearing loss claim.

¹ Liberty contends, relying on Boise Cascade Corp. v. Starbuck, supra, that it can shift responsibility by "showing that the cause of claimant's hearing loss is employment during SAIF's coverage, a cause unrelated to the employment or that the hearing loss is not related to a work exposure during its coverage." However, the difference in Starbuck, as in Bracke v. Baza'r, supra, from this case was the inapplicability of the last injurious exposure rule in the initial assignment of responsibility, because the claimant had established actual causation as to a particular employer. That difference was relied upon by the court in FMC Corp. v. Liberty Mutual Ins. Co., supra, when it established the standard to shift responsibility to an earlier employer.

Attorney Fees

At hearing, claimant's right to compensation was at risk due to SAIF's denial of compensability. That denial justifiably prompted claimant's active participation at hearing to protect his right to compensation. Liberty denied responsibility only and, therefore, did not place claimant's compensation at risk. Since SAIF created the need for claimant to establish the compensability of his claim, SAIF remains responsible for the Referee's \$2,500 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, claimant's compensation was also at risk on Board review due to SAIF's appeal and its continued assertion that claimant's hearing loss was not compensable. Because claimant's compensation was at risk of disallowance as a result of SAIF's appeal, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, also payable by SAIF. See Internation 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 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 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 April 23, 1993 is reversed. The SAIF Corporation's denial of responsibility is reinstated and upheld. Liberty Northwest Insurance Corporation's denial is set aside and the claim is remanded to Liberty for processing according to law. The Referee's attorney fee award shall be paid by SAIF. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by SAIF.

December 13, 1993

Cite as 45 Van Natta 2360 (1993)

In the Matter of the Compensation of
DONALD G. STACY, Claimant
 WCB Case No. 91-06613 & 91-05641
 ORDER ON REVIEW
 Max Rae, Claimant Attorney
 Bonnie Laux (Saif), Defense Attorney

Reviewed by the Board en banc.¹

Claimant requests review of Referee Poland's order that: (1) held that the Hearings Division lacked jurisdiction over an "aggravation claim" on the grounds that claimant's aggravation rights had expired; and (2) upheld the SAIF Corporation's denial of his occupational disease claim for a stress-related mental disorder. On review, the issues are jurisdiction, aggravation and compensability.

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

Claimant filed an occupational disease claim for mental stress in January 1987. On the 801 claim form, claimant indicated August 1, 1986 as the date of injury. The insurer accepted the claim as nondisabling in October 1987. In 1991 claimant filed claims for his current stress condition, both as an aggravation of the accepted stress condition and as a new occupational disease.

¹ Member Gunn has recused himself and has not participated in this review. OAR 438-11-023.

The Referee held that claimant had failed to establish a new occupational disease. The Referee also held that the Hearings Division lacked jurisdiction over the aggravation claim because claimant's aggravation rights had expired prior to the December 5, 1991 aggravation date. In reaching this conclusion, the Referee found that claimant's "date of injury" was August 1, 1986, and that his aggravation rights expired five years after that date. On review, claimant does not dispute the date of injury, but contends that the aggravation of his condition occurred prior to expiration of his aggravation rights.

The filing requirements of ORS 656.273 are jurisdictional. SM Motor Co. v. Mather, 117 Or App 176 (1992); Timothy D. Beard, 43 Van Natta 432 (1991). A claim for additional compensation made outside the time limits of ORS 656.273 falls within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Edward R. Reuter, 42 Van Natta 19 (1990).

In order to determine whether we have jurisdiction over the aggravation claim, it is necessary to identify claimant's "date of injury." In Robert E. Wolford, 45 Van Natta 435 (1993), we held that in the case of an occupational disease claim, the "date of injury" for purposes of determining a claimant's aggravation rights is the date that the insurer accepts the occupational disease claim. However, in Papen v. Willamina Lumber Company, 123 Or App 249 (1993), the Court of Appeals held that the "date of injury" in the case of an occupational disease claim is either the date of disability or the date when medical treatment is first sought. See Medford Corp. v. Smith, 110 Or App 486, 488 (1992). Inasmuch as our holding in Wolford conflicts with the court's decision in Papen, we disavow Wolford and hold that, for purposes of determining aggravation rights, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought.

Here, there is no evidence that claimant was disabled due to his stress condition prior to filing his claim in January 1987. Therefore, we look to the date he first sought treatment for stress. See Papen v. Willamina Lumber Company, supra. Claimant stated on his 801 form that the date of injury was August 1, 1986. (Ex. 2). The record shows, however, that claimant first sought treatment with Dr. Klass on July 11, 1986. (Ex. 3). Hence, we find that claimant's "date of injury" was July 11, 1986.

Further, we find that claimant's accepted claim was in nondisabling status for more than one year after the date of injury; therefore, claimant's aggravation rights expired five years after the date of injury, or on July 11, 1991. See ORS 656.273(4)(b).²

We also agree with the Referee's finding that claimant's compensable condition worsened in December 1991, after the expiration of his aggravation rights. See ORS 656.273(4)(b). While we recognize that claimant purportedly filed a claim for aggravation in May 1991, that is not enough to preserve a valid aggravation claim.

The court has held that, inasmuch as an aggravation claim is notification of a worsened condition, the worsening must precede the claim filing and expiration of aggravation rights. Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds 307 Or 654 (1989). See also Mary M. Hudson, 41 Van Natta 803 (1989). Here, claimant's compensable condition did not worsen prior to the expiration of his aggravation rights. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated April 9, 1992 as reconsidered April 24, 1992 and May 28, 1992 is affirmed.

² As discussed by the Court of Appeals in DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993) (a claim classification case): "The substantive advantage to the employer of classifying a claim as nondisabling is that the aggravation rights run from the date of the injury rather than from the date of the first determination order or notice of closure." Further, the Court of Appeals pointed out: "If the claim is reclassified more than one year from the date of the injury, the claimant is precluded, through no fault of her own, from seeking reconsideration by DIF." The same may be said of an original classification of an occupational disease claim (i.e., acceptance and classification more than one year after "injury").

It is this potential problem (a right expiring before claimant even receives notice of the right, i.e., before notice of claim acceptance or classification) that the Board attempted to address in Wolford. This is, probably, a situation or problem best addressed by the legislature. (See potential conflict between ORS 656.262(6)(c), 656.273 and 656.277).

In the Matter of the Compensation of
JON F. WILSON, Claimant
WCB Case No. 91-18179 & 91-11606
ORDER ON REVIEW

Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by the Board en banc.

American International Adjustment Company, Inc. (AIAC) requests review of Referee Menashe's order which: (1) denied its motion for dismissal; (2) set aside its denial of claimant's occupational disease claim for a right knee condition; and (3) upheld Industrial Indemnity Company's (II) denial for the same condition. In its brief, AIAC contends that its denials of responsibility for claimant's bilateral knee conditions preclude further litigation of claimant's right knee condition. On review, the issues are res judicata, dismissal, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

We adopt the Referee's conclusion with respect to this issue.

Dismissal

AIAC argues that its motion for dismissal should have been granted by the Referee, and that II is precluded from arguing that AIAC is responsible for claimant's condition because II 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 another employment exposure caused a claimant's need for medical services. Byron E. Bayer, 44 Van Natta 1686, 1687 (1992).

When II issued its disclaimer, it incorrectly listed the insurer it believed responsible for claimant's condition. Because II listed an insurer that did not insure the employer, claimant did not file a claim against AIAC, pursuant to ORS 656.308(2). Therefore, we agree that II did not follow the procedure set out in ORS 656.308(2) and is precluded from arguing that AIAC is responsible for claimant's current right knee condition. Furthermore, AIAC is not precluded from avoiding responsibility by proving that II should be responsible for the claim. Nevertheless, II's noncompliance with the disclaimer notice requirement of ORS 656.308(2) does not preclude claimant from establishing a compensable occupational disease claim against AIAC. Rachel J. Dressler-Iesalnieks, 45 Van Natta 1792 (1993).

Accordingly, claimant may prove that his work activities while AIAC was on the risk were the major contributing cause of his current right knee condition. ORS 656.802(2); See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). AIAC, however, contends that claimant's failure to file a claim with it within 60 days of II's disclaimer precludes him from asserting compensability against AIAC. We disagree.

The Referee reasoned that, because II's disclaimer did not identify AIAC, II's omission did not compel claimant to file a claim with AIAC within the time limits set out in ORS 656.308(2). Further, the Referee concluded that the incorrect disclaimer did not bar claimant from otherwise asserting his rights under ORS Chapter 656.

We agree with the Referee's reasoning. ORS 656.308(2) addresses responsibility for a claim; it does not pertain to the compensability of a claim. ORS 656.807 expressly addresses the timely filing of

an occupational disease claim. Inasmuch as II's incorrect disclaimer notice failed to trigger the 60-day filing requirement of ORS 656.308(2), we conclude that claimant was subject to the occupational disease claim filing requirement set forth in ORS 656.807(1).¹

ORS 656.807(1) provides that an occupational disease claim shall be void unless it is filed with the insurer or self-insured employer by whichever is the later of the following dates:

- "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
- (b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

In Bohemia Inc. v. McKillop, 112 Or App 261, 265 (1992), the court held that the phrase "the later of the following dates" modifies each clause within subparagraphs (a) and (b) and, therefore, the relevant date for filing a claim was the later of the dates in each subparagraph. The court further held that the legislature intended that the dates in subparagraph (a) are alternative dates to be compared with the dates in subparagraph (b) to determine the later date. See Joanne C. Rockwell, 44 Van Natta 2290, 2291 (1992).

Here, in January 1991, claimant returned to Dr. Gripekoven, his treating physician since a 1983 left knee injury, complaining of a catching sensation in the right knee and a feeling that the right knee "goes out." (Ex. 20-1). At that time, Dr. Gripekoven diagnosed bilateral chondromalacia and probable torn right medial meniscus, and recommended a course of physical therapy and an MRI. (Ex. 20-2). In March 1991, Dr. Gripekoven reported to II's claim representative that the reason claimant had sought treatment in January 1991 was for increasingly severe knee discomfort related to work activities. (Ex. 47). Subsequently, II arranged for Dr. Thompson to examine claimant in an independent medical examination. In May 1991, Thompson also related claimant's right knee condition to work activities, especially those after changing his job to cleaning the inside of airplanes in late 1990. (Ex. 50A-7).

On July 19, 1991, II issued its disclaimer which incorrectly named Crawford and Company as the responsible insurer. (Ex. 51). The only response to that disclaimer, besides claimant's August 26, 1991 request for hearing, was a December 13, 1991 denial letter from AIAC. In that letter, AIAC informed claimant that, because he had not timely filed a claim with AIAC within the 60 day time limit set out in ORS 656.308(2), AIAC must deny compensability of and responsibility for claimant's knee conditions. (Ex. 54-1).

AIAC contends that claimant has not filed a written claim. We do not agree. A claim for compensation may be filed by someone on the worker's behalf. See ORS 656.005(6). Further, an occupational disease claim must be filed within one year from the date a physician suggests that the condition was due to work activities. See ORS 656.807(1)(b).

After reviewing the medical evidence concerning claimant's right knee condition, we conclude that Dr. Gripekoven's January 1991 chart note (Ex. 20-2) was sufficient to constitute a claim for claimant's right knee condition. See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992) (physician's report requesting medical treatment for specified condition constitutes claim).

AIAC issued a denial of claimant's right knee claim in December 1991. (Ex. 54). Because AIAC's December 1991 denial referred to the previous II denial (indicating knowledge of a right knee claim), it is apparent that AIAC had notice that claimant was seeking compensation for a right knee condition resulting from his work activities. Although it is unclear exactly when AIAC received notice of claimant's occupational disease claim, it is apparent that AIAC received that notice within one year of claimant's discovery (at the earliest, January 1991) that he was suffering from an occupational disease. Bohemia Inc. v. McKillop, *supra*. Accordingly, we conclude that claimant has timely filed an occupational disease claim against AIAC, and may proceed to prove compensability of an occupational disease against AIAC. See ORS 656.807(1).

¹ Moreover, we are unable to detect an intent in the legislative history of ORS 656.308 to supplant or otherwise alter the one-year claim filing period set out in ORS 656.807.

Furthermore, in the alternative, in order for the insurer to prevail on a "timeliness defense," it must prove prejudice due to the late filing. See Joanne C. Rockwell, supra. Here, AIAC has not contended that it has been prejudiced by claimant's alleged failure to timely file his occupational disease claim.

Compensability

We adopt the Referee's conclusion concerning this issue.

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing over AIAC's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$800, to be paid by AIAC. 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 July 14, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$800, payable by AIAC.

December 14, 1993

Cite as 45 Van Natta 2364 (1993)

In the Matter of the Compensation of
GEORGE K. FRANZEN, JR., Claimant
 WCB Case No. MS-93005

ORDER ON REVIEW OF DIRECTOR'S ORDER (ORS 656.327(1)(b))
 Pozzi, et al., Claimant Attorneys
 Hoffman, et al., Defense Attorneys

Claimant requests review under ORS 656.327(1)(b) of a Director's order finding no bona fide medical services dispute. We set aside the order and remand.

In December 1991, claimant compensably injured his low back. After declaring claimant medically stationary, Dr. Lorish prescribed a self-directed exercise program at a health club and requested approval for the treatment by the insurer. When the insurer denied approval, Dr. Lorish sought approval from the Director pursuant to ORS 656.245(1)(b).

The Director initially issued a Palliative Care Order approving the treatment. The insurer then sought administrative review under OAR 436-10-008(6). Thereafter, the Director issued an order finding no bona fide medical services dispute. Specifically, the Director found that the disputed treatment did not qualify as a medical service under the administrative rules. See ORS 656.327(1)(b). Claimant requested review by the Board. Id. Claimant had not begun the prescribed exercise program at the time the Director issued his order finding no bona fide medical services dispute.

On Board review, claimant asserts that, because ORS 656.245(1)(b) includes a reference to ORS 656.327(3), the only avenue for review of the Palliative Care Order available to the insurer was to request a hearing. See ORS 656.327(2). Claimant contends that, because OAR 436-10-008(6) allows for administrative review of the order, it is in conflict with the statute and, therefore, invalid. Claimant further maintains that, because the administrative rule is invalid and review of the order was sought under this provision, the order finding no bona fide medical services dispute also is invalid. We agree that the Director's "no bona fide medical services dispute" order is invalid based on the following reasoning.

The Director's authority to issue an order finding no bona fide medical services dispute is derived entirely from ORS 656.327, which provides, in pertinent part:

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

"(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. 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." (Emphasis supplied.)

Paragraph (1)(a) sets forth the limits of the Director's jurisdiction under ORS 656.327. It provides for Director review of medical treatment that an injured worker "is receiving" which is alleged to be excessive, inappropriate, ineffectual or in violation of medical services rules. In Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applies only to treatment that the claimant "is receiving" at the time Director review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) does not apply to requests for future medical treatment. Id. at 466-67.

Here, the dispute concerns the propriety of a proposed exercise program. Because the exercise program is not treatment that claimant "is receiving," the Director did not have jurisdiction over this dispute under ORS 656.327. Inasmuch as the Director's authority to issue a "no bona fide medical services dispute" order is derived entirely from ORS 656.327, we conclude that the Director lacked authority to issue such an order in this case. In this regard, we note that ORS 656.245(1)(b) does not invest the Director with any authority, independent of ORS 656.327, to issue an order finding no bona fide medical services dispute.

Accordingly, we set aside the Director's "no bona fide medical services dispute" order as invalid. ORS 656.327(1)(b). Furthermore, we remand to the Director for further consideration of this dispute, which would necessarily include review of claimant's contention that the Director is without statutory authority to review the Palliative Care Order.

ORDER

The Director's order dated February 12, 1993 is set aside as invalid.

December 14, 1993

Cite as 45 Van Natta 2365 (1993)

In the Matter of the Compensation of
TY M. HAWKINS, Claimant
WCB Case No. 92-05001
ORDER ON REVIEW
Dobie & Associates, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Referee Neal's order which: (1) affirmed the Director's order finding claimant ineligible for vocational assistance; and (2) affirmed an Order on Reconsideration awarding 28 percent (89.6 degrees) unscheduled permanent disability for his low back condition and 5 percent (6.75 degrees) scheduled disability for loss of use or function of his right foot. In his brief, claimant contends he has been prejudiced because he was denied the right to cross-examine the employer's investigator. On review, the issues are evidence, vocational assistance, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant contends that the Referee improperly admitted notes and reports prepared by the employer's investigator, thereby denying him the right to cross-examine the employer's investigator.

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. SAIE, 67 Or App 498, 501 n.2 (1984). Evidence is not deemed inadmissible solely on the basis that it is hearsay. Id. Thus, the Referee did not abuse her discretion by admitting the investigator's reports on a limited basis. (See Tr. 139-140).

The Referee did not rely solely on the investigator's testimony in making her credibility findings. In addition, our holding does not turn on the Referee's finding that claimant lacked credibility. Therefore, we conclude that any error in admitting the investigator's reports was harmless.

Vocational Assistance

The Director relied upon the report of Dr. Fuller and claimant's treating physician's concurrence with that report to conclude that claimant was ineligible for vocational assistance because he had received a regular work release. The Referee found that claimant exaggerated his disabilities. The Referee also found that claimant was able to return to his regular work, but the reason he was unable to return to his former job was for reasons unrelated to his injury, specifically, closure of the plant. Relying on the Court of Appeal's decision in Colclasure v. Washington County School District, 117 Or App 128 (1992), the Referee found that the Director did not abuse his discretion in finding claimant ineligible for vocational assistance.

Subsequent to the Referee's order, the Supreme Court in Colclasure v. Washington County School Dist. No. 48-I, 317 Or 526 (1993), explained the scope of a referee's review of a Director's order. In Colclasure, in determining that the claimant was ineligible for vocational assistance, the Director had developed no evidentiary record and held no evidentiary hearing. On review of the referee's order, which reversed the Director's order, we held that the referee was not permitted to find facts in relation to a review to determine eligibility for vocational services, and that an error of fact could not serve as a basis in itself for modifying the Director's decision under ORS 656.283(2). Richard A. Colclasure, 42 Van Natta 2454 (1990).

The Court of Appeals affirmed our decision. Colclasure v. Washington County School Dist. No. 48-I, 117 Or App 128 (1992). The Supreme Court reversed, stating that the provisions of ORS 656.283 contemplated, at a minimum, an opportunity to be heard, an opportunity to present and rebut evidence, and a reviewable record. The Court reasoned that where the Director informally investigated and issued an order, the referee's role was to conduct 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 then reviews under ORS 656.283(2) upon the record developed before the referee. Colclasure v. Washington County School Dist. No. 48-I, supra.

In this case, the procedures conducted at the hearings level comport with this process. The parties developed a record before the Referee, and on the basis of that record, the Referee found that claimant was able to perform his regular job, but could not return to work for a reason unrelated to his injury. Based upon these findings, the Referee concluded that the Director did not abuse his discretion. We agree.

Claimant contends that the Director made erroneous factual findings. He maintains that he actually performed heavy work and that based on Dr. Bald's report, he is only capable of performing light duty work and thus, he is unable to perform his regular job.

The record developed before the Director supports a conclusion that claimant was able to return to regular work. The subsequent medical arbiter report does not change this determination. Dr. Bald recommended that claimant could return to light duty work. Claimant testified that he could perform his regular job as outlined in the job analysis approved by Dr. Fuller. That job analysis, which claimant helped to prepare, was for light duty work. We, thus, find that claimant is physically able to return to regular work, as defined in the job analysis. Therefore, we affirm the Referee's conclusion that the Director did not abuse his discretion in finding that claimant was ineligible for vocational assistance.

Extent of Unscheduled Permanent Disability

The parties only contest the adaptability factor. Relying on our decision in Heather M. Smith, 44 Van Natta 2207 (1992), the Referee reasoned that claimant's adaptability was to be determined as of the date of the Determination Order. Thus, relying on Dr. Fuller's release for regular work, the Referee concluded that claimant was not entitled to an adaptability factor. The Referee further stated that even if the medical arbiter report was considered, the medical arbiter's release for light work would be compatible with a release to claimant's former job.

Subsequent to the Referee's order, the court reversed our decision in Smith and held that a claimant's adaptability value was to be determined as of the date of the reconsideration order. Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993). On review, we have considered the medical arbiter report in determining claimant's adaptability factor.

However, claimant, in effect, contends that the applicable DOT (512.135-010) does not adequately describe his at-injury job. While we consider the record as a whole, the most applicable DOT determines the strength category of the at-injury job. See William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993). The most applicable DOT identifies "pot room supervisor" as being in the "light" category. The medical arbiter, Dr. Bald, limited claimant to performing light work.

OAR 436-35-310(1) provides that the adaptability value is determined by comparing the highest prior strength demands based on the jobs the worker has performed during the past ten years preceding the time of determination with the worker's residual functional capacity (RFC). Here, claimant's RFC is the same as it was prior to the compensable injury. Accordingly, claimant's adaptability value is 1. OAR 436-35-310(2); England v. Thunderbird, 315 Or 633 (1993); Melvin E. Schneider, Jr., 45 Van Natta 1544 (1993).

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 (2) is multiplied by the adaptability value (1), the total is 2. When this value is added to the value for impairment (24), the result is 26. Inasmuch as claimant has failed to establish that he is entitled to a greater award of permanent partial disability than that awarded by the Order on Reconsideration, and the insurer has not cross-appealed or sought a reduction in claimant's permanent disability award, the Order on Reconsideration is affirmed.

ORDER

The Referee's order dated March 4, 1993 is affirmed.

In the Matter of the Compensation of
KATHLEEN L. HOFRICHTER, Claimant

WCB Case No. 92-15904

ORDER ON REVIEW

Robert G. Dolton, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Referee Tenenbaum's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not entitled to an impairment rating due to an abnormality, if any, in range of motion measurements, since the physicians who examined claimant, including her treating physician, found no permanent impairment. We agree.

On review, claimant contends that she should receive a 9 percent award for reduced lumbosacral flexion and lumbar extension ranges of motion pursuant to OAR 436-35-360(19), (20) and (21). Claimant argues that on the basis of the range of motion measurements reported by the medical arbiter, she has established that she suffers permanent impairment due to her compensable low back strain.

Claimant became medically stationary after July 1, 1990, and she made a request for reconsideration pursuant to ORS 656.268. Therefore, in rating her permanent disability, we apply the disability rating standards in effect on the date of the August 24, 1992 Determination Order. OAR 438-10-010, 436-35-003(2). Those standards are provided in WCD Admin. Order 2-1991.

Impairment is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). The medical evidence in this case regarding that issue comes from Dr. Kenyon, attending physician, Dr. Duff, independent medical examiner, and Dr. Gritzka, medical arbiter.

On June 1, 1992, Dr. Kenyon declared claimant medically stationary. When he submitted an 828 form he checked the box: "impairment undetermined." Dr. Kenyon released claimant for "modified" work "but not at old job no repetitive motions of the back or forward bending type job [sic]" and checked the box indicating these limitations are "permanent" (Ex. 9).

Dr. Duff, who examined claimant on June 3, 1992, noted that claimant complained of intermittent back discomfort. However, Dr. Duff concluded that claimant had no permanent residuals from her work injury. On June 11, 1992, Dr. Kenyon concurred with Dr. Duff's report. On June 10, 1992, Dr. Kenyon noted that claimant was still having pain with certain activities. However, Dr. Kenyon reported that claimant's closing examination showed "normal range-of-motion measurements." Further, Dr. Kenyon reported that claimant "has not sustained a permanent partial disability as a result of the industrial injury," and he anticipated her subjective complaints would completely resolve with time over the next several months (Ex. 13).

Dr. Gritzka, who examined claimant on November 23, 1992, noted that she complained of pain. Dr. Gritzka found that claimant had 58 degrees of retained lumbar flexion and 12 degrees retained lumbar extension. Dr. Gritzka also reported that claimant had 14 degrees of retained right side flexion and 20 degrees retained left side flexion. Nonetheless, Dr. Gritzka concluded that claimant had "a normal objective physical examination."

We find nothing in the reports of Drs. Kenyon, Duff or Gritzka which supports a finding of rateable impairment. Pain is considered in the standards only to the extent it results in measurable impairment. OAR 436-35-320(2). While each doctor reported that claimant had intermittent low back pain, there is no medical evidence that the pain resulted in measurable impairment. To the contrary, each doctor reported that claimant's range of motion measurements were within normal limits. While Dr. Gritzka indicated that claimant had some diminished range of motion upon examination, he evidently concluded that such findings did not reflect any corresponding permanent impairment caused by the March 25, 1992 compensable injury. See Lydia L. Kent, 44 Van Natta 2438 (1992).

On this record, we conclude that claimant has failed to establish that she suffered permanent measurable impairment as a result of her compensable low back strain. Accordingly, we are precluded from awarding any benefits for unscheduled permanent partial disability. OAR 436-35-270(2); SAIF v. Bement, 109 Or App 387 (1991).

In the alternative, claimant contends that she should receive a 5 percent award for a chronic condition limiting repetitive use of the lumbar spine pursuant to OAR 436-35-320(5)(a). We disagree.

Former OAR 436-35-320(5) provides that a "worker may be entitled to unscheduled chronic condition impairment when 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. 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).

However, we conclude that the record contains no medical evidence that claimant was unable to repetitively use her low back. Dr. Kenyon recommended that claimant avoid repetitive motions of the back. He also recommended that claimant avoid work which required forward bending, in order to prevent an increase in symptoms. However, this evidence is insufficient to establish a permanent and chronic impairment of the back. OAR 436-35-010(6); Lowry, supra; Rae L. Holzapfel, 45 Van Natta 1748, 1749 (1993) (Based on an assessment of the claimant's continuing symptoms of aching and occasional tingling and numbness in her wrists, the examining physicians' recommendation that the claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms, was insufficient to establish a permanent and chronic impairment of the wrists.)

Moreover, Dr. Gritzka reported that "no objective evidence was found that would render the claimant unable to repetitively use her body part due to a diagnosed chronic and permanent medical condition." The record contains no other medical evidence which supports a finding of a chronic condition.

Finally, although claimant testified to her pain that limited her ability to engage in activities involving repetitive use of her back, lay testimony is insufficient to establish "impairment" under the standards. ORS 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991) (To be entitled to permanent disability under the "standards," a claimant must establish "impairment" which is defined under the "standards" as a decrease in function of a body part or system, as measured by a physician). Accordingly, claimant is not entitled to an award for a chronic condition limiting repetitive use of the lumbar spine. William K. Nesvold, supra.

ORDER

The Referee's order dated March 16, 1993 is affirmed.

In the Matter of the Compensation of
MARIA L. MARTINEZ, Claimant
WCB Case No. MS-93009
ORDER ON REVIEW OF DIRECTOR'S ORDER UNDER ORS 656.327(1)(b)
Steven M. Schoenfeld, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of the Director's order finding no bona fide medical services dispute under ORS 656.327(1)(b). On review, the issue is jurisdiction. We set aside the order.

Claimant has an accepted June 1985 low back injury claim. Her claim was first closed by Determination Order on December 13, 1988. Claimant continued to exhibit pain, and in 1991 Dr. Nash, neurosurgeon, became her attending physician.

On September 11, 1991, Dr. Nash recommended that claimant undergo a surgical decompression and discectomy at L4-5 on the left. On December 18, 1991, in response to Dr. Nash's recommendation, the SAIF Corporation contended that Nash could no longer act as claimant's attending physician. Specifically, SAIF asserted that claimant was enrolled in a managed care organization (MCO) and Dr. Nash was not a member of that MCO. Subsequently, Dr. Gray, D.O., became claimant's attending physician. Dr. Gray opined that any lumbar disc surgery for claimant would be palliative, but would not enable her to return to work.

Claimant requested a hearing regarding the surgery dispute. That request was dismissed by a referee's order. That order was not appealed.

Claimant then requested Director review under ORS 656.327(1). Finding that Dr. Gray (claimant's current attending physician) had not proposed surgery, the Director concluded that no bona fide medical services dispute existed. Thereafter, claimant requested Board review.

ORS 656.327(1) provides for review by the Director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services[.]" In Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment.

Here, the dispute pertains to the propriety of the proposed low back surgery. Based on Jefferson v. Sam's Cafe, supra, we find that the procedure contained in ORS 656.327(1) is not applicable and, therefore, claimant was not entitled to Director review under the statute. Consequently, because the Director lacked jurisdiction to address claimant's request for review of the proposed low back surgery, we set aside the order finding no bona fide medical services dispute. See ORS 656.327(1)(b); Jefferson v. Sam's Cafe, supra.¹

Parenthetically, we note that claimant has also requested a hearing regarding this medical services matter. (WCB Case No. 93-11459). In light of Jefferson v. Sam's Cafe, supra, it would appear that the Hearings Division is the appropriate forum to consider claimant's contentions.

ORDER

The Director's order dated August 13, 1993 is set aside.

¹ SAIF notes that it has requested the Supreme Court's review of the Court of Appeal's decision in Jefferson v. Sam's Cafe, supra. Reasoning that "reversal is a high probability," SAIF suggests that we stay further proceedings until the Court issues its decision in Jefferson. We decline SAIF's suggestion. Unless and until Jefferson v. Sam's Cafe, supra, is reversed, it is valid law and we are bound to follow it. See Alfonso S. Alvarado, 43 Van Natta 1303 (1991).

In the Matter of the Compensation of
MINDI M. MILLER, Claimant
WCB Case No. 92-04937
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of those portions of Referee Livesley's order that: (1) awarded claimant temporary disability benefits; (2) assessed a penalty for its allegedly unreasonable refusal to pay temporary disability benefits; (3) directed it to pay the fee for Dr. MacRitchie's medical report; and (4) assessed a penalty for its allegedly unreasonable failure to pay the medical report fee. On review, the issues are res judicata, temporary disability benefits, medical services and penalties.

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

On review, the insurer contends that the Referee lacked jurisdiction to order payment of Dr. MacRitchie's medical report fee. The insurer reasons that the payment of the medical report fee is a matter within the Director's exclusive jurisdiction under ORS 656.327. We disagree.

Subsequent to the Referee's order, in Meyers v. Darigold, Inc., 123 Or App 217 (1993), the Court of Appeals considered the Director's jurisdiction over medical treatment disputes under ORS 656.327. The court held that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create that jurisdiction occur. The court observed that, among those conditions, there must be a "wish" by a party or the Director for Director review of the treatment and notice must be filed with the Director. The court concluded that, if those conditions are not satisfied, the medical treatment dispute is a "matter concerning a claim" over which the Board and Hearings Division retain jurisdiction. See ORS 656.704(3).

Here, there is no indication in the record that either party or the Director has filed a notice to seek Director review of this medical treatment dispute. Absent that notice, the conditions necessary for the Director to acquire jurisdiction under ORS 656.327 have not been satisfied. Accordingly, this dispute is a "matter concerning a claim" over which the Referee and the Board have jurisdiction. See ORS 656.704(3); Meyers v. Darigold, Inc., supra.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the res judicata, temporary disability and medical services 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 and statement of services), the complexity of the issues, and the value of the interest involved. Inasmuch as penalties are not "compensation," claimant's counsel is not entitled to an attorney fee for defending on that issue. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The Referee's order dated January 12, 1993 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
STEPHEN M. PETRICEVIC, Claimant
WCB Case No: 92-09738
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's occupational disease claim for his bilateral plantar fasciitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the first sentence of the ultimate findings of fact.

On April 30, 1992, Dr. Denker, M.D., treated claimant regarding his foot complaints. On May 21, 1992, Dr. Barnhouse, M.D., began treating claimant regarding his foot complaints. Claimant was referred to Dr. Granville, podiatrist, and began treating with him on June 3, 1992. All of these doctors are with Kaiser.

On October 5, 1992, Dr. Neufeld, orthopedist, and Dr. Peterson, podiatrist, examined claimant in an independent medical examination.

CONCLUSIONS OF LAW AND OPINION

By way of explanation regarding his conclusion that claimant had proven his case for compensability, the Referee adopted claimant's written closing arguments. 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 the evidence lead to the conclusion. Jack S. Koehler, 45 Van Natta 1728 (1993); Nancy L. Cook, 45 Van Natta 977 (1993); see also Armstrong v. Astén-Hill Co., 90 Or App 200 (1988). Although the Referee's order contained an organized set of facts, by simply adopting claimant's written closing arguments, the order failed to set forth conclusions of law with an explanation of why the facts supported by the evidence lead to the conclusion.

In his closing arguments, claimant argues that his preexisting high arch constituted a predisposition for the development of plantar fasciitis condition and, as such, should not be considered in determining compensability of that condition. In addition, he argues that the symptoms of plantar fasciitis condition are the disease; therefore, a worsening of those symptoms caused by work activities establishes compensability. On review, the employer argues that claimant has not met his burden of proving a compensable occupational disease. We agree with the employer.

To establish a compensable occupational disease, claimant must prove, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his diagnosed foot condition or its worsening. ORS 656.802(2). A "major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983). An "occupational disease" includes any series of traumatic events or occurrences which requires medical services or results in disability. ORS 656.802(1)(c).

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; however, all causes of a disease must be considered in determining which, if any, is the major contributing cause. Id. at 569. See also Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993).

Here, it is undisputed that claimant has a preexisting high arch condition that makes him susceptible to developing plantar fasciitis. Furthermore, claimant does not contend and the record does not support a finding that work activities caused or worsened the preexisting high arch condition. However, the record also does not merely indicate that claimant had a susceptibility or predisposition to developing plantar fasciitis. Instead, the record establishes that claimant's high arch condition is an actual cause of his bilateral plantar fasciitis condition.

The record contains opinions from five physicians regarding causation. Claimant was examined by two independent medical examiners. On October 5, 1992, Dr. Neufeld, examining orthopedist, examined claimant and diagnosed "bilateral foot pain." (Ex. 17-4). He speculated that claimant "may have some type of inflammatory bowel disease that may be related to an arthropathy or inflammatory process involving his feet." (Ex. 17-5). Dr. Neufeld opined that the major contributing cause of claimant's foot condition was this unrelated inflammatory process, not the work activities. (Exs. 17-5, 22). However, he opined that the work activities caused claimant to be more symptomatic. (Ex. 22-1). We do not find Dr. Neufeld's speculation as to a "possible" unrelated inflammatory process persuasive. Gormley v. SAIE, 52 Or App 1055 (1981). Therefore, we accord his opinion little weight.

Dr. Peterson, examining podiatrist, examined claimant on October 5, 1992 and diagnosed plantar fasciitis syndrome. (Ex. 18-3). He opined that the major contributing cause of claimant's foot condition and need for treatment was his mechanical foot structure, not his work activities. (Exs. 18-4, 19, 20-14, 20-15, 20-26, 20-27, 20-34, 20-35, 20-36, 20-38). Dr. Peterson explained the mechanics of the problem in much the same way that Dr. Granville, claimant's treating podiatrist, did, in that claimant's foot collapses on weightbearing, overstretching the fascial band in the foot causing it to pull on the heel and resulting in inflammation and pain. (Exs. 16, 19, 20-35, -36).

Dr. Denker, a treating M.D. at Kaiser, treated claimant on April 30, 1992, diagnosed "bilateral foot strain," and checked a box indicating that claimant's condition was the result of industrial exposure or injury. (Ex. 4A). Dr. Barnhouse, another treating M.D. at Kaiser, first treated claimant on May 21, 1992, and diagnosed "plantar fasciitis." Dr. Barnhouse issued several treatment summary reports which included "check-the-box" indications that claimant's condition was the result of industrial exposure or injury. (Exs. 5B, 10A, 12). In response to claimant's attorney's inquiry, Dr. Barnhouse summarized claimant's care and opined, without explanation, that the major cause of claimant's foot condition is "prolonged standing at work on concrete and brick floors." (Ex. 18A-2). Because both Dr. Denker's and Dr. Barnhouse's opinions are conclusory, we do not find them persuasive. Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Granville, a treating podiatrist at Kaiser, began treating claimant on June 3, 1992 and diagnosed "plantar fasciitis, heel pain bilaterally." (Ex. 9). Dr. Granville offered several opinions regarding the cause of claimant's plantar fasciitis condition. (Exs. 16, 19A, 24, 25). Considering Dr. Granville's opinions as a whole, we find that he opined that the congenital high arch condition was a cause of claimant's plantar fasciitis condition, although not the major contributing cause. (Exs. 16, 24-1). Furthermore, he opined that the work activities were not the major contributing cause of the plantar fasciitis condition, although the work activities caused a symptomatic rather than a pathologic worsening of that condition. (Exs. 16, 24-2, 25-1).

We note that Dr. Granville's second opinion regarding causation, rendered on October 13, 1992, indicated that the nature of claimant's employment "in all likelihood brought on his condition and the associated symptoms." (Ex. 19A). However, his previous opinion regarding causation and his two subsequent opinions on the issue repeatedly stated that he could not say that the work activities were the major contributing cause of claimant's plantar fasciitis. (Exs. 16, 24-2, 25-1). We find that Dr. Granville's October 13, 1992 opinion represents an unexplained change of opinion. In addition, following his October 13, 1992 opinion, Dr. Granville returned to his original opinion that the work activities were not the major cause of the plantar fasciitis condition. For these reasons, we do not find Dr. Granville's October 13, 1992 opinion persuasive.

Although we do not find Granville's unexplained, inconsistent October 13, 1992 opinion persuasive, we find the remainder of his opinions persuasive. 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). After excluding the inconsistent

October 13, 1992 opinion, there are no persuasive reasons not to defer to Dr. Granville's remaining opinions. In addition, we note that the opinions of Drs. Granville and Peterson do not differ that greatly, although Peterson opined that claimant's foot mechanics were the major contributing cause of the plantar fasciitis condition and Granville was unwilling to go that far, both agreed that the work activities were not the major contributing cause of the condition.

The remaining opinions from Dr. Granville do not indicate that the work activities were the major contributing cause of claimant's plantar fasciitis condition, although those activities symptomatically worsened that condition. Therefore, Granville's opinions are not sufficient to meet claimant's burden of proof. ORS 656.802(2). Furthermore, Dr. Granville opined more than simply that claimant's high arches predisposed claimant to development of plantar fasciitis condition, he opined that the high arches were an actual cause of that condition. Liberty Northwest Insurance Corp. v. Spurgeon, supra.

On this record, claimant has not established that the work activities were the major contributing cause of his bilateral plantar fasciitis condition. No persuasive medical evidence found that the work activities were the major contributing cause of the plantar fasciitis condition, although several physicians opined that the work activities symptomatically worsened the condition.

Claimant argues that, where the medical evidence shows that the symptoms are the disease, a symptomatic worsening is enough to support compensability. In Georgia-Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991), the Court of Appeals considered whether claimant's carpal tunnel syndrome was a compensable occupational disease when evidence showed that the claimant also suffered from an underlying condition of "entrapment neuropathy." The court explained that "sometimes the medical evidence will support the conclusion that the symptoms for which compensation is sought are the disease." The court concluded that, because claimant sought compensation for the syndrome and the syndrome was caused by work activity, the syndrome was compensable. Id. at 278; Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990).

However, contrary to claimant's argument, the record here does not establish that the symptoms are the disease. Instead, as discussed above, the medical opinions of Drs. Granville and Peterson agree that claimant's plantar fasciitis condition is caused by a flattening of the arches to such an extent that the plantar fasciitis pulls on the heel causing pain. (Exs. 16, 19, 20-35, 36). Although both Granville and Peterson agree that the result of the process is the symptom of pain and that the condition is manifested by the symptom of pain, neither opine that the symptoms are the disease.

Furthermore, even assuming that one could conclude from Granville's and Peterson's opinions that the symptoms are the disease in this case, we conclude that claimant's work was not the major contributing cause of his symptoms. Georgia-Pacific Corp. v. Warren, supra; Teledyne Wah Chang v. Vorderstrasse, supra. As discussed above, no persuasive medical opinion opined that claimant's work was the major contributing cause of his symptoms.

Accordingly, on this record, we conclude that claimant has failed to establish the compensability of his bilateral plantar fasciitis condition.

ORDER

The Referee's order dated April 23, 1993 is reversed. The self-insured employer's denial is reinstated and upheld. The assessed attorney fee awarded by the Referee is also reversed.

In the Matter of the Compensation of
MARVIN L. WALL, Claimant
WCB Case No. 91-18451
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of those portions of Referee T. Lavere Johnson's order that: (1) set aside its partial denial of claimant's cervical condition; (2) found that claimant's back injury claim was prematurely closed; and (3) vacated its denial of claimant's aggravation claim. In his brief, claimant requests a \$2,000 attorney fee for prevailing on the compensability of his current low back condition. In addition, if the claim was not prematurely closed and claimant's condition has not worsened, claimant requests remand for further proceedings on the extent of permanent disability issue. On review, the issues are compensability, premature closure, attorney fees and, if the claim was not prematurely closed, aggravation, remand, or extent of permanent disability.

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

Claimant requests a \$2,000 attorney fee for his services at hearing in connection with allegedly prevailing against the employer's "at-hearing" denial of claimant's then-current low back condition.

At hearing, the employer supplemented its aggravation denial as follows:

"We'll take the position that there has been no worsening since the last arrangement of compensation in relation to the low back since the -- and that the condition for which he seeks any worsening, if there is a worsening, is not causally related to the industrial injury." (Tr. 5)

In our view, the employer thus challenged the compensability of claimant's low back condition only in the context of its denial of the aggravation claim. Furthermore, that denial was contingent on a finding that the claim was not prematurely closed. Because we uphold the Referee's decision to vacate the aggravation denial, as a result of the premature claim closure finding, claimant did not prevail against it. Consequently, claimant is not entitled to an attorney fee under ORS 656.386(1) on this basis. See Candy M. Kayler, 44 Van Natta 2424 (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 premature closure and compensability issues is \$1,500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 30, 1992 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of \$1,500, payable by the self-insured employer.

In the Matter of the Compensation of
JESUS FLETES, Deceased, Claimant
WCB Case No. 92-02935
And, In the Matter of the Compensation
GABRIEL L. ALVAREZ, Claimant
WCB Case No. 92-01344
And, In the Matter of the Complying Status of
EDWIN HAYES, Noncomplying Employer
WCB Case No. 92-02586
SECOND ORDER OF DISMISSAL
Bischoff & Strooband, Claimant Attorneys
Bruce D. Smith, Claimant Attorney
Cowling & Heysell, Attorneys
James Dodge (Saif), Defense Attorney

Edwin Hayes, an alleged noncomplying employer, has requested reconsideration of our November 30, 1993 order that dismissed Hayes' request for Board review of a Referee's order. In dismissing Hayes' request for review, we concluded that appellate authority over the Referee's order rested with the Court of Appeals under ORS 656.740(4). Reiterating that it had requested hearings regarding both the Department's noncomplying employer (NCE) order and the SAIF Corporation's acceptances of the claimants' injury claims under ORS 656.054, Hayes contends that we have appellate review authority because the hearing before the Referee involved not only the NCE order but a "matter concerning a claim." See ORS 656.740(4)(c). On reconsideration, we continue to hold that appellate jurisdiction lies with the Court of Appeals.

In reaching our prior conclusion, we acknowledged that Hayes had contested at the hearing not only the NCE order, but also SAIF's claim acceptances. Nevertheless, noting the Referee's clarification of the issues (as well as Hayes' counsel's statement that the issues were narrowly focused on whether the claimants were subject workers under ORS 656.027(3)), we reasoned that the only disputed issues were whether the claimants were subject workers and whether Hayes was a subject employer. Since these issues arose from the Director's NCE order, we were unable to conclude that Hayes' "subjectivity" objections to SAIF's acceptances (which were based on the identical grounds as his objection to the NCE order) represented the contesting of a "matter concerning a claim" at the same hearing as the NCE order. See ORS 656.740(4)(c). Consequently, we held that appellate review authority was not vested in this forum.

Characterizing our conclusion as essentially rendering his appeal of SAIF's claim acceptances a "nullity," Hayes seeks reconsideration. Furthermore, reasoning that our analysis conflicts with the rationale expressed in Gary Redden, 43 Van Natta 1525 (1991), and Patricia Hinsen, 45 Van Natta 1563 (1993), Hayes argues that we retain jurisdiction over the Referee's order.

We disagree with Hayes' contentions. To begin, our decision does not "nullify" Hayes' appeal of SAIF's claim processing actions. To the contrary, those objections remain viable within the confines of the Referee's order.¹ Moreover, as noted in our dismissal order, had Hayes contested SAIF's acceptances on "compensability" grounds (e.g., contested the existence of the claimants' injuries or their relationship to the alleged incident), we would have retained appellate review authority over the Referee's order. See Michael D. Owings, 42 Van Natta 626 (1990). We would have reached such a conclusion because such "compensability" challenges could not have been encompassed within the Director's NCE order and, thus, the NCE order would have been contested at the same hearing as a matter concerning a claim. See ORS 656.740(4)(c).

However, as we have previously discussed, Hayes confined his objections to SAIF's claim acceptances to whether the claimants were subject workers under ORS 656.027(3). Inasmuch as such issues were included within the NCE order, it follows that the consolidated hearing did not also involve an issue other than these subjectivity issues. Consequently, appellate review authority over the Referee's order rests with the Court of Appeals.

¹ We note that Hayes has also petitioned the Court of Appeals for judicial review of the Referee's order.

Our decision is not controlled by the Hinsen and Redden holdings. First, neither holding pertains to the issue of appellate review authority under ORS 656.740(4). Thus, this case is subject to the points and authorities discussed above and in our prior dismissal order. Moreover, the Hinsen and Redden holdings do not compel an alteration of our prior reasoning.

In Hinsen, a NCE (who had not appealed a NCE order) subsequently challenged SAIF's "back-up" denial of the claimant's claim. We reasoned that the NCE could contest "compensability" of the claim (whether the claimant was acting within the course of her employment when injured). Nevertheless, since the NCE's challenge was solely confined to the claimant's "subject worker" status, we reasoned that the NCE was precluded from contesting that issue because it had failed to appeal the NCE order which had previously found that the claimant was a subject worker for the NCE.

Based on this latter conclusion in Hinsen, we distinguished Redden. In Redden, we held that a NCE (who had not timely appealed a NCE order) was not precluded from contesting SAIF's acceptance of the claim based on "subjectivity" grounds. In reaching this conclusion, we were unable to determine whether it was essential to the NCE order to have found the claimant (as opposed to other alleged employees) to be a subject worker nor were we able to identify the "claims" concerning the NCE order and SAIF's contested acceptance.

Our reasoning distinguishing between "subjectivity" and "compensability" challenges to claims is entirely consistent with that expressed in Hinsen. We recognize that the Redden holding does suggest that a "subjectivity" challenge to SAIF's claim acceptance is an issue separate from a NCE "subjectivity" order. Furthermore, as in Redden, we acknowledge that the NCE order in this case does not expressly base its subjectivity determination on the subject worker status of these particular claimants.

Nevertheless, as we have previously noted, Redden did not address the precise "appellate jurisdiction" issue which we are presently entertaining. Moreover, based on the Referee's clarification at the hearing, it is apparent that the contested subjectivity determination specifically arose from the subject worker status of these particular claimants. Thus, in these respects, we find Redden to be distinguishable.

In conclusion, we continue to find that Hayes expressly and unambiguously confined his objections at hearing to the claimants' status as subject workers. Since such a determination was encompassed within the Director's NCE order and because no other issues regarding a matter concerning a claim were contested at that hearing, we adhere to our holding that appellate review authority over the ensuing Referee's order rests with the Court of Appeals.

Finally, claimants seek an attorney fee award for services rendered before this forum. Specifically, they rely on ORS 656.388(1). Inasmuch as the statute pertains to finally prevailing "after remand," that statutory authorization for an attorney fee award is not applicable. Furthermore, when a request for Board 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, based on the aforementioned reasoning, the request for an attorney fee award is denied.

Accordingly, we withdraw our November 30, 1993 order. On reconsideration, as supplemented herein, we republish our November 30, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ABBY L. FULLER, Claimant
WCB Case No. 92-09651
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Referee McCullough's order that affirmed an Order on Reconsideration which awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability for a neck and right shoulder injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck and right shoulder on May 1, 1991. Following the compensable injury, claimant was treated by Dr. Zirschky, orthopedist.

Claimant's claim was closed by a May 20, 1992 Notice of Closure. The Notice of Closure found claimant medically stationary as of April 27, 1992 and awarded her 21 percent unscheduled permanent disability. Claimant requested reconsideration of the Notice of Closure. A July 15, 1992 Order on Reconsideration reduced claimant's award of unscheduled permanent disability to 18 percent, but otherwise affirmed the May 20, 1992 Notice of Closure.

As a result of the compensable injury, claimant sustained permanent impairment based upon a partial range of motion loss with regard to the cervical spine. Her retained motion is: flexion, 60 degrees; extension, 45 degrees; right lateral flexion, 30 degrees; left lateral flexion, 30 degrees; right rotation, 65 degrees; and left rotation, 65 degrees.

At hearing, the parties stipulated that the total value for the factors of age, formal education, and skills is 4. In addition, the parties stipulated that claimant's at-injury job had a 75-pound lifting limit, but that claimant had to occasionally lift patients in excess of 100 pounds.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to an award of 18 percent unscheduled permanent disability. We modify.

As noted above, the parties stipulated to a total value of 4 for the factors of age, formal education and skills. Therefore, we will only address impairment and adaptability.

Impairment

With regard to impairment, we agree with and adopt the Referee's conclusions and reasoning. Therefore, claimant's value for impairment is 6.

Adaptability

The Referee found that claimant was entitled to an adaptability value of 3. In reaching this conclusion, the Referee found that claimant's prior strength level was medium, based on the DOT strength value assigned to claimant's at-injury job. (DOT Code 355.377-014).

On review, claimant contends that her prior strength level should be heavy based on the parties' stipulation that her at-injury job required lifting 75 pounds and occasionally 100 pounds. We agree.

Generally, the strength category assigned to the most applicable DOT is the determining factor in assigning an adaptability value for purposes of evaluating the extent of a worker's permanent disability. See OAR 436-35-300(3); OAR 436-35-270(3); Thomas D. Porter, 45 Van Natta 2218 (1993)(Citing William L. Knox, 45 Van Natta 854 (1993) and Arliss J. King, 45 Van Natta 823 (1993), the Board continues to hold that the record as a whole is considered in determining which DOT is the most applicable under the Director's temporary rules set forth in WCD Admin. Order 93-052).

However, we have previously stated that it is our policy to encourage parties to resolve disputed issues and to approve agreements reached by the parties, unless it appears that the agreement was obtained by a party's unfair advantage over another. Adelaida Robles-Castaneda, 44 Van Natta 2553 (1992); Dana W. Wood, 44 Van Natta 2241 (1992). Here, there is no evidence to support a finding that the parties' agreement was by virtue of one party's unfair advantage over the other. Therefore, based on the parties' agreement at hearing, claimant's strength level prior to the injury was in the heavy category. Robles-Castaneda, *supra*.

With regard to claimant's residual functional capacity, we agree with and adopt the Referee's conclusion and reasoning. Therefore, claimant's residual functional capacity is light. A prior strength level in the heavy category and a residual functional capacity in the light category produces an adaptability value of 5. OAR 436-35-310(3).

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 (4) is multiplied by the adaptability value (5), the total is 20. When this value is added to the value for impairment (6), the result is 26 percent unscheduled permanent disability.

ORDER

The Referee's order dated February 22, 1993 is modified. In addition to the 18 percent unscheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 8 percent (25.6 degrees) for a total of 26 percent (83.2 degrees) unscheduled permanent disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800.

December 15, 1993

Cite as 45 Van Natta 2379 (1993)

In the Matter of the Compensation of
JEAN K. ELLIOTT-MOMAN, Claimant
WCB Case No. 92-06386
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The self-insured employer requests reconsideration of our November 16, 1993 Order on Review that affirmed a referee's order setting aside its partial denial of claimant's degenerative lumbar spine condition. On reconsideration, the employer objects to that portion of our order that concluded that it accepted claimant's preexisting degenerative lumbar condition when it accepted her injury claim pursuant to the 801 injury claim form.

Specifically, the employer contends that claimant did not raise a "back-up" theory of compensability at hearing. Further, the employer argues, because it specifically accepted claimant's thoracolumbar sprain/strain and subluxation complex, and disc bulges at L3-4 and L4-5, the Board may not enlarge the employer's acceptance to encompass claimant's subsequently diagnosed degenerative disc disease.

In order to further consider the employer's request, we withdraw our November 16, 1993 order. Claimant is granted an opportunity to respond to the employer's motion. To be considered, claimant's response must be submitted 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
CLARENCE E. GOFF, Claimant
WCB Case No. C3-03077
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kirkpatrick & Zeitz, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

On November 30, 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 agreement.

The SAIF Corporation accepted a "left open compound supracondylar fracture, humerus and ulna." However, the proposed disposition provides that a dispute exists between claimant and SAIF as to the compensability of nocturnal shaking episodes. Specifically, the CDA provides:

"On August 26, 1992, SAIF Corporation issued a partial denial for claimant's requested treatment of nocturnal shaking episodes, which claimant alleged were related to the accepted industrial injury. Claimant filed a request for hearing to appeal the denial and raise other issues."

* * *

"The parties also stipulate that this agreement includes settlement of all issues related to claimant's request for hearing on SAIF's August 26, 1992 denial, and that said denial shall remain in full force and effect."

P. 2, lines 15-18; P. 3 lines 15-18.

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 concerning compensability. There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations and disputed claim settlements. See Donald Rhuman, 45 Van Natta 1493 (1993); Frederick M. Peterson, 43 Van Natta 1067 (1991). Consequently, because the abovementioned 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 (1990). Consequently, we decline to approve the agreement and we, therefore, return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, SAIF 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).

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). However, it is noted that if a request for reconsideration involves an altered amount of consideration underlying the agreement, we would be without authority to approve such an agreement. Mary A. Smith, 45 Van Natta 1072 (1993). Therefore, a revised agreement that alters the amount of consideration would be considered a resubmission of the CDA, and claimant's 30-day period to request disapproval would begin to run from that date. ORS 656.236.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUNE A. GONSHOROWSKI, Claimant
WCB Case Nos. 92-14022 & 92-14201
ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests reconsideration of our December 3, 1993 Order on Review which reversed a Referee's attorney fee award for the SAIF Corporation's allegedly unreasonable denial. Specifically, claimant asserts that SAIF requested dismissal of its appeal prior to issuance of our decision. In response, SAIF acknowledges that it intended to withdraw its appeal. Consequently, SAIF seeks withdrawal of our order and dismissal of its request for Board review.

Accordingly, we withdraw our December 3, 1993 order in its entirety. In accordance with SAIF's request, we dismiss the request for Board review. The Referee's order is final by operation of law.

IT IS SO ORDERED.

December 16, 1993

Cite as 45 Van Natta 2381 (1993)

In the Matter of the Compensation of
HARTMUT KARL, Claimant
WCB Case No. 92-04048
ORDER ON RECONSIDERATION
Bottini, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

The insurer requests reconsideration of our October 4, 1993 Order on Review. In that order, we awarded claimant a \$2,500 assessed attorney fee for finally prevailing over a "de facto" denial of certain medical bills for claimant's left knee condition which had been found compensable in a prior proceeding. On November 2, 1993, we abated our order to allow claimant an opportunity to respond to the insurer's motion for reconsideration. Having received claimant's response and the insurer's reply, we proceed with our reconsideration.

In a prior hearing, a referee found that claimant had not established compensability of his left knee condition as an aggravation claim. Claimant appealed that referee's order and in a December 31, 1992 Order on Review, we reversed the prior referee's order and found claimant's left knee condition compensable as an aggravation of his April 1990 industrial injury. In reaching that decision, we specifically found claimant's left knee condition causally related to his compensable injury.

In the meantime, prior to the issuance of our order in the "aggravation" case, claimant requested a hearing seeking payment of certain disputed medical bills for the left knee condition. The present Referee concluded that the prior litigation had no preclusive effect on this dispute. On review of the Referee's order, we disagreed and held that the prior litigation barred the insurer from asserting that claimant's left knee condition was not compensably related to claimant's April 1990 injury. Based on that reasoning, we set aside the insurer's "de facto" denial of the disputed medical bills and awarded a \$2,500 assessed fee to claimant's attorney for prevailing over a "de facto" denial of medical services.

On reconsideration, the insurer contends that it paid the disputed medical bills in response to our prior decision setting aside the aggravation denial. Therefore, the insurer argues that claimant's attorney has already received a fee for setting aside the aggravation denial in the prior litigation and is not entitled to an additional fee in this matter.

Subsequent to the date of our initial order, the court issued its decision in SAIF v. Allen, 124 Or App 183 (1993). In Allen, the court reversed that portion of a Board order which awarded the claimant a carrier-paid attorney fee under ORS 656.386(1) for prevailing against a carrier's "de facto" denial of medical bills without a hearing. Citing Shoulders v. SAIF, 300 Or 606, 611 (1986), and O'Neal v. Tewell, 119 Or App 329 (1993), the court stated that a claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." Relying on Short v. SAIF, 305 Or 541, 545 (1988), the court reasoned that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute."¹ The Allen court concluded that inasmuch as the hearing pertained to the carrier's nonpayment of some medical bills and since the compensability of the claimant's injury was never disputed, claimant's attorney was not entitled to an attorney-fee award under ORS 656.386(1).

Claimant contends that Allen is distinguishable. Specifically, he reasons that the present insurer had denied compensability of the claim, whereas in Allen, the underlying claim had been accepted and the dispute solely involved payment of some medical bills. We disagree.

The present dispute involves unpaid medical bills in a claim that was found compensable in the prior litigation. Since compensability of the left knee condition was resolved by the earlier litigation, compensability was not in question here. Rather, the disputed medical bills were unpaid pending the result of the prior litigation. This conclusion is supported by the fact that, at the hearing, counsel for the insurer argued that the prior litigation in this matter had a res judicata effect on this litigation. (Tr. 7). Essentially, the insurer's counsel argued that compensability of claimant's current condition (and the disputed medical treatment) depended on the outcome of the prior litigation. We agree that compensability of claimant's condition (and the medical treatment for it) was decided by that prior litigation. Since claimant has already received an attorney fee for prevailing over the insurer's aggravation denial in the first proceeding, he is not entitled to a second fee for prevailing over that same denial in this proceeding.

In accordance with the court's holding in Allen and the aforementioned reasoning, an attorney fee may not be awarded under ORS 656.386(1) since the subject of the hearing was a dispute about payment of medical bills rather than the compensability of claimant's injuries. Therefore, we conclude that claimant is not entitled to the \$2,500 attorney fee granted in our initial order.

Accordingly, on reconsideration, as modified and supplemented herein, we republish our October 4, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ Member Gurin is bound by stare decisis to follow the court's reasoning in Allen, supra, but finds it difficult to believe that compensable medical services denied by an employer do not constitute a denial of compensation.

In the Matter of the Compensation of
DORIS A. PACE, Claimant
WCB Case No. 90-08372
SECOND ORDER ON REMAND
David C. Force, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

On November 4, 1993, we withdrew our October 21, 1993 Order on Remand that: (1) awarded interim compensation from January 18, 1990 to April 16, 1990, whereas we had previously awarded interim compensation from January 18, 1990 to July 11, 1990; and (2) assessed a 25 percent penalty (to be shared equally by claimant and her counsel) based on the interim compensation award, whereas our prior order had assessed a 25 percent penalty based on our previous interim compensation award. We took this action to consider claimant's contention that she is entitled to an attorney fee award for services rendered in prevailing against the self-insured employer's request for Board review and petition for judicial review. Having received the parties' respective responses, we proceed with our reconsideration.

The relevant facts are summarized as follows. A Referee awarded interim compensation from January 18, 1990 through April 16, 1990. The self-insured employer was also assessed a 25 percent penalty based on this award to be shared equally between claimant and her counsel. The Referee also upheld the employer's "de facto" denial of claimant's aggravation claim and declined to assess a penalty-related attorney fee for allegedly unreasonable claim processing. Finally, the Referee awarded 5 percent scheduled permanent disability for the right arm and reduced claimant's unscheduled award from 17 percent to 3 percent.

Claimant requested Board review, seeking a penalty-related attorney fee for the employer's allegedly unreasonable failure to process an aggravation claim and an increase in her unscheduled permanent disability award. The employer cross-requested review, objecting to the Referee's interim compensation award, penalty assessment, and scheduled permanent disability award.

On review, we found that claimant was entitled to interim compensation. Doris A. Pace, 43 Van Natta 2526 (1991). In addition, we increased claimant's award to run through July 11, 1990, rather than through April 16, 1990. We also assessed a 25 percent penalty on this increased compensation. Those portions of the Referee's order pertaining to no penalty-related attorney fee award and to the extent of scheduled/unscheduled permanent disability were affirmed. Finally, we awarded claimant \$500 for services on review regarding the interim compensation and extent of scheduled permanent disability issues.

The employer petitioned for judicial review of our order. Two major contentions were raised by the employer. One, claimant was not entitled to interim compensation. Two, even if she was entitled to interim compensation, the Board's award should be reduced.

The court held that claimant was entitled to interim compensation. Stanley Smith Security v. Pace, 118 Or App 602 (1993). However, reasoning that our order neglected to make findings consistent with the termination of temporary total disability benefits under ORS 656.268(3)(b), the court remanded for modification of our interim compensation award. Id.

Thereafter, claimant moved for partial reconsideration of the court's decision. Specifically, claimant objected to the court's designation of the employer as the prevailing party and contended that remand to the Board was unnecessary. In response, the employer argued that it had prevailed before the court concerning the Board's interim compensation award and that remand for further findings was appropriate. Claimant replied, reiterating her prior contentions.

In addition, claimant submitted a motion for an attorney fee award seeking \$4,000 for services before the court in addition to the Board's previous \$500 award. (Claimant had already deducted \$80 from her "court" services for the 1/2 hour of time her counsel asserted had been devoted to the "interim compensation award" issue as opposed to the "interim compensation - entitlement" issue).

While claimant's motions remained pending, the employer petitioned the Supreme Court for review of the Court of Appeals decision. The Court of Appeals denied claimant's motions for reconsideration. Noting that the employer's petition also constituted a motion for reconsideration, the court denied that motion.

Following the Supreme Court's denial of the employer's petition for review, an appellate judgment issued. Designating the employer as the prevailing party, the court remanded the case to the Board.

On remand, we noted that the court had affirmed that portion of our order which held that claimant was entitled to interim compensation. Doris A. Pace, 45 Van Natta 2061 (1993). Turning to the amount of claimant's interim compensation award, we found that claimant was released to regular work by her attending physician on April 17, 1990. Id. Consequently, we held that claimant was entitled to interim compensation from January 18, 1990 to April 17, 1990.¹

Claimant moved for reconsideration of our order. Expanding on the arguments which had been posed to the court, claimant sought a carrier-paid attorney fee award totalling \$4,500 for services before the Board and court.

In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, the referee, board, or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). Such authority pertains to any claim or award for compensation. Id.; Cleo I. Beswick, 43 Van Natta 876 (1991), on recon 43 Van Natta 1314 (1991).

Here, the court affirmed that portion of our prior order which held that claimant was entitled to interim compensation. Nevertheless, since the court remanded the case for reconsideration of claimant's interim compensation award, claimant did not finally prevail on her claim for interim compensation until the issuance of our remand order. ORS 656.388(1); Cleo I. Beswick, supra. In other words, claimant was not the prevailing party before the court, but she did "finally prevail" after remand regarding her interim compensation claim.

Consequently, claimant is entitled to a reasonable attorney fee award before every prior forum. ORS 656.388(1). In making such a determination, we consider the factors set forth in OAR 438-15-010(4). After applying those factors to this case, we find that a reasonable fee for claimant's attorney's services on Board review, before the court, and on remand is \$3,000, to be paid by the employer. This fee is in addition to our prior \$500 carrier-paid attorney fee award for services on Board review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and motions), the complexity of the issue, the value of the interest involved, the result secured for claimant, and the risk that claimant's counsel might go uncompensated.²

Accordingly, on reconsideration, as supplemented and modified herein, we republish our October 21, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

¹ Our order provided that the Referee's awards of interim compensation and penalties were "modified." Nevertheless, since we found that claimant was released to regular work on April 17, 1990, it follows that she was not entitled to interim compensation from that date forward. Inasmuch as the Referee awarded interim compensation through April 16, 1990, it likewise follows that our order did not increase claimant's awards of interim compensation or penalties. Consequently, although our decision was based on different reasoning than that expressed by the Referee, we actually "affirmed" the Referee's order.

² Claimant's counsel has successfully defended claimant's entitlement to interim compensation. However, the employer has also prevailed in overturning our prior "six month" interim compensation award and returning the award to the "three months" granted by the Referee's order. In reaching our determination of a reasonable attorney fee award, we note that approximately twenty of claimant's twenty-two page respondent's brief to the court was devoted to her entitlement to (as opposed to the amount of) interim compensation. These circumstances have been of particular significance to us in determining a reasonable attorney fee award.

In the Matter of the Compensation of
BOBBI J. ALLEN, Claimant
WCB Case No. 92-09890
ORDER ON REVIEW
Dobbins, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Haynes.

The self-insured employer requests review of that portion of Referee Thye's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings. However, we do not adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established a compensable aggravation. We disagree.

In January 1992, claimant's attending physician, Dr. Berselli, wrote to the employer requesting an MRI of claimant's lumbar spine for purposes of determining whether claimant had suffered a worsening of her accepted low back condition. (Ex. 57). An MRI scan was performed on March 3, 1992. (Ex. 58). Dr. Berselli interpreted the scan as showing a central disc herniation at the L5-S1 level with involvement of the S1 nerve roots bilaterally. (Ex. 58a). Dr. Berselli recommended surgery at the L5-S1 level.

Also in March 1992, Dr. Berselli requested authorization from the employer for an epidural steroid injection as "palliative" care for claimant's compensable low back condition. Authorization was given and claimant received the epidural steroid injection on April 16, 1992. Dr. Berselli reported that claimant had "a somewhat exaggerated response" to the steroid injection. (Ex. 58a). Dr. Berselli noted bilateral paralumbar muscle spasm following the injection.

Claimant was seen by Dr. Wade, orthopedist, for a second opinion regarding her need for surgery at L5-S1. Dr. Wade reviewed claimant's MRI and noted bulging at the L5-S1 level, but did not think it represented a herniation. He advised against surgery. In a letter to the employer's processing agent, Dr. Berselli acknowledged that Dr. Wade was not sure that surgery would benefit claimant. Dr. Berselli believed that there was an honest difference of opinion between he and Dr. Wade and recommended that claimant be seen by a second neurosurgeon for a "deciding" opinion regarding surgery.

Claimant was seen by Dr. Grewe in August 1992 for a second opinion. Noting that claimant had reacted badly to previous invasive diagnostic tests and that claimant no longer had positive straight leg raising and had unimpressive MRI scans, Dr. Grewe recommended against surgery. Dr. Grewe reported that claimant's exam in August 1992 was normal as compared to the closing exam he performed in January 1991.

Dr. Coit, radiologist, reviewed claimant's lumbar and cervical spine studies for the employer. Dr. Coit noted no difference in the L5-S1 disc in studies of claimant's low back done both before and after the alleged worsening.

To establish a compensable worsening of her unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

The Referee found that claimant had not established that her condition had worsened after claim closure due to a further herniation of the L5-S1 disc. We agree with the Referee's analysis and conclusions concerning a worsening of the L5-S1 disc. The only physician who believed that claimant had a herniation at L5-S1 was Dr. Berselli. All of the other physicians who examined claimant found no herniation at L5-S1. Moreover, it is not clear that Dr. Berselli's opinion supports a worsening of claimant's condition since he deferred to Dr. Grewe's "deciding" opinion concerning claimant's need for surgery at L5-S1. Finally, Dr. Grewe who had examined claimant before the alleged worsening, opined that claimant's exam in August 1992 was normal. Based on a preponderance of the medical evidence, we agree with the Referee that claimant did not establish a worsening of her L5-S1 disc condition after claim closure.

Although he found that claimant had not established a worsening of her disc condition, the Referee concluded that claimant had established a symptomatic worsening of her low back condition after receiving the epidural steroid injection in April 1992. On the basis of her reaction to the steroid injection, the Referee found that claimant had established a compensable aggravation. We disagree.

Multiple physicians have noted that claimant exhibits pain behavior out of proportion to her objective physical findings. Even Dr. Berselli opined that claimant had a "good deal of functional components to her complaints of back pain." In an April 1992 chart note, under the section titled "subjective," Dr. Berselli wrote that claimant was "worse" following an epidural steroid injection. In the same chart note, under the heading "objective," Dr. Berselli stated that claimant had "a somewhat exaggerated response" to the injection.

Given claimant's history of exaggerated pain behavior, we are not persuaded that claimant's reaction to the "palliative" epidural steroid injection represented a worsening of her condition or her low back symptoms. We find it likely, on the basis of this record, that Dr. Berselli did not mean that claimant had suffered a true worsening of her symptoms or condition when he stated in a chart note that claimant had an "exaggerated" response to the steroid injection. Moreover, we note that no physician has opined that claimant's reaction to the steroid injection represented a worsening, symptomatic or otherwise, of her low back condition. In fact, the preponderance of the medical evidence indicates that claimant's low back condition was not worse.

In reaching this decision, we are aware that Dr. Berselli noted paralumbar muscle spasms after the epidural steroid injection. Muscle spasms constitute objective findings. ORS 656.005(19); Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). However, the worsening of claimant's condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). In light of claimant's tendency toward exaggerated pain behavior, we conclude that medical evidence is necessary to establish that claimant's reaction to the steroid injections represented a symptomatic worsening of claimant's low back condition. ORS 656.273(1);(3). Given the absence of medical evidence, we conclude that claimant has failed to carry her burden of proof to establish a worsening. Accordingly, we conclude that claimant has not established a compensable aggravation.

ORDER

The Referee's order dated December 11, 1992 is reversed. The employer's denial is reinstated and upheld. The \$1,500 assessed attorney fee is also reversed.

December 17, 1993

Cite as 45 Van Natta 2386 (1993)

In the Matter of the Compensation of
LAUREL D. CUTLER, Claimant
 WCB Case No. 91-12283
 ORDER ON REVIEW
 Pozzi, Wilson, et al., Claimant Attorneys
 Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Barber's order that upheld the self-insured employer's denial of claimant's aggravation and medical services claim for her current back condition. On review, the issue is compensability

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

On review, claimant concedes that she must prove that her 1988 compensable low back injury is the major contributing cause of her current back condition. See ORS 656.005(7)(a)(A),(B); Gray v. SAIF, 121 Or App 217 (1993). She argues that, because Dr. Sirounian, her treating physician, testified that her back injury was "the major contributing cause" of her current condition, she has met her burden of proof. We disagree.

Simply reciting the "magic words" is not sufficient to carry a claimant's burden of proof when the preponderance of medical evidence does not support such a conclusion. See Debra L. Godell, 45 Van Natta 34 (1993). Here, for the reasons expressed by the Referee and articulated below, we conclude that the preponderance of the evidence does not support the conclusion that claimant's back injury was the major contributing cause of her current condition.

Although Dr. Sirounian recites the proper legal standard, (Exs. 45, 46-28), he repeatedly admits that he cannot identify the cause or the date of onset of claimant's current condition. (Ex. 46-22, 27, 45). Sirounian also appears to attribute claimant's current condition to a continuation of an underlying noncompensable degenerative process. (See Ex. 46-34). These inconsistencies render his opinion unpersuasive. Because claimant did not meet her burden of proof, the Referee correctly upheld the employer's denial of claimant's current back condition.

ORDER

The Referee's order dated April 21, 1993 is affirmed.

December 17, 1993

Cite as 45 Van Natta 2387 (1993)

In the Matter of the Compensation of
MARK R. LYSYK, Claimant
WCB Case No. 92-09157
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The insurer requests review of those portions of Referee Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for left ear tinnitus; and (2) allegedly awarded an excessive attorney fee. On review, the issues are compensability and attorney fees.

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

Occupational disease claim

On review, the insurer argues that claimant is not a credible witness, and therefore, has not established that work is the major contributing cause of his left ear tinnitus condition. Moreover, the insurer argues that the occupational disease claim is not compensable because claimant's tinnitus condition does not require medical treatment, nor has it resulted in disability.

The Referee specifically found claimant to be a credible witness. Our review of the record does not convince us that claimant is not a credible witness.

Claimant must show that his condition required medical services or resulted in disability. ORS 656.802(1). Claimant testified that due to work related noise he experienced ringing in his left ear. For this condition he sought medical care at Kaiser Hospital. He was seen by Mary Engel, an audiologist, on April 8, 1992. She took claimant's history of noise exposure, conducted an examination, performed testing, diagnosed left ear tinnitus, and recommended that claimant wear hearing protection. (See Ex. A; Tr. 20-22). We find such care constitutes medical services. The fact that claimant's condition required only one treatment and is nondisabling does not defeat compensability of the claim. See Arlene M. Mason, 44 Van Natta 1162 (1992).

We conclude, as did the Referee, that the record supports a finding that claimant's work exposures, when compared with nonwork exposures, were the major contributing cause of claimant's left ear tinnitus condition supported by objective findings. (See Exs. A, 2, 3, 7-11-13).

Attorney fee at hearing

On review, the insurer argues that the \$3,000 attorney fee awarded by the Referee for prevailing at hearing on the compensability issue was excessive. See ORS 656.386(1). In support of its position, the insurer contends that this was a simple and straightforward tinnitus case. Moreover, the insurer argues there was no monetary value to this claim in that no treatment has been recommended and no disability exists.

In determining a reasonable attorney fee the Referee and the Board shall consider the following factors as set forth in OAR 438-15-010(4):

- (a) The time devoted to the case;
- (b) The complexity of the issue(s) involved;
- (c) The value of the interest involved;
- (d) The skill of the attorneys;
- (e) The nature of the proceedings;
- (f) The benefit secured for the representative party;
- (g) The risk in a particular case that an attorney's efforts may go uncompensated; and
- (h) The assertion of frivolous issues or defenses."

After considering the above factors and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue is \$3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Attorney fee on review

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 concerning the compensability issue is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee on review for services devoted to the attorney fee issue. Dorson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated April 2, 1993 is affirmed. For services on Board review claimant's counsel is awarded an assessed attorney fee of \$750, payable by the insurer.

In the Matter of the Compensation of
MARTIN O. TADLOCK, Claimant
WCB Case No. 92-10524
ORDER OF ABATEMENT
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney

The self-insured employer requests reconsideration of our November 19, 1993 Order on Review that reversed a referee's order upholding its denial of claimant's head and upper body injury claim. On reconsideration, the employer objects to that portion of our order that found that claimant, a corrections officer and deputy sheriff, is a "peace officer" who is subject to the policy set out in the employer's Public Safety Standards and Training Manual. Therefore, the employer argues that we erred in concluding that claimant's injury, which occurred when he was off-duty, arose out of and in the course and scope of his employment.

In order to further consider the employer's request, we withdraw our November 19, 1993 order. Claimant is granted an opportunity to respond to the employer's motion. To be considered, claimant's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

December 20, 1993

Cite as 45 Van Natta 2389 (1993)

In the Matter of the Compensation of
NANCY L. CORONA, Claimant
WCB Case No. 92-05752
ORDER ON REVIEW
Ransom, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable April 16, 1992 denial of claimant's right forearm tendinitis/overuse syndrome; and (2) upheld SAIF's January 14, 1993 denial to the extent it denied claimant's occupational disease claim for right radial tunnel and right carpal tunnel syndromes. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings," except for the last paragraph, and supplement with the following.

On March 6, 1992, Dr. Olenick completed a form 827. He noted claimant's complaints of right wrist and forearm pain, and diagnosed right wrist tendinitis. Olenick further noted that only a part of the "body part" had been injured before in that "1.5 - 3 yrs. ago right thumb had slight irritation."

On that same date, Dr. Klubert reported that claimant had experienced progressive right arm pain since beginning her job with SAIF's insured. He diagnosed right wrist and forearm tendinitis, and opined that claimant's condition was "directly related to her occupation as a legal transcriptionist."

SAIF interviewed claimant's supervisor and a co-worker. They related that claimant had mentioned developing a carpal tunnel condition during a prior employment.

Thereafter, on April 16, 1992, SAIF denied claimant's "right wrist tendonitis" claim.

At the time SAIF denied the right forearm tendinitis/overuse syndrome claim, it did not have a legitimate doubt concerning the compensability of the claim. SAIF's April 16, 1992 denial was unreasonable.

CONCLUSIONS OF LAW AND OPINIONPenalties: April 16, 1992 Right Forearm Overuse Syndrome Denial

In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability at the time of its denial. If the insurer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. This analysis is made in the first instance by examining the facts and circumstances as they existed when the carrier denied the claim. Hutchison v. Fred Meyer, Inc., 118 Or App 288 (1993).

Here, the only contemporaneous medical reports in the record (Drs. Olenick and Klubert's March 6, 1992 reports), concerned claimant's tendinitis/overuse syndrome, not a carpal tunnel condition. Moreover, Dr. Klubert attributed claimant's tendinitis to extensive hand activity as a typist for SAIF's insured. Thus, the only medical evidence available to SAIF at the time it issued its denial supported the compensability of claimant's tendinitis. In light of the unrebutted medical evidence, it was not reasonable, in this case, for SAIF to rely on lay statements concerning a possible prior carpal tunnel syndrome, in processing claimant's current tendinitis claim.

Accordingly, based on the record before us, we find nothing that would have provided SAIF with a legitimate doubt concerning the compensability of claimant's right forearm tendinitis/overuse syndrome at the time of its denial. Consequently, we assess SAIF a penalty for its unreasonable resistance to the payment of compensation equal to 25 percent of the temporary disability benefits and outstanding medical bills due under the right forearm overuse syndrome claim through January 29, 1993, the date of hearing. ORS 656.262(10). See Conagra, Inc. v. Jeffries, 118 Or App 373 (1993); Wacker Siltronic Corp. v. Satcher, 91 Or App 654, 658 (1988). Of that amount, one-half shall be paid to claimant and one-half shall be paid to claimant's counsel, in lieu of an attorney fee. ORS 656.262(10)(a). Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Compensability: Right Radial Tunnel and Carpal Tunnel Syndromes

We adopt the Referee's reasoning and conclusion concerning this issue.

ORDER

The Referee's order dated February 25, 1993 is affirmed in part and reversed in part. The SAIF Corporation is assessed a penalty of 25 percent of the temporary disability benefits and outstanding medical bills due under the right forearm overuse syndrome claim through January 29, 1993, the date of hearing, to be divided equally between claimant and her attorney. The remainder of the order is affirmed.

December 20, 1993

Cite as 45 Van Natta 2390 (1993)

In the Matter of the Compensation of
RANDEL G. JENSEN, Claimant

WCB Case No. 93-01085

ORDER ON REVIEW

Hollander & Lebenbaum, Claimant Attorneys

Lane, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband and Neidig.

The self-insured employer requests review of Referee Podnar's order that: (1) awarded temporary disability until such benefits could be properly terminated under ORS 656.268; and (2) assessed a penalty under ORS 656.262(10) for an allegedly unreasonable unilateral termination of temporary disability. On review, the issues are temporary disability and penalties.

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

Since claimant was terminated from his employment prior to the filing of his claim, the employer contends that it was under no obligation to pay temporary disability once he became disabled. Likewise, the employer asserts that it was not subject to the requirements of ORS 656.268(3) for the termination of such temporary disability benefits.

Subsequent to the Referee's order, we have held that claimant was entitled to temporary disability benefits. Randel G. Jensen, 45 Van Natta 1749 (1993). Moreover, we have concluded that these benefits must continue until the occurrence of one of the prerequisites for unilateral termination of temporary disability under ORS 656.268(3). Id.

Here, inasmuch as none of those "unilateral termination" requirements have been satisfied, we concur with the Referee's conclusion that the employer is required to continue to pay temporary disability until it may properly terminate such benefits. See Douglas G. Reed, 44 Van Natta 2427, 2428 (1992) (Employer was not authorized to terminate temporary disability under ORS 656.268(3) when it informed the claimant of a modified job that would have been available to him had the claimant not been previously fired). Furthermore, we agree with the Referee's holding that the employer's unilateral termination without statutory authorization was unreasonable.

Inasmuch as no briefs have been filed, claimant is not entitled to an attorney fee under ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated March 9, 1993 is affirmed.

Board Member Neidig dissenting.

This case marks the third Board decision concerning this claimant's entitlement to temporary disability. For the reasons expressed in my prior dissents, I continue to conclude that he is not entitled to such benefits because he was terminated (prior to the filing of his claim) for reasons unrelated to his compensable condition. Therefore, I again respectfully dissent.

In addition to my previous reasoning, I would argue that the employer may terminate claimant's temporary disability once he received a release to modified employment. In reaching this conclusion, I note that ORS 656.268(3) obviously envisions a worker who has maintained an employment relationship with his employer. Thus, on receipt of a "modified work" release from a worker's attending physician, an employer may extend the "modified job" offer to the worker, and if the worker fails to begin such employment, temporary total disability may be unilaterally terminated. ORS 656.268(3)(c).

However, where, as here, claimant has been previously discharged from his employment for reasons unrelated to his compensable injury, the employer is placed in an untenable position under the majority's interpretation of the statute; i.e., either extend an offer to a former worker who has been discharged for an employment violation or continue to pay temporary total disability to the former worker who is capable of performing modified duties. I submit that, when viewed within the context of the entire statutory scheme, the employer's actions in terminating claimant's temporary total disability on his release to modified work were justified and did not violate ORS 656.268(3).

ORS 656.268(3) is premised on claimant's status as a "worker." "Worker" means any person who engages to furnish services for a remuneration, subject to the direction and control of an employer. ORS 656.005(28). As I have argued in my prior dissents, claimant lost his identity as a worker for this employer upon his discharge for violation of the employer's drug policy. Consequently, on his subsequent release to modified employment, I would conclude that the employer was not required to extend an offer of re-employment before terminating claimant's temporary total disability.

In this respect, I would analyze this procedure in a manner similar to a situation where a claimant has been released to modified work in a job where his wage earning power is equal to or exceeds his pre-injury wage earning power. In such a situation, claimant's temporary total disability would be converted into temporary partial disability, which would equal zero. OAR 436-60-030(2), (3). This disability (which would equal zero) would continue despite the fact that claimant had not returned to work for his former employer because claimant's discharge based on a violation of his employer's normal employment standards would not be treated as a withdrawal of a job offer. See OAR 436-60-030(4)(b).

In conclusion, I continue to believe that an award of temporary disability to this claimant under these circumstances is inappropriate. Accordingly, based on the foregoing reasoning, I respectfully dissent.

December 20, 1993

Cite as 45 Van Natta 2392 (1993)

In the Matter of the Compensation of
HENRY B. SCOTT, JR., Claimant

WCB Case No. 93-00169

ORDER ON REVIEW

Stoel, et al., Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Referee Menashe's order that dismissed his request for hearing. On review, the issue is propriety of the Referee's dismissal order.

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

On January 11, 1993, claimant retained an attorney to represent him. On April 7, 1993, claimant's attorney wrote to the Referee requesting dismissal of the hearing that had been scheduled for March 29, 1993. Thereafter, in response to claimant's attorney's request, the Referee dismissed claimant's request for hearing.

Claimant does not dispute his former attorney's authority to act on his behalf, nor does he dispute the fact that the Referee dismissed his request for hearing in response to his former attorney's express withdrawal of the hearing request. Under these circumstances, we find no reason to alter the Referee's dismissal order. See Mike D. Sullivan, 45 Van Natta 990 (1993).

ORDER

The Referee's order dated April 9, 1993 is affirmed.

December 20, 1993

Cite as 45 Van Natta 2392 (1993)

In the Matter of the Compensation of
HEATHER I. SMITH, Claimant

WCB Case No. 91-05062

SECOND ORDER ON REMAND

Francesconi & Busch, Claimant Attorneys

Meyers & Radler, Defense Attorneys

On November 15, 1993, we withdrew our October 28, 1993 Order on Remand which reduced claimant's unscheduled permanent disability award from 13 percent (41.6 degrees), as granted by a Referee's order, to 8 percent (25.6 degrees). We took this action to consider claimant's contention that she is entitled to an attorney fee award for "finally prevailing" before the Board and the Court of Appeals.

Before proceeding with our reconsideration, we granted the parties an opportunity to submit their respective positions regarding claimant's motion. In response to our implementation of this "supplemental briefing schedule," claimant has withdrawn her request for an attorney fee. There being no further objection to our October 28, 1993 order, we adhere to our decision in its entirety.

Accordingly, on reconsideration, as supplemented herein, we republish our October 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
JOHN L. MYERS, Claimant
WCB Case Nos. 93-02124 & 92-14697
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Referee Myzak's order which set aside its denial of claimant's occupational disease claim for bilateral ulnar nerve palsies. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, 62 years old at the time of hearing, has worked for the employer as a millwright for 35 years. His work as a millwright included repetitive use of the upper extremities bilaterally in activities requiring both force and precision. During the course of his employment, claimant struck his elbows "many times" and had shooting-type pains down his arms. (See Tr. 6-9).

Claimant had the insidious onset of progressive bilateral hand weakness and numbness, beginning with tingling and numbness in the fourth and fifth digits bilaterally, particularly when he worked with his arms or held them overhead. (See Tr. 10; Ex. 9-2).

He first brought these symptoms to the attention of Dr. Englander, neurologist, in July 1980, when bilateral ulnar padding was prescribed. (Ex. 9-2). Dr. Englander again noted symptoms of ulnar neuropathy in 1982 and 1991, but no treatment was prescribed at those times. (Ex. 9-5, 9-8). In October 1991, Dr. Englander noted that the ulnar nerve dysfunction "was evident with atrophy." (Ex. 9-8).

Claimant last worked in June 1991. His symptoms continued to progress. In May and June 1992, atrophy was readily apparent. Nerve conduction studies revealed severe bilateral ulnar nerve palsies. (See Exs. 9-9, 9-10, 43).

Claimant did not have any elbow injuries prior or subsequent to his employment for this employer.

By letter dated November 2, 1992, the employer denied the compensability of the claim for bilateral ulnar palsies. (Ex. 51).

Claimant is credible.

ULTIMATE FINDING OF FACT

The major contributing cause of claimant's bilateral ulnar palsies is his 35 years of work activities for this employer.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's finding regarding claimant's credibility based on his demeanor at the hearing, and we find claimant credible.

To establish a compensable occupational disease claim, a worker must prove by a preponderance of the evidence that the work activities, when compared to non-work causes, were the major contributing cause of either the onset or worsening of the condition. ORS 656.802(2); Dethlefs v. Hyster Co., 295 Or 298 (1983); Weller v. Union Carbide, 288 Or 24, 35 (1979). Major contributing cause means an activity or exposure, or combination of activities or exposures, that contributes more to the onset or worsening than all other conditions, explanations, or exposures combined. Linda L. Nelsen, 44 Van Natta 53 (1992); David K. Boyer, 43 Van Natta 561 (1991). The medical evidence must establish compensability within reasonable medical probability; a mere possibility is not enough. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

The question presented is a medical one. Claimant's conclusion as to the causal nexus between his work and his condition is nothing more than a lay analysis and is insufficient to carry his burden of proof. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). The resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 240, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence is divided. We agree with the Referee that this case pivots on analysis, not observation; thus, we do not defer to the treating physician's opinion on the basis of his position as treating physician.

The medical evidence consists of a number of reports by three doctors and the depositions of two of those doctors. Dr. Schachner, claimant's treating orthopedic physician, supports compensability, while Dr. Englander, claimant's treating neurologist, and Dr. Jewell, independent medical examiner and plastic surgeon, do not.

After our review of the evidence, we conclude that Dr. Schachner's opinion, based on his reports and deposition testimony, establishes that claimant's work activities over 35 years as a millwright for this employer are the major contributing cause of his bilateral ulnar nerve palsies. While Drs. Englander and Jewell conclude that claimant's work activities are not, within reasonable medical probability, the major contributing cause of his condition, we find Dr. Schachner's opinion more persuasive.

Dr. Englander noted that he was unaware of any specific on-the-job cause of claimant's ulnar neuropathies, and concluded that the condition was not "clearly" or "directly" related to his work activities. (See Exs. 43, 57). Considering that Dr. Englander first noted ulnar neuropathy symptoms in 1980 associated with claimant's use of his arms, yet failed to address these findings in his opinion or to consider the potential cumulative effect of claimant's work activities over 35 years, we find his opinion unpersuasive.

Dr. Jewell, plastic and hand surgeon, performed an independent medical examination in October 1992; he also testified by deposition. (See Exs. 50, 52 and 58). Dr. Jewell opined that the etiology of claimant's ulnar nerve condition is "obscure" and idiopathic. Yet, he also opined that the condition is unrelated to work and was most likely caused by nerve entrapment by fibrous bands in the cubital tunnel. (See Exs. 50-3 to -4, 52, 58-13 to -14). We find his opinions to be internally contradictory. Accordingly, we agree with the Referee's finding that Dr. Jewell's opinion lacks logical force and cogency and, therefore, is less persuasive.

We adopt the Referee's discussion and conclusions regarding Dr. Schachner's opinion. After our review of the record, we find Dr. Schachner's opinion to be better reasoned and more completely explained. Accordingly, we rely on his opinion to find claimant's occupational disease claim for bilateral ulnar palsies to be compensable. See Somers v. SAIF, 77 Or App 259, 263 (1986).

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

ORDER

The Referee's order dated March 10, 1993 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
ALFRED R. WENDELL, Claimant
WCB Case No. C3-03017
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On November 19, 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 his compensable injury.

On December 6, 1993, the Board received the parties' addendum reducing the attorney fee to \$1,625, thereby increasing the total due claimant to \$10,875.

We have previously concluded that, where the claimant's actual monetary recovery has been increased, due to a proportionate decrease in his counsel's attorney fee, the total consideration for the CDA remains the same. See Richard R. Millus, 45 Van Natta 758, on recon 45 Van Natta 810 (1993). Consequently, we find that the parties' changes to the CDA represent merely a "re-distribution" of funds. Millus, supra.

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 \$12,500, with an attorney fee of \$1,625 to claimant's attorney and total due claimant of \$10,875.

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
RAYMOND E. ALDINGER, Claimant
WCB Case No. 91-07449
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Westerband and Hall.

Claimant requests review of those portions of Referee Barber's order which: (1) upheld the SAIF Corporation's denial of claimant's bilateral inner ear condition; and (2) upheld the SAIF Corporation's denial of claimant's sleep apnea condition. The SAIF Corporation cross-requests review of that portion of the Referee's order that assessed an attorney fee under ORS 656.382(1) for its allegedly late processing of claimant's inner ear condition claim. In its appellate brief, the SAIF Corporation also moves to strike portions of claimant's brief that allegedly raised and argued issues which were not litigated at the hearing. On review, the issues are motion to strike, compensability, and penalty-related attorney fee. We deny the motion to strike, and reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. In the second full paragraph on page 3 of the Referee's order, we change the phrase, "[w]hen Dr. Black lost his medical privileges," to "when Dr. Black stopped treating patients."

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

In its appellate brief, SAIF moves to strike portions of claimant's appellate brief which allegedly raised and argued issues not litigated at the hearing. Specifically, SAIF contends that: (1) only compensability of the condition of sleep apnea was litigated, not compensability of treatment for the condition; (2) only compensability of perilymph fistulas was litigated, not the symptoms of vertigo, headaches, nausea, or hearing change; and (3) compensability of the conditions of an inner ear injury or benign paroxysmal positional vertigo (BPPV) were not litigated. We disagree.

In its June 8, 1992 partial denial, SAIF denied treatment for "bilateral inner ear concussion syndrome and possible perilymph fistulas which includes symptoms of vertigo, dizziness, headaches, nausea and hearing changes." (Ex. 214). Claimant challenged this denial, which gave rise to the present litigation. (See Tr. 1-2). The Referee's order identified "denial of compensability of several conditions involving the ear" as one of the issues raised by claimant. He analyzed claimant's ear-related problems in the context of claimant's symptoms of dizziness and vertigo. SAIF agreed that the issues at the hearing included inner ear concussion syndrome and possible perilymph fistulas, but it distinguished those conditions from BPPV, which it contends is a separate diagnosis and not at issue in this case. (See SAIF's Closing Argument at 9; Tr. 4).

We find that the parties litigated compensability of claimant's alleged inner ear condition, including the compensability of allegedly related symptoms. We find that the specific diagnoses of inner ear concussion syndrome, perilymph fistulas and BPPV were litigated by the parties and considered by the Referee under the broader issue of the compensability of claimant's alleged inner ear injury.

We have previously held that a referee may consider a new diagnosis (as distinguished from a new issue) first raised in closing argument. Julie A. Gros (Pool), 45 Van Natta 1705 (1993). Here, we find that the parties litigated, and the Referee considered, alternative diagnoses for claimant's inner ear condition. Accordingly, we find no merit in SAIF's argument that claimant raised issues in his appellate brief regarding his inner ear injury that were not litigated at the hearing.

Regarding the sleep apnea claim, we find that claimant raised both the issues of the compensability of the condition itself and compensability of treatment for the condition. SAIF's April 24, 1991 partial denial of the sleep apnea condition referred to a claim for "diagnostic testing and treatment for sleep apnea." (Ex. 197). The Referee's order addressed both compensability of the

condition itself and claimant's alternative argument, that treatment for sleep apnea is compensable because it is necessary to treat the perilymph fistula condition. Furthermore, the Referee had jurisdiction to address the question of whether treatment for sleep apnea is necessary in order to treat claimant's fistulas. See Meyers v. Darigold, Inc., 123 Or App 217 (1993). Accordingly, we find no merit in SAIF's argument that claimant first raised the issue of the compensability of treatment for sleep apnea in his appellate brief.

SAIF's motions to strike are denied.

Inner Ear Condition

Claimant contends that his bilateral inner ear condition was directly caused by a compensable motor vehicle accident in 1982, in which he sustained multiple, serious injuries. Therefore, in order to establish the compensability of his inner ear condition, claimant has the burden to prove that the on-the-job injury was at least a material contributing cause of his disability or need for medical treatment resulting from the inner ear condition. ORS 656.005(7)(a); see also Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Claimant must establish the existence of his condition by medical evidence supported by objective findings. ORS 656.005(7)(a).

Because of the nature of the condition, as well as the long time period between the accident and this claim, we conclude that the issue of causation of claimant's current condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence is divided. Claimant's treating otolaryngologists, Drs. Epley and Black, believe that claimant's current inner ear condition was directly caused by the 1982 motor vehicle accident; their opinions support compensability. Dr. Brown, an otolaryngologist who performed an independent medical examination, disagrees with the diagnoses of Drs. Epley and Black and believes claimant's current condition is unrelated to the 1982 accident. For the reasons discussed below, we find the opinions of Drs. Epley and Black more persuasive.

The Referee discounted the opinions of Drs. Epley and Black because they relied on claimant's history regarding the onset and continuity of his symptoms, and the Referee found claimant's history unreliable. The Referee based his finding on his determination that there are discrepancies in the substantive record. He did not evaluate claimant's credibility based on demeanor. Under such circumstances, we are equally able to evaluate the reliability of claimant's history. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After conducting our review, we do not find significant discrepancies between the medical records and claimant's testimony regarding the history of his symptoms.

Claimant testified that he has experienced the symptoms of vertigo, dizziness, nausea, headaches, disequilibrium, and ringing in his ears continuously since about two weeks after the motor vehicle accident in May 1982. He testified that he complained of these symptoms to various medical providers, beginning in 1982.

Claimant initially treated with Dr. Medak following the accident in May 1982. Dr. Medak's medical records reflect complaints of headaches and vertigo in 1982, and a diagnosis of "labyrinthine disease," associated with complaints of vertigo with head movements, in 1984. (Exs. 4-1, 4-3, 14, 30A, 219A). In an independent examination in 1983, claimant complained of headaches, dizzy spells, nausea, photophobia, and problems with his hearing. (Exs. 19-3, 28-4).

In 1985, claimant came under the care of orthopedist Dr. Puziss. He reported complaints of headaches and nausea in 1985 and 1986. (See Exs. 56, 73-1, 86 and 92). In an independent examination in 1987, claimant complained of daily headaches. (Ex. 107-4).

In 1989, neurologist Dr. Robert Rosenbaum, physical medicine specialist Dr. Lee, and neurosurgeon Dr. Berkeley all noted complaints of headaches and dizziness with head turning.

(Exs. 132-2, 134-1, 156, 160). In May 1989, Dr. Puziss examined claimant and reported complaints of continuing headaches, present since the 1982 accident. Dr. Puziss noted that claimant's previous medical records confirm the presence of headaches since the accident, and he acknowledged that because doctors, including himself, had focused more on surgical problems, claimant's nonsurgical, cervical-headache problems "have been lost in the shuffle." (Ex. 139).

Based on our review of the record, we conclude that claimant's testimony regarding the onset and continuity of his symptoms is substantially consistent with the medical records which indicate repeated, albeit intermittent, complaints of headache, nausea, dizziness, and ear problems since shortly after the accident in May 1982. Therefore, we find claimant's testimony regarding the history of his symptoms to be credible and reliable.

Dr. Black examined claimant in December 1990. (See Ex. 183). Claimant reported a history of headache, nausea, dizziness, and imbalance symptoms since shortly after the 1982 accident, with the sensation of disequilibrium becoming progressively worse over time. (Ex. 183-1). Dr. Black diagnosed inner ear concussion syndrome, resulting directly from the 1982 motor vehicle accident. (Ex. 183-5).

Dr. Epley began treating claimant in June 1991. Claimant reported a similar history of symptoms since the 1982 accident. (Ex. 199). Based on his examination and vestibular testing, Dr. Epley diagnosed a right inner ear concussion syndrome with possible perilymph fistula, and recommended surgery. (See Exs. 199, 206, 207). Dr. Epley explained that claimant's complaint of continuous and progressively worsening symptoms is "evidence of an active dysfunctional vestibular lesion" and is typical of an inner ear concussion syndrome, rather than of cervical injury. (Ex. 207). He concluded that claimant's vestibular findings are due to the 1982 accident and are the major contributing cause of his current need for surgery. (*Id.*; see also Ex. 222-5).

Independent examiner Dr. Brown initially disagreed with a labyrinthine diagnosis of claimant's symptoms and believed instead that his symptoms of dizziness and disequilibrium were due to a cervical syndrome, initially caused by the 1982 accident, accompanied by symptom magnification. (Ex. 196-13 to -14). Dr. Brown's initial opinion was based on the inaccurate history that claimant reported no dizziness before 1989; thus, he concluded that claimant's history was unreliable. (Ex. 196-12; see also Ex. 217-39 to -40). After reviewing earlier medical records, Dr. Brown acknowledged that claimant had complained of dizziness shortly after the May 1982 accident, and he changed his diagnosis from cervical vertigo to benign positional vertigo, caused by the 1982 accident. (Ex. 220). However, he then opined that claimant's initial condition resolved, then recurred in 1984, and subsequently resolved again. He concluded that claimant's current symptoms are exaggerated and essentially benign. (*Id.*).

When medical evidence is divided, we give more weight to those opinions which are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Based on our earlier finding that claimant's testimony is credible and reliable, we find that both Dr. Black and Dr. Epley based their diagnoses and opinions on an accurate and complete history, and we defer to their diagnoses. We further find that all three medical experts are well-qualified to render an opinion regarding the etiology of claimant's condition. However, we find Dr. Brown's opinion less persuasive, because it was first based on an inaccurate history, and then based on a speculative and unexplained hypothesis of resolving and recurring inner ear problems. We conclude that Dr. Brown's opinion is neither well-reasoned nor based on complete information.

By contrast, we find Dr. Epley's causation opinion to be well-reasoned and based on complete information. Accordingly, we rely on Dr. Epley's opinion to conclude that claimant's current inner ear condition was directly and at least materially caused by the compensable 1982 accident. Therefore, we find the condition compensable.

Sleep Apnea Condition

In April 1991, SAIF issued a partial denial of diagnostic testing and treatment for sleep apnea. (Ex. 197). On review, claimant contends that the medical treatment for sleep apnea is compensable because it is necessary in order to treat claimant's inner ear condition. We agree.

Dr. Rich, Director of the Pacific Northwest Sleep/Wake Disorders Program, examined claimant in consultation in January 1991 and diagnosed obstructive sleep apnea syndrome. (Ex. 188-2). After neurophysiological testing, he recommended treatment for the sleep apnea condition, which he stated was essential for the successful management of claimant's perilymph fistulas. (Exs. 191-5, 209). Dr. Puziss, claimant's primary treating physician, agreed that treatment for the sleep apnea condition was necessary for successful perilymph fistula repair. (Ex. 210).

The only contrary opinion is from SAIF's Medical Consultant, Dr. Jansen. However, her opinion focuses on the cause of the sleep apnea condition, rather than on the question of whether treatment of the condition is necessary in order to successfully treat claimant's inner ear condition. (See Ex. 202-3).

Accordingly, we find that claimant has established by a preponderance of the evidence that treatment for his sleep apnea condition is necessary and reasonable in order to successfully treat his compensable inner ear condition. Therefore, we conclude that medical services for the sleep apnea condition, including diagnostic services, are compensable. ORS 656.245(1)(a); see also Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987); SAIF v. Roam, 109 Or App 169 (1991).

Penalty and Attorney Fees

SAIF cross-requests review of that portion of the Referee's order which assessed a penalty-related attorney fee under ORS 656.382(1), in the amount of \$400, for SAIF's unreasonable failure to process the claim for inner ear conditions within 90 days. We agree that an assessed, penalty-related attorney fee is not appropriate in this case, for the following reasons.

We agree with the Referee's finding that SAIF's failure to timely process the claim was unjustified and unreasonable. We further find that SAIF's untimely processing of a claim which we have found compensable constitutes unreasonable delay in the denial of a claim, for which it is appropriate to assess a penalty under ORS 656.262(10). Accordingly, we assess a penalty in the amount of 25 percent of amounts due as of the date of the denial, payable by SAIF, one half to claimant and one half to his attorney. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988); John Davison, 44 Van Natta 518 (1992).

However, no other unreasonable conduct is alleged or shown. Therefore, there is no basis for assessing a separate, penalty-related attorney fee under ORS 656.382(1). See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992); Laurie A. Bennion, 45 Van Natta 829 (1993).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issues. 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 issues 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, and the value of the interest involved.

ORDER

The Referee's order dated November 27, 1992 is reversed in part and modified in part. That portion of the order which upheld the SAIF Corporation's April 24, 1991 and June 8, 1992 partial denials is reversed. The SAIF Corporation's partial denials are set aside and the claims for an inner ear condition and treatment for sleep apnea are remanded to SAIF for processing in accordance with law. In lieu of the Referee's \$400 penalty-related attorney fee for SAIF's untimely denial of the inner ear condition claim, SAIF is assessed a penalty in the amount of 25 percent of amounts due as of the date of the June 8, 1992 denial, payable in equal shares to claimant and his attorney.

In the Matter of the Compensation of
STEVEN C. DeWITT, Claimant
WCB Case Nos. 92-08077 & 92-04725
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Schultz's order that: (1) affirmed an Order on Reconsideration award of 14 percent (44.8 degrees) unscheduled permanent disability for a neck, low back, bilateral knee and right ankle injury; and (2) awarded \$1,800 to claimant's counsel as an assessed attorney fee for his services at hearing. Claimant cross-requests review of that portion of the Referee's order which declined to find his claim was prematurely closed. On review, the issues are premature claim closure, extent of unscheduled permanent disability, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

We are in receipt of a December 16, 1992 letter from the employer in which it responds to claimant's reply/cross-respondent's brief. The briefing schedule closed on December 9, 1992. We will consider supplemental authorities but no argument after briefing is completed. See Betty Juneau, 38 Van Natta 553, 556 (1986); Debra West, 43 Van Natta 2299 (1991). Accordingly, we have not considered the employer's December 16, 1992 letter in our review.

Premature Closure

The Referee concluded that the Hearings Division did not have jurisdiction over the premature closure issue because claimant did not first raise that issue in his request for reconsideration by the Department. We disagree.

Subsequent to the Referee's order, the Board held that a claimant is precluded from raising at hearing an issue concerning a determination order or notice of closure if that issue was not first raised at the reconsideration proceeding before the Department. Raymond L. Mackey, 45 Van Natta 776 (1993). However, in reliance on the Court of Appeals' decision in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), we later disavowed the Mackey holding. Darlene K. Bentley, 45 Van Natta 1719 (1993).

In Bentley, we held that a party may raise at hearing an extent of disability issue that was not first raised at the reconsideration proceeding. The claimant in Bentley had requested reconsideration of the Notice of Closure award of permanent disability; however, on the Department's reconsideration request form, she expressly declined to challenge the non-impairment (i.e., age, education and adaptability) factors used in calculating her unscheduled permanent disability award. Following issuance of the Department's Order on Reconsideration, the claimant requested a hearing challenging the adaptability value used in calculating her unscheduled permanent disability award. We concluded that the claimant had not waived her challenge to the adaptability value used by the Department in calculating her permanent disability award. Id.

The specific holding in Bentley was limited to extent of disability issues raised for the first time at hearing; it did not address whether a party may raise at hearing a premature closure issue that was not first raised at the reconsideration proceeding. However, we need not address that question in this case because we find that the premature closure issue was, in fact, raised at the reconsideration proceeding.

Whether a party has raised an issue at the reconsideration proceeding is a question of fact. See Dale A. Pritchett, 44 Van Natta 2134 (1992) (Whether a party has objected to the attending physician's impairment findings is a question of fact.) Here, on the Department's reconsideration request form, claimant checked the box "no" indicating no objection concerning the premature closure issue. At the same time, though, he checked the "yes" box indicating an objection to the medically stationary date (November 15, 1991) on the Determination Order. (Ex. 35A-2).

Claimant clarified his objection to the Determination Order on the additional pages that were attached to his reconsideration request form. Claimant asserted that his doctor had declared him not to be medically stationary as of February 13, 1992. Claimant did not indicate that he had become medically stationary at any time subsequent to that date.¹ (Ex. 35A-3). Inasmuch as his claim had been closed by Determination Order on February 18, 1992, only five days after his doctor had declared him not to be medically stationary, we conclude that claimant was asserting that his claim had been closed prematurely, *i.e.*, before he had become medically stationary.

Our conclusion is further supported by other language in the written attachment to claimant's reconsideration request. Following his assertion that he was not medically stationary, claimant wrote in bold print that "[a]lternatively," he is entitled to additional permanent disability benefits. (Ex. 35A-3). An argument concerning extent of permanent disability is made as an alternative only when the primary argument is that the claim was prematurely closed. In other words, the extent of disability issue will be reached only if the claim is found not to have been prematurely closed. Therefore, when claimant's reconsideration request and written attachment are read as a whole, we are persuaded that the premature closure issue was sufficiently raised before the Department for reconsideration. Further, insofar as the reconsideration request could be viewed as ambiguous, the Department should have sought further clarification of claimant's position.

Having found that the premature closure issue was raised at the reconsideration proceeding before the Department, we conclude that the issue was properly before the Referee. We now turn to the merits of that issue.

In order to establish that his claim was prematurely closed, claimant has the burden of proving that he was not medically stationary when his claim was closed by Determination Order on February 18, 1992. See Berliner v. Weyerhaeuser Co., 54 Or App 624, 628 (1981). "Medically stationary" means that no further improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The determination 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).

Claimant sustained multiple compensable injuries, including back and neck strains, in a trucking accident while working as a truck driver in July 1991. He was taken off work and treated conservatively. He subsequently came under the care of his current attending physician, Dr. Beck. Dr. Beck declared claimant medically stationary as of November 15, 1991. (Ex. 24). That same day, Dr. Beck also released claimant for regular work without limitations. (*Id.*) Claimant subsequently returned to work as a truck driver/loader. (Ex. 25-3). On December 27, 1991, Drs. Wilson and Neufeld, examining physicians, agreed that claimant was medically stationary and opined that he can perform his truck driver job without limitations. (Ex. 25-6).

On January 30, 1992, claimant returned to Dr. Beck with complaints of increasing back pain following three weeks of long-haul truck driving. He reported that his symptoms worsened with the increased jarring of his truck. Dr. Beck reported a worsening of claimant's condition, prescribed physical therapy and restricted claimant from operating heavy equipment and from prolonged sitting. (Ex. 27).

On February 13, 1992, claimant returned to Dr. Beck with complaints of continuing pain and muscle spasm in his neck. Dr. Beck administered a pain injection and prescribed further physical therapy. (Ex. 29). That same day, Dr. Beck wrote the insurer withdrawing his previous declaration that claimant was medically stationary. He stated that claimant was not medically stationary, explaining that he still expected further improvement in claimant's condition with the passage of time. (Ex. 30).

¹ The absence of any assertion by claimant that he had become medically stationary on a date prior to the date of claim closure distinguishes this case from Nannette L. White-Goings, 45 Van Natta 484 (1993). In White-Goings, the claimant asserted that she had become medically stationary on a date subsequent to the medically stationary date indicated on the Determination Order, thereby entitling her to additional temporary disability benefits; however, she did not challenge the finding that she was medically stationary on the date of claim closure. *Id.*

On April 18, 1992, Drs. Wilson and Neufeld examined claimant and opined that he remained medically stationary and that he did not suffer a material worsening since their last examination. (Ex. 34-6). On April 21, 1992, Dr. Beck wrote that his earlier declaration that claimant was medically stationary was "overly optimistic" because it was made without first testing claimant's condition at work. (Ex. 34A).

After reviewing the aforementioned medical evidence, we defer to Dr. Beck. As claimant's attending physician since August 1991, Dr. Beck had a better opportunity to evaluate the progress of claimant's condition than Drs. Neufeld and Wilson, who examined claimant only three times. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Therefore, we find that claimant has met his burden to prove that he was not medically stationary at the time of claim closure. Accordingly, the February 18, 1992 Determination Order is set aside as premature.

Given our conclusion that the Determination Order was premature, the extent of disability issue is moot. We also reverse the Referee's assessed fee award for claimant's attorney's services rendered at hearing in defending the Determination Order award of permanent disability benefits. Instead, we approve an out-of-compensation attorney fee payable out of any additional compensation created by this order, not to exceed \$3,800. See ORS 656.386(2); OAR 438-15-055(1).

ORDER

The Referee's order dated July 22, 1992, as reconsidered on August 6, 1992, is reversed in part and affirmed in part. Those portions of the Referee's order that modified the Order on Reconsideration to award additional temporary disability benefits and affirmed the Order on Reconsideration as modified are reversed. The Determination Order is set aside as premature, and the claim is remanded to the insurer for further processing according to law. The Referee's assessed fee award is also reversed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of any additional compensation created by this order, not to exceed \$3,800. The remainder of the Referee's order is affirmed.

December 22, 1993

Cite as 45 Van Natta 2402 (1993)

In the Matter of the Compensation of
LYNDA M. ENGLAND, Claimant
 WCB Case No. 92-08135
ORDER ON RECONSIDERATION (REMANDING)
 Schneider, et al., Claimant Attorneys
 Meyers & Radler, Defense Attorneys

Claimant has requested reconsideration of our November 16, 1993 Order on Review (Remanding) which vacated the Referee's order which found that the Director had jurisdiction over the issue of proposed surgery. On reconsideration, claimant objects to that portion of our order which remanded the case to the Referee. In order to fully consider the matter, we abated our prior order and granted the self-insured employer an opportunity to respond. After receiving the employer's response, we make the following conclusions:

On reconsideration, claimant contends that the only issue at hearing was whether the Director had jurisdiction to issue his order. Claimant argues that she has never raised the issue of a denial of proposed surgery and the only resolution she seeks is an order setting aside the Director's order. Finally, claimant disagrees with that portion of the Referee's order which found that an agreement existed between claimant's former counsel and the employer pertaining to withdrawal of claimant's request for hearing.

We continue to conclude that, in light of the court's decision in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), and because of the lack of development of the record due to the Referee's decision on a procedural basis, this matter must be remanded to the Referee. All of the following contentions asserted by claimant may be addressed and resolved by the Referee on remand: (1) whether or not a denial of proposed surgery was at issue; (2) whether or not an "agreement" existed concerning the withdrawal of claimant's request for hearing; and (3) whether the Director's order should be vacated. As noted in our Order on Review which remanded the case to the referee, Referee Neal is authorized to conduct further proceedings in any manner that will achieve substantial justice.

Accordingly, because the Board and the Hearings Division have jurisdiction over matters concerning a proposed surgery, we continue to conclude that remand is appropriate. If a dispute over proposed surgery no longer exists, claimant may withdraw her hearing request and choose not to proceed.

On reconsideration, as supplemented by this order, we republish our November 16, 1993 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

December 22, 1993

Cite as 45 Van Natta 2403 (1993)

In the Matter of the Compensation of
GEORGE W. HANLON, Claimant
WCB Case Nos. 91-17563 & 89-00708
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Beers, et al., Defense Attorneys
Jeff Gerner (SAIF), Defense Attorneys

Reviewed by Board Members Haynes, Westerband and Gunn.

Claimant requests review of those portions of Referee Barber's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a left shoulder condition; and (2) did not award an assessed attorney fee under ORS 656.386(1). On review, the issues are aggravation and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant has an accepted 1986 left shoulder claim with SAIF. In 1987, the claim closed and claimant was awarded 25 percent unscheduled permanent disability. The claim was reopened and closed twice more; on both occasions claimant was awarded temporary disability with no increase in permanent disability. The claim last closed on July 9, 1991.

In September 1991, claimant again sought treatment for his left shoulder and filed an aggravation claim. The Referee found that claimant proved a symptomatic worsening, but failed to show that the worsening was greater than a waxing and waning of symptoms contemplated by the last award of compensation. On review, claimant asserts that he proved a compensable aggravation.

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since his last award or arrangement of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687, rev den 312 Or 150 (1991). Furthermore, because claimant has received a previous permanent disability award for his injury, he must establish that any worsening is more than waxing and waning of symptoms, if such was contemplated by the previous permanent disability award. See ORS 656.273(8).

Dr. Verzosa, claimant's treating physician, reported that claimant experienced increased left shoulder symptoms in September 1991 and attributed the exacerbation to the 1986 injury. (Exs. 51, 54A, 66-2). In contrast, Dr. Fuller, orthopedic surgeon who conducted an independent medical examination, found no objective evidence of a worsening and attributed any increased symptoms to psychogenic magnification of symptoms. (Exs. 59, 63).

In evaluating the weight to be given to the competing opinions, we find no persuasive reasons not to defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Therefore, based on Dr. Verzosa's opinion, we conclude that claimant experienced increased symptoms resulting from his compensable injury. See ORS 656.273(1).

Furthermore, we disagree with the Referee that it was necessary for claimant to prove that the worsening was greater than a waxing and waning contemplated by the previous award of permanent disability. The medical evidence and previous award of permanent disability contain no reference to a possibility of future flare-ups or exacerbations of claimant's left shoulder injury. Consequently, we find the requirement contained in ORS 656.273(8) to be inapplicable. See Lucas v. Clark, *supra*, 106 Or App at 690-91; Dana J. Fisher, 45 Van Natta 225 (1993).

However, we conclude that claimant failed to prove a diminished earning capacity. The last arrangement of compensation is the July 1991 Determination Order. Shortly before that date, claimant was participating in vocational assistance, receiving training as an offset printer. Two weeks before the completion of the program, training ended due to conflict with claimant's trainer. (Ex. 44-1). Claimant received sufficient training to work as an entry-level offset press operator. (*Id.* at 2). Furthermore, shortly after the issuance of the Determination Order, Dr. Versosa released claimant to work driving truck with modifications. (Ex. 47-1). In August 1991, claimant began work as a press operator and laborer. (Ex. 47A).

Contrary to the dissent's assertion, there is no evidence that, after claimant's August 1991 increase in symptoms, he was unable to perform work after that he was able to perform at the time of the July 1991 Determination Order. Following the exacerbation, Dr. Verzosa indicated that claimant was capable of light duty work, restricting him from lifting over 25 pounds, repetitively pushing and pulling or pushing and pulling over 25 pounds, and repetitively reaching overhead. (Ex. 52-1). Such restrictions were similar to the press operator job requirements performed by claimant at the time of his exacerbation. (Ex. 47A). Furthermore, there is no proof from Dr. Verzosa, or any other physician, that claimant's physical capacities were less than at the time of the July 1991 Determination Order. In fact, claimant began working as a truck driver following the exacerbation.

Consequently, finding no evidence that claimant's earning capacity was diminished by the August 1991 exacerbation, in comparison to his earning capacity in July 1991, we conclude that claimant failed to prove a compensable aggravation.

Attorney Fees

Claimant contends that, even if he failed to prove a compensable aggravation, he is entitled to an attorney fee under ORS 656.386(1). Apparently, claimant believes that SAIF denied the compensability of claimant's current condition and that such denial was either rescinded prior to hearing or set aside by the Referee. We agree with the Referee that SAIF's denial was limited to the compensability of an aggravation and compensability of claimant's current condition was neither denied nor litigated at hearing. (See Ex. 61A, Tr. 2). Accordingly, claimant is not entitled to an assessed attorney fee. See ORS 656.386(1).

ORDER

The Referee's order dated December 7, 1992, as reconsidered January 11, 1993, is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant did not prove a compensable aggravation because he did not have a diminished earning capacity. In order to show diminished earning capacity, claimant must have evidence that his worsened condition resulted in a capacity to earn below the level fixed at the last arrangement of compensation.

The majority's findings regarding claimant's work restrictions at the time of the July 1991 Determination Order do not rely on direct evidence from claimant's treating physician and, in one case, relate to claimant's condition almost two years before the issuance of the Determination Order. (See Exs. 39-2, 47A). Furthermore, even assuming the validity of such work restrictions, claimant nevertheless was capable of working as a printer press operator and laborer prior to his condition worsening.

Following the exacerbation, claimant's treating physician noted that the range of motion of claimant's left shoulder was more limited. Moreover, claimant was no longer able to perform his job. In my opinion, such evidence proves that claimant's capacity to work was less than at the time of the last arrangement of compensation; I find it to be stronger evidence than the majority's questionable comparison of claimant's work restrictions. Therefore, I dissent.

December 22, 1993

Cite as 45 Van Natta 2405 (1993)

In the Matter of the Compensation of
MICHAEL J. MELVIN, Claimant
WCB Case Nos. 92-05534, 92-05533 & 92-03604
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Kelly E. Ford, Defense Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Westerland, Haynes and Gunn.

The SAIF Corporation requests review of that portion of Referee Brown's order that awarded claimant an assessed attorney fee to be paid by SAIF on behalf of a noncomplying employer (NCE) for successfully defending against the NCE's request for hearing concerning SAIF's acceptance of claimant's claim on behalf of the NCE. In his respondent's brief, claimant essentially asserts that, in the event SAIF's attorney fee assessment is reversed, his attorney fee award to be paid by Liberty Northwest (the carrier who was ultimately found responsible for the claim), should be increased in an amount equal to SAIF's attorney fee award. On review, the issue is attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

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

Claimant filed an 801 form alleging an injury with Jack Foust Logging (Foust), on June 17, 1991 (not 1992).

CONCLUSIONS OF LAW AND OPINION

The Referee denied Foust's challenge to compensability and, pursuant to ORS 656.054, awarded claimant an assessed fee of \$2,000 for successfully defending against Foust's challenge, to be paid by the SAIF Corporation. The Referee also set aside Liberty Northwest Insurance Corporation's denial, on behalf of Olson Berg Lumber Company, and remanded the claim to it for processing. Claimant was awarded an assessed fee of \$2,000 for overcoming Liberty Northwest's denial.

SAIF contends that the Referee erred in assessing it an attorney fee, first, because the setting aside of Liberty Northwest's denial had the effect of rescinding SAIF's acceptance, which eliminated a "compensable claim" against the NCE, and, second, because any award of attorney fees pursuant to ORS 656.386(1) should be assessed against Liberty Northwest. Claimant contends that the Referee's order is a final order against Foust finding Foust non-complying and the claim compensable; thus, SAIF should be liable for a part of the attorney fee. Alternatively, noting that no carrier contests that \$4,000 for claimant's counsel's services at hearing was excessive, claimant essentially reasons that Liberty Northwest should be held responsible for the Referee's entire attorney fee award.

ORS 656.054 provides in relevant part:

"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 [Chapter 656]. * * * If an order becomes final holding the claim to be compensable, the employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim."

We interpret the statute to provide that to be entitled to an assessed attorney fee for services rendered in connection with the NCE's objection to the claim, the claim must be found compensable as to the NCE. Specifically, the fee provision of ORS 656.054 applies where the NCE's objection is overruled and the NCE is held liable for all costs of the compensable claim, including reasonable attorney fees.

Here, the Referee concluded that claimant's claim was compensable as to Liberty Northwest's insured, not to the NCE. Once Liberty Northwest was found to be responsible for the claim under ORS 656.029, that finding effectively vacated SAIF's acceptance of the claim on behalf of the NCE. Liability for the compensable claim was assigned to Liberty. We conclude that under these circumstances, ORS 656.054 does not authorize the Board to award claimant attorney fees payable by the NCE. Accordingly, SAIF, on behalf of the NCE, is not liable for any portion of the attorney fee.

Finally, claimant asserts that total attorney fee award for services at hearing of \$4,000 was reasonable. Neither carrier has contested that assertion. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing concerning the compensability issue is \$4,000. Since Liberty Northwest is responsible for the claim, we conclude that it is solely responsible for payment of the Referee's attorney fee award. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, and the value of the interest involved. Claimant's counsel is not entitled to an attorney fee award for services on Board review. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 12, 1993 is reversed in part, modified in part, and affirmed in part. That portion of the order that awarded an assessed fee of \$2,000 to be paid by the SAIF Corporation is reversed. That portion of the order that awarded an assessed fee of \$2,000 for overcoming Liberty Northwest Insurance Corporation's denial of compensability is increased to a total of \$4,000. The remainder of the order is affirmed.

Board Member Gunn dissenting.

The majority holds that to be entitled to an assessed attorney fee pursuant to ORS 656.054 for services rendered in connection with an NCE's objection to a claim, the claim must be found compensable as to the NCE. Because I disagree with their interpretation of the statute, I respectfully dissent.

Here, the NCE requested a hearing challenging compensability and responsibility for claimant's injury. The Referee denied the NCE's challenge to compensability on the grounds that it was not timely. Nevertheless, the Referee awarded an attorney fee to claimant's attorney pursuant to ORS 656.054 for services rendered in connection with the NCE's objection to the claim, to be paid by SAIF on behalf of the NCE. Even though Liberty Northwest was later found to be responsible for the claim, that finding does not diminish the fact that the NCE challenged compensability and lost. I believe the majority's interpretation of the statute is too narrow and fails to provide substantial justice. Therefore, I would affirm the Referee's opinion on the attorney fee issue.

In the Matter of the Compensation of
REGINALD C. NORBURY, Claimant
WCB Case No. C3-03005
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bradley C. Grove, Claimant Attorney
Bottini, et al., Defense Attorneys

Reviewed by Board Member Neidig and Gunn.

On November 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On November 24, 1993, we requested an addendum to clarify claimant's accepted condition. On December 17, 1993, we received the parties' addendum which clarified that claimant's only accepted condition was a fractured left scapula. In addition, the parties' addendum advised us that, since the original CDA was submitted, claimant had settled a third-party action for a stated amount. The parties' amended CDA provided that the lump sum amount payable to claimant (\$6,000) remained the same. However, the parties' amended agreement also provided that, as further consideration for the CDA, the insurer waived recovery of its current lien against claim costs.

We have previously held that, where the parties' revision of a proposed agreement substantially alters the amount of consideration underlying the bargain, the modified agreement constitutes a new CDA. In such cases, the claimant's statutory 30 days to request disapproval is reimplemented, beginning from the date the revised CDA is acknowledged. Mary A. Smith, 45 Van Natta 1072 (1993).

We find the present case to be distinguishable from Smith, *supra*. In Smith, the revised agreement provided for less consideration than the original agreement. Here, however, the revised agreement continues to provide for a lump sum cash amount of \$6,000, which is identical to the amount specified in the original agreement.

Moreover, in cases where the revised agreement results in a "redistribution" of funds and an additional recovery to the claimant, we have found that the revised agreement may be approved without a resubmission of the CDA. Richard R. Millus, 45 Van Natta 810 (1993).

In the present case, the parties' amended agreement actually provides claimant with additional consideration by including the insurer's waiver of its lien. In other words, without such a waiver, the insurer would have been lawfully entitled to recover a portion of its claim costs from claimant's third party recovery. See ORS 656.593(1), (3). This lien could have extended to the insurer's payment of the CDA proceeds themselves. See Scott Turo, 45 Van Natta 995 (1993).

Here, the insurer has expressly waived its statutory right to recover a portion of its claim costs from its statutory share of a third party settlement. Such a concession represents further consideration for the CDA, notwithstanding the fact that the consideration does not increase claimant's cash payment for the CDA.

Under such circumstances, we find that, although claimant's lump sum cash payment remains the same (i.e., \$6,000), the amended agreement actually provides claimant with additional consideration. Therefore, consistent with Millus, *supra*, we find no reason to treat the amended agreement as a new "CDA," or to require resubmission and reacknowledgment of the agreement.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
CURTIS W. STINSON, Claimant
WCB Case No. 89-16397
ORDER ON REMAND
Whitehead & Klosterman, Claimant Attorneys
David O. Horne, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Hammon Stage Line v. Stinson, 123 Or App 418 (1993). The court has reversed that portion of our prior order, Curtis W. Stinson, 44 Van Natta 1024, on recon 44 Van Natta 1181, corrected 44 Van Natta 1206 (1992), that held that claimant was precluded from challenging the wage rate used to calculate his temporary total disability (TTD) rate in his reopened claim. Reasoning that claimant's challenge to his TTD rate concerning his reopened claim remained viable, the court has remanded for reconsideration.

Claimant was injured in 1982. Several years after the initial closure of his injury claim, the claim was reopened for vocational assistance. The reopened claim was closed in 1988 by a determination order that awarded claimant TTD and permanent partial disability. A referee subsequently granted claimant permanent total disability (PTD).

While the insurer's appeal of the PTD award was pending, claimant asserted, for the first time, that the insurer had miscalculated both his TTD and PTD rates. The Referee concluded that claimant was entitled to contest each of these rates. Specifically, the Referee found that claimant's rates should be based on a weekly wage of \$352.03. Claimant's attorney was awarded 25 percent of the increased compensation created by the Referee's order, not to exceed \$1,050.

On review, we determined that claimant was precluded from challenging the TTD rate with respect to both the original and the reopened claim, but not the PTD rate. Curtis W. Stinson, supra. Thus, we reversed those portions of the Referee's order that pertained to the TTD rates and affirmed that portion of the order concerning the PTD rate. Claimant's attorney was awarded a \$500 attorney fee under ORS 656.382(2) for services concerning the PTD rate issue.

The Court of Appeals reversed our order as to the TTD rate in the reopened claim. The Court reasoned that, under Drews v. EBI Companies, 310 Or 134 (1990), since review of the reopened claim was still pending when claimant challenged the TTD rate calculation, as to the reopened claim, claimant's challenge was not barred by claim preclusion. Hammon Stage Line v. Stinson, supra, 123 Or App at 422. The court affirmed the remaining portions of our order. Claimant's attorney was awarded \$1,280 for services before the court regarding the PTD rate issue.

On reconsideration, we affirm and adopt the Referee's order with respect to claimant's challenge to the wage rate used to calculate claimant's TTD rate in the reopened claim.

We turn to a determination of claimant's attorney fee award. See ORS 656.388(1).

In a case in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991). Claimant has finally prevailed on the TTD rate calculation issue in the reopened claim. Therefore, claimant is entitled to a reasonable attorney fee for services concerning that issue before the Referee, the Board and the Court of Appeals.

Inasmuch as we have affirmed that portion of the Referee's order that concerns claimant's TTD rate in the reopened claim and that approves an out-of-compensation fee, it is unnecessary for us to address further the amount of attorney fees that claimant should be awarded for services at the hearing level. Thus, we proceed to address the amount of attorney fees claimant should be awarded for services at the Board and court levels.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the Board and court levels concerning claimant's reopened claim TTD rate challenge is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief to the Board and cross-petitioner's brief to the Court of Appeals), the complexity of the issue, and the value of the interest involved. We further note that, in addition to the Referee's out-of-compensation award, claimant has received attorney fee awards totalling \$1,780 for services rendered before the Board and the court regarding the PTD rate issue.

Accordingly, subject to this modification, we adhere to and republish our May 22, 1992 order, as reconsidered on June 19, 1992, and corrected on June 23, 1992, in its entirety. The parties' rights to appeal shall run from the date of this order.

IT IS SO ORDERED.

December 23, 1993

Cite as 45 Van Natta 2409 (1993)

In the Matter of the Compensation of
JAMES S. DALY, Claimant
WCB Case No. 89-20181
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of those portions of Referee Barber's order which: (1) declined to find claimant permanently and totally disabled; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay bills for psychiatric treatment. The SAIF Corporation cross-requests review of those portions of the order which: (1) increased claimant's unscheduled permanent disability award for his low back and psychological conditions from 55 percent (176 degrees), as awarded by a May 9, 1990 Determination Order, to 72 percent (230.4 degrees); and (2) set aside its denial of claimant's current psychological condition. On review, the issues are permanent total disability, extent of unscheduled permanent disability, 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

Permanent Total Disability

To prove entitlement to permanent total disability, claimant must establish that he is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

The Referee found that claimant had failed to establish that he is totally incapacitated on a medical basis alone, considering both claimant's physical and psychological conditions. We affirm and adopt the Referee's reasoning and conclusion regarding this issue, with the following supplementation.

After rendering an opinion in October 1991 that claimant is permanently and totally disabled on a medical basis due to his psychological and physical conditions, Dr. Martin, claimant's treating psychiatrist, observed one month later that claimant was "moving along nicely now" and having "one of the best periods that he has had in some time." (See Ex. 34-8; Ex. 42). Claimant continued to do well psychologically during 1992, despite a period of increased depression due to not taking his medications for five weeks. (See Exs. 44, 48A, 49B, 51A, 54).

In February 1992, Dr. Parvaresh, psychiatrist, participated in an independent medical examination. He opined that claimant's current psychological problems should not interfere with his ability to work. (Ex. 49d-9 to -10). Considering the psychological improvement documented in Dr. Martin's 1992 chart notes and reflected in the February 1992 independent psychiatric examination, we do not find Dr. Martin's October 1991 opinion persuasive in establishing that claimant was totally incapacitated at the time of the hearing in June 1992.

In October 1991, Dr. Whitney, claimant's treating orthopedist, also opined that claimant was permanently and totally disabled. However, Dr. Whitney's opinion relies in part on Dr. Martin's opinion regarding claimant's psychological condition, which we have found unpersuasive. (See Ex. 27-2). Moreover, we agree with the Referee that Dr. Whitney failed to explain the basis for changing his opinion between June and October 1991 regarding claimant's physical condition. (See Exs. 33, 41-23).

Finally, in an independent medical examination in February 1992, Drs. Podemski, neurologist, and Marble, orthopedist, opined that neither claimant's back condition nor his knee conditions prevent him from working in a light/sedentary category of employment. (Ex. 49d-21). A physical capacities evaluation completed the same day found claimant capable of work in a modified sedentary category. (Exs. 49e, 49f-3). For these reasons, we find Dr. Whitney's October 1991 opinion unpersuasive in establishing that claimant was totally incapacitated on a medical basis at any time at or prior to the hearing in June 1992.

Because we have found that claimant is not totally incapacitated on a medical basis alone, he may prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

However, in order to qualify for permanent total disability benefits under the "odd-lot" doctrine, claimant also has the burden to establish that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that such efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983). Even if a work search would be futile, claimant must establish that, but for the compensable injury, he would be willing to seek regular gainful employment. SAIF v. Stephens, 303 Or 41 (1989).

Here, the Referee found that claimant failed to make reasonable efforts to seek employment. Therefore, he concluded that claimant is not permanently and totally disabled. We agree. We affirm and adopt the Referee's order regarding this issue, with the following supplementation.

A claimant's "unreasonable refusal to undertake or complete an offered course of vocational rehabilitation constitutes a failure to show that claimant was willing to seek regular gainful employment and * * * ha[d] made reasonable efforts to obtain such employment." Delaney v. Western Shake Co., 96 Or App 699, 704 (1989). Claimant, however, contends that he reasonably cooperated with vocational services and, therefore, demonstrated that he had made reasonable efforts to obtain such employment. We disagree.

After two unsuccessful vocational retraining programs, SAIF again offered claimant vocational services beginning in January 1991. (See Ex. 22). Vocational activities were interrupted for right knee surgery in April 1991, but by early June 1991, Dr. Whitney declared claimant medically stationary and approved job analyses, with some modifications, for cashier, counter clerk and general office clerk positions. (See Exs. 26B, 27-1, 33). The vocational counselor scheduled weekly appointments for claimant to come to the counselor's office to make telephone contacts with prospective employers. (Ex. 28-1). However, by August 22, 1991, claimant had kept only two appointments, although he remained medically released to participate in vocational activities; a warning letter was sent. (See Ex. 35).

On August 28, 1991, Dr. Martin indicated that claimant had been having increased pain for the past three weeks, that he was "resisting further efforts with vocational rehabilitation," and that he (Dr. Martin) recommended no further vocational rehabilitation "at this time." (Ex. 36). However, prior to that time, Dr. Martin had been seeing claimant regularly, knew that he was participating in vocational services, but had indicated no impediment to claimant's participation. (See Exs. 23, 27A, 32).

In November 1991, Dr. Martin noted some improvement in claimant's psychological condition. (Ex. 42). In December 1991, SAIF again offered vocational assistance, based on claimant's improved condition. (Ex. 43). However, claimant refused to participate in further vocational efforts, despite approval by his attorney and Dr. Martin. (See Exs. 46, 49c; Tr. 131-32). Subsequently, claimant understood that he could choose his own vocational counselor, but he had made no efforts in that regard by the time of the hearing. (Tr. 185-86).

Under these circumstances, we find that claimant unreasonably failed to participate in vocational activities after he became medically stationary in June 1991. Accordingly, we agree with the Referee's determination that claimant failed to make reasonable efforts to obtain employment. Therefore, claimant is not entitled to permanent total disability benefits.

Extent of Unscheduled Permanent Disability

The Referee increased claimant's unscheduled permanent disability award for his low back and psychological conditions from 55 percent, as awarded by a May 9, 1990 Determination Order, to 72 percent. With respect to the psychological condition, the Referee relied primarily on Dr. Martin's 1990 report and found claimant to have a loss of function due to Class 2 moderate psychoneurosis, with an impairment factor of 35 percent. OAR 436-35-400(5)(b) (WCD Admin. Order 2-1991, effective April 1, 1991).

SAIF cross-requested review of that portion of the Referee's order that increased claimant's permanent disability award. In its appellate brief, SAIF challenged the increased award only on the basis of the psychological impairment, contending that the impairment should be 25 percent, as awarded by the May 1990 Determination Order. In response, claimant contended that his psychological condition should be classified as moderate Class 3 psychoneurosis, with an impairment rating of 81 percent, based on Dr. Martin's September 25, 1991 evaluation. (Ex. 34-8).

We review only the impairment factor for claimant's psychological condition, since this is the only factor challenged by the parties. We affirm and adopt the Referee's reasoning and conclusion on this issue, with the following supplementation.

Dr. Martin, claimant's attending psychiatrist, rated his psychological impairment as Class 2, moderate psychoneurosis in March 1990, which at that time carried an impairment value of 35-49 percent. See former OAR 436-35-400(4)(b) (WCD Admin. Order 7-1988, effective January 1, 1989). (Ex. 12). However, the Evaluation Division awarded claimant only 25 percent impairment, which is a rating in the Class 2, mild category. See former OAR 436-35-400(4)(b). We are unable to determine the basis for that award. (See Ex. 13A). Moreover, ORS 656.245(3)(b)(B) now provides that only the attending physician at the time of claim closure may make impairment findings. Accordingly, we rely on Dr. Martin's impairment findings in rating the extent of claimant's disability due to his psychological condition. Furthermore, after our review of the record, we agree with the Referee's determination that Dr. Martin's initial impairment rating of Class 2, moderate psychoneurosis is more persuasive than the findings derived from his September 1991 evaluation.

Compensability of Current Psychological Condition

The Referee set aside SAIF's May 13, 1992 denial of claimant's current psychological condition and any treatment or disability related thereto. (Ex. 56). The Referee found insufficient evidence to establish the existence of a preexisting psychological condition. He further found that claimant's current psychiatric condition remains a compensable part of his industrial injury.

SAIF cross-requested review of this portion of the Referee's order, contending that the Referee should have relied on Dr. Parvaresh's causation opinion rather than on Dr. Martin's.

Claimant contends, based on Dr. Martin's opinion, that his psychological condition was caused by his compensable injury and its sequelae. Accordingly, in order to establish the compensability of his psychological condition as a consequence of his compensable injury, claimant must prove that his 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 (1992).

We understand SAIF's position to be, based on Dr. Parvaresh's February 1992 report, that claimant has a preexisting psychological condition, and that the 1984 injury is no longer the major contributing cause of claimant's current psychological condition. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993).

Dr. Parvaresh, psychiatrist, examined claimant once on February 25, 1992, and concluded that claimant's psychological problems are longstanding. (Ex. 49d-9). In the context of rating claimant's psychological impairment, Dr. Parvaresh opined that claimant has some degree of functional impairment and disability due to his longstanding psychological problems (Class 2), but no impairment due to his psychological problems resulting from the industrial injury (Class 1). (Ex. 55).

Based on Dr. Parvaresh's report, SAIF issued a partial denial of claimant's current psychological condition on May 13, 1992, alleging that the 1984 injury is not the major contributing cause of claimant's current psychological condition. (Ex. 56).

After our review of the record, we agree with the Referee that Dr. Parvaresh's opinion is not persuasive to establish the existence of a preexisting psychological condition. Dr. Parvaresh identified problems claimant had as a child, adolescent and eventually as an adult, and concluded that his psychological problems are longstanding. (Ex. 49d-9). However, Dr. Parvaresh identified no psychological treatment prior to claimant's 1984 compensable injury. (See Ex. 49d-4). Although Dr. Parvaresh alluded generally to "ongoing adjustment problems, nervous disorders, a variety of psychosomatic problems" as problems that claimant has had "over the years," he did not specifically identify these conditions or when they arose. Nor did he discuss their relationship to claimant's compensable injury, other than to state that they seem to have contributed to claimant's prolonged convalescence. (Ex. 49d-9).

Dr. Holland, who conducted an independent psychiatric examination in December 1989 and obtained substantially the same pre-injury history from claimant, found there was insufficient evidence to establish that claimant had a preexisting psychiatric condition. He observed that such a diagnosis could only be based on a history of prior psychological hospitalization, treatment by a mental health provider, or evidence of impaired vocational or interpersonal functioning due to an emotional disorder, none of which he found in claimant's history. (Ex. 7-28). Furthermore, Dr. Martin also found no evidence of a preexisting psychological condition.

Under these circumstances, we are not persuaded that claimant had a preexisting psychological condition. Accordingly, we reject SAIF's theory that due to a preexisting psychological condition, claimant's compensable injury is no longer the major contributing cause of his current psychological condition.

We turn now to claimant's compensability theory. Dr. Martin, claimant's treating psychiatrist since 1989, opined that the major contributing cause of claimant's psychological condition, as well as resultant disability and need for treatment, was and continues to be the 1984 compensable injury and its sequelae. (See Exs. 12, 34-2, 57-39). Dr. Martin explained that since his work injury, claimant has become increasingly discouraged and depressed, has developed problems with alcohol, and has at times become suicidal; whereas prior to the injury, claimant got along well. (Ex. 34-2). Even considering claimant's problems which are unrelated to the work injury, Dr. Martin adhered to his opinion that the 1984 work injury and its sequelae are the major contributing cause of claimant's psychological condition. (Ex. 57-79 to -80).

When there is a difference of medical evidence, we ordinarily give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no reason not to defer to Dr. Martin's opinion in this case. Accordingly, we find that claimant's psychological condition is a consequence of his compensable 1984 injury and its sequelae. We further find that his current psychological condition is caused, in major part, by the compensable 1984 injury and, therefore, is compensable.

Penalties/Failure to Pay Psychiatric Billings

Claimant seeks penalties and related attorney fees for SAIF's failure to pay certain bills for psychiatric treatment. Claimant contends that SAIF agreed to pay for psychiatric treatment pursuant to a September 12, 1991 stipulation. (Ex. 36A). We disagree.

Pursuant to the stipulation, the parties agreed, inter alia, that SAIF "rescinds its denial in reference to the compensability of the current psychiatric condition." (Ex. 36A-2). The agreement is silent regarding SAIF's duty to pay for psychiatric treatment, which, for other reasons, may not be compensable. Therefore, SAIF's failure to pay the psychiatric treatment bills pursuant to the stipulation was not unreasonable.

Alternatively, claimant contends that the psychiatric treatment was compensable under ORS 656.245(1)(b), because it was necessary to monitor claimant's medications. We agree. (See e.g., Ex. 32). SAIF does not argue otherwise. Accordingly, if SAIF's failure to pay the bills was unreasonable, given its knowledge at the time its duty to pay arose, claimant is entitled to a penalty and related attorney fee for unreasonable resistance to the payment of compensation. ORS 656.262(10).

On July 1, 1991, SAIF rescinded its denial of claimant's current need for psychiatric treatment. (Ex. 28A). However, SAIF refused to pay for psychiatric treatment on July 31, 1991. (See Ex. 41A). Subsequently, the parties entered into a stipulation on September 12, 1991 whereby SAIF agreed to rescind its denial of claimant's current psychiatric condition. (Ex. 36A). In October 1991, claimant's counsel sought an explanation for SAIF's refusal to pay the bill. (Ex. 41A-1). In February 1992, SAIF advised claimant's psychiatrist that the bills were not paid because they were for palliative care, which is compensable only in limited circumstances. (Ex. 50). By March 1992, seven psychiatric bills were unpaid, from July 31, 1991 through February 14, 1992. (Ex. 51).

Dr. Martin's office sent chart notes with each billing. (See Ex. 41A-2). The chart notes indicated that Dr. Martin was monitoring claimant's medications for his psychiatric condition. (See e.g., Exs. 32, 36, 42, 44, 48A, 49B). Palliative care is compensable when necessary to monitor prescription medications required to maintain the worker in a medically stationary condition. ORS 656.245(1)(b). Accordingly, we find no reasonable basis for SAIF's failure to pay or otherwise process the psychiatric bills. Therefore, we find that penalties and attorney fees are warranted for SAIF's unreasonable resistance to the payment of compensation with respect to the unpaid compensable psychiatric bills. We assess an amount equal to 25 percent of the unpaid psychiatric bills due at the time of hearing as a result of the Referee's order, payable by SAIF, one half to claimant and one half to his attorney. ORS 656.262(10).

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation'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 issues of extent of unscheduled permanent disability and compensability of claimant's current psychological condition is \$1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's cross-respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 16, 1992 is affirmed in part and reversed in part. That portion of the Referee's order which declined to assess a penalty for SAIF's failure to pay psychiatric treatment bills is reversed. The SAIF Corporation is assessed a penalty to 25 percent of unpaid psychiatric bills due at hearing as a result of the Referee's order, payable in equal shares to claimant and his attorney. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded \$1,500 for services on Board review, to be paid by the SAIF Corporation.

December 23, 1993

Cite as 45 Van Natta 2413 (1993)

In the Matter of the Compensation of
TUAN A. HO, Claimant
WCB Case No. 92-06578
ORDER ON REVIEW
Thomas A. Coleman, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant requests review of those portions of Referee Davis' order that: (1) upheld the insurer's denial of claimant's low back injury or occupational disease claim; and (2) did not assess a penalty for an allegedly unreasonable denial. The insurer requests review of that portion of the order that denied its motion to dismiss on timeliness grounds. On review, the issues are timeliness of the hearing request, compensability and penalties. We vacate.

FINDINGS OF FACT

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

The Workers' Compensation Board received a letter from claimant on May 4, 1992. That letter is reasonably interpreted as a request for hearing concerning the insurer's denial of claimant's claim for a low back injury.

CONCLUSIONS OF LAW AND OPINION

On August 23, 1991, claimant filed a claim for a low back injury allegedly sustained on August 20, 1991. On November 5, 1991, the insurer denied the claim on the grounds that claimant's low back condition did not arise out of, nor was it worsened by, claimant's employment. Claimant received the denial on November 8, 1991.

The Workers' Compensation Board received a letter from claimant on May 4, 1992. That letter is reasonably interpreted as a request for hearing concerning the insurer's denial of claimant's claim.

A request for hearing from a denial must be filed within 60 days of notification of the denial. ORS 656.319(1)(a). If the hearing request is filed after 60 days, but within 180 days of the denial, the Hearings Division has jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

In this case, the request for hearing was filed more than 60 days, but less than 180 days, following claimant's receipt of the denial. The Referee found that claimant had good cause for filing his request for hearing more than 60 days (but less than 180 days) after receipt of the denial. In reaching this result, the Referee determined that claimant was unable to comprehend the meaning and import of the denial letter, because he could not read English.

Claimant's inability to read English is uncontroverted. However, that inability does not establish good cause sufficient to excuse an untimely request for hearing. Bertha Vega, 45 Van Natta 378 (1993), Aff'd mem Vega v. Imperial Hotel, 125 Or App 338 (1993). Moreover, even if claimant did not receive "actual" notice because he could not read the denial, such a circumstance would not constitute good cause unless claimant proved reasonable diligence, which he has not done. Id.

Accordingly, we conclude that claimant filed his request for hearing more than 60 days after notification of the denial and that he failed to prove good cause for filing the request more than 60 days but within 180 days after notification.

Because we have found the filing of claimant's request for hearing did not satisfy ORS 656.319(1), we do not reach the remaining issues.

ORDER

The Referee's order dated March 18, 1993 is vacated. Claimant's hearing request concerning the insurer's denial is dismissed.

December 23, 1993

Cite as 45 Van Natta 2414 (1993)

In the Matter of the Compensation of
THOMAS A. ROBERTSON, Claimant

WCB Case No. 92-0484M

OWN MOTION ORDER

Skalak & Alvey, Claimant Attorneys

David J. Lillig (Saif), Defense Attorney

Roberts, et al., Defense Attorneys

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights relating to that injury claim expired on June 4, 1980. On September 4, 1992, SAIF denied the compensability of and responsibility for claimant's current condition. In addition, SAIF contended that claimant had removed himself from the work force at the time of disability. Claimant filed a request for hearing with the Hearings Division regarding SAIF's denial. (WCB Case Nos. 92-12550, 92-15002).

On November 19, 1992, the Board consolidated the own motion matter with the pending litigation. Specifically, the Board requested that, if SAIF was found responsible and the current low back condition was found compensable, the Referee was to take evidence and make a recommendation on the issue of whether claimant was in the work force at the time of disability.

By an order dated April 30, 1993, Referee Barber found claimant's current low back condition compensable and set aside SAIF's September 4, 1992 denial. SAIF requested Board review of that order and, by an order issued this date, the Board affirmed and adopted Referee Barber's order. Therefore, claimant's current low back condition is compensable and SAIF is responsible for that condition. We proceed with our consideration of the own motion matter. We note that the exhibit numbers referenced below refer to exhibits admitted at hearing in WCB Case Nos. 92-15002 and 92-12550.

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 March 17, 1992, claimant experienced an immediate onset of severe back pain. Claimant treated with Dr. Craft, M.D., who subsequently referred claimant to Dr. Brett, neurosurgeon. On June 2, 1992, Dr. Brett opined claimant required "prompt operative intervention" regarding the L4-5 disc herniation. On June 6, 1992, claimant underwent lumbar surgery performed by Dr. Brett to correct the L4-5 disc herniation. On June 25, 1992, Dr. Craft deferred further opinions and treatment regarding claimant's low back condition to Dr. Brett. (Ex. 55). On this record, we conclude that, as of June 2, 1992, claimant's compensable condition worsened requiring surgery, which is the time of disability.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof regarding the work force issue.

Pursuant to SAIF's recommendation that claimant's claim not be reopened based, in part, on its contention that claimant was not in the work force at the time of disability and the Board's consolidation order, the work force issue was put before the parties at hearing. (Tr. 4). Although the Referee made no findings of fact regarding the work force issue, he admitted exhibits and testimony regarding that issue and made the following recommendation:

"Claimant has not worked since approximately 1990, but much of that time has been spent disabled from this and other injuries. Although his motivation is borderline questionable, there is insufficient evidence to show that he has withdrawn from the workforce."

We do not adopt the Referee's recommendation regarding the work force issue. Instead, we find that, on the record developed at hearing, claimant has failed to prove that he was in the work force at the time of disability.

Following his July 11, 1974 compensable low back injury, claimant sustained a compensable knee injury in April 1990 while working for a subsequent employer. That knee injury required surgery and resulted in at least temporary disability. However, regarding that knee injury, as of October 16, 1990, a physical capacities test was approved by claimant's physician which indicated that claimant was released to full time work in the light/medium range with restrictions. (Ex. 29). Claimant was restricted from squatting, crawling, climbing, and working at heights, and he was limited to three hours of sitting, three hours of standing, and two hours of walking in an eight hour work day. (Ex. 29).

Dr. Wells, claimant's treating physician for his knee injury, declared claimant medically stationary regarding that injury as of November 13, 1990 and indicated that, as of November 5, 1990, claimant was released to modified work with no kneeling or lifting or carrying of over 40 pounds. (Ex. 31). Thus, on this record, at least as of November 5, 1990, claimant was able to perform full time light-medium work with restrictions. The record contains no subsequent release from work or reduction in work capacity prior to the worsening of claimant's low back condition in the spring of 1992.

On November 30, 1990, claimant was found ineligible for vocational services because he did not have a substantial handicap to employment, given his work history and educational background. (Ex. 32). The vocational consultant found that claimant's work history provided him with sufficient transferable skills to locate employment which would pay within 80 percent of his at injury wage. (Ex. 32-7). In addition, claimant has an Associate of Science degree in Management and a Bachelor's of Art degree in Management and Communication. The vocational consultant listed seven types of jobs that claimant would qualify for and noted that, with his Bachelor's degree, claimant could be considered for a management training program and/or a sales representative position. (Ex. 32-6).

In addition, although the vocational consultant found claimant ineligible for vocational services, claimant was provided a month of "optional services." (Ex. 35). As part of these "optional services," the consultant provided claimant with several suggestions as to an employment search. However, claimant did not follow up on most of those suggestions and failed to keep in touch with the consultant. On January 18, 1991, noting claimant's lack of follow up, the vocational consultant recommended that claimant's "optional services" be terminated. (Ex. 35-2).

On February 13, 1991, claimant underwent an independent medical examination (IME) regarding his compensable knee injury. (Ex. 38). The examiners noted that claimant had not worked since July 1990. (Ex. 38-3). They opined that claimant "could do management work, although being on his feet all day could give him discomfort." (Ex. 38-4).

On April 29, 1991, claimant's claim regarding his knee injury was closed with a medical stationary date of February 13, 1991, the date of the IME. (Ex. 40). Claimant was awarded temporary partial disability through February 13, 1991.

At hearing, claimant testified that from March 1992 through the date of the April 9, 1993 hearing, he had attempted to find work by sending resumes to "various types of employers," and listing himself in his church's employment office and through the paper. (Tr. 21-24).

Given the record developed at hearing, we do not find claimant's unsupported testimony sufficient to meet his burden of proof. As noted above, claimant's low back condition did not become a problem until March 1992 and that condition did not worsen requiring surgery until June 1992. However, the record establishes that: (1) claimant was released to perform full time light/medium work with restrictions at least as early as November 5, 1990; and (2) claimant had the work skills and education to perform several jobs within that category. However, there is no evidence that claimant made a reasonable job search prior to the time he became disabled in June 1992. To the contrary, the vocational consultant indicated that claimant did not make reasonable attempts to find work.

In addition, claimant must prove that he was in the work force at the time of his disability in June 1992. Weyerhaeuser v. Kepford, supra. To the extent claimant's testimony at hearing refers to any job search efforts following his recovery from his low back surgery, those job search efforts are irrelevant to the issue of whether claimant was in the work force at the time of his disability.

Finally, we note that, on December 18, 1992, Dr. Craft stated that claimant has been unable to work since his back injury in March 1992. At first glance, Dr. Craft's statement appears to support a finding that claimant remained in the work force at the time his condition worsened requiring surgery in June 1992 by virtue of an inability to work due to the compensable back condition. However, such a finding would overlook the fact that claimant was not in the work force in March 1992, at the time Dr. Craft opined that he was initially unable to work because, although claimant was able to perform light/medium work with restrictions, he was not making reasonable efforts to find work.

On this record, we conclude that claimant has failed to prove that he was in the work force at the time of 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 from 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
KENNETH C. FANNING, Applicant
WCB Case No. CV-93004
CRIME VICTIM ORDER

Dianne Brissenden, Assistant Attorney General

Kenneth C. Fanning (hereinafter referred to as "applicant") has requested Board review of the Department of Justice's March 2, 1993 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on the finding that applicant's injuries were attributable, in part, to applicant's wrongful actions. See ORS 147.015(5), 147.125(3).

Following our receipt of the request for Board review, applicant was advised that he is 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 its record.

The Department mailed a copy of its record to applicant on June 29, 1993. We have received no hearing request within the requisite time period. However, applicant submitted a written argument on July 23, 1993. On September 13, 1993, the Department submitted a written response to applicant's argument. Applicant was granted 14 days to submit a written reply to the Department's response. Having received no reply within the requisite time period, we have conducted our review based on the record, applicant's written argument and the Department's written response. The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings and conclusions.

FINDINGS OF FACT

On August 7, 1992, applicant filed an application for benefits with the Department. He claimed that he had been the victim of an assault on April 24, 1992. Specifically, applicant claimed that when he answered a knock at his door Duane Kennedy (hereinafter called "Duane") "grabbed me by the hair and started busting [applicant] in the head with a pipe." He further claimed that when he tried to stop Kennedy, Terry Ross (hereinafter called "Ross") approached him and applicant felt a sharp pain in his side.

After the assailants left, applicant summoned help at a nearby store. He was taken by ambulance to the hospital emergency room, where he was diagnosed with scalp lacerations and stab wounds to the right abdomen and left buttock. He admitted drinking about a case of beer during the day. His blood alcohol level was .182.

Applicant underwent surgery for exploratory laparotomy, appendectomy and repair of renal and scalp lacerations. His post-operative care was complicated and prolonged when he became agitated and ripped out his catheter and NG and IV tubes. Applicant was eventually discharged from the hospital on May 16, 1992, after three weeks of hospitalization. Five days later, claimant underwent additional surgical repair procedures.

On January 6, 1993, the Department issued its Findings of Fact, Conclusions and Order. The Department found that applicant was assaulted in retaliation for his earlier assault of his girlfriend, Lori Kennedy (hereinafter called "Lori"), who is Duane's ex-wife and Ross' aunt. Specifically, the Department found that on April 23, 1992, applicant and Lori became involved in a physical confrontation during which applicant ordered Lori off his property and, as she was getting into the car to leave, slammed the car door on her ankle. The Department found that Lori later told Duane and Ross what had happened and that the two men went to applicant's home and assaulted him. The Department concluded that if applicant had not assaulted Lori, his injuries would not have occurred. The Department denied applicant's claim for benefits based on his failure to meet the requirements of ORS 147.015(5) and 147.125(3).

On February 1, 1993, applicant requested reconsideration of the Department's decision. Applicant denied that he had injured Lori prior to his assault. He alleged that Lori tried to start an argument with him a few hours before the assault but that he told her to leave and pushed her out the door. He denied following her outside. He also alleged that Lori injured her ankle 10 days before his assault when she tried to kick him and hit the bottom of a couch instead. He added that the occurrence of her ankle injury is documented in hospital records.

The Department issued an Order on Reconsideration on December 4, 1992, which adhered to its prior order. Thereafter, applicant requested timely review by the Workers' Compensation Board.

There is conflicting evidence in the record concerning the circumstances leading up to applicant's injuries. After reviewing the record, we make the following findings concerning the facts in dispute.

Applicant and Lori were living together in applicant's trailer home in Hermiston. They frequently argued and fought with each other. On Wednesday evening, April 22, 1992, Duane and his nephew Ross drove to Hermiston because Duane wanted Lori to sign some documents. Duane and Ross stayed overnight at Pam Young's residence.

The next morning, on April 23, 1992, Duane, Ross and Young drove to applicant's trailer, picked Lori up, and went out to breakfast. They returned to Young's residence and began drinking. Sometime during the afternoon, Lori, Duane, Ross and Young returned to applicant's trailer where they continued drinking. Applicant also drank a few beers. About an hour or so later, Lori, Duane, Ross and Young left applicant's trailer and went out drinking at taverns. Intoxicated, they arrived back at Young's residence at about 11 p.m.

A short time later, Ross drove Lori back to applicant's trailer. When they arrived, applicant and Lori got into a heated argument. Applicant told Lori to leave and pushed her out the trailer door. Applicant and Ross exchanged heated words. Ross drove Lori back to Young's residence and told Duane what had happened.

Lori, Duane and Ross drove back to applicant's trailer. They arrived shortly after midnight, on April 24, 1992. Applicant came out of the trailer and stood on the front steps. Carrying a metal pipe or bat, Duane approached applicant, and the two men fell to the ground fighting. During the altercation, Duane struck applicant on the head with the pipe or bat. As the two men struggled on the ground, Ross stabbed applicant with a hunting knife. Duane and Ross drove Lori back to Young's residence.

Duane and Ross packed up and drove home to Hillsboro, where they were arrested the next day. Duane was charged with assault, while Ross was charged with attempted murder and two counts of assault.

CONCLUSIONS OF LAW

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

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

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

The Department's denial of applicant's claim is based on its finding that applicant's injuries were precipitated by his assault on Lori. Specifically, the Department found that, during the argument between applicant and Lori on the night of April 23, 1992, applicant ordered Lori off his property, and as she was getting into the car to leave, applicant slammed the car door on her ankle. In retaliation, the Department found, Duane and Ross assaulted applicant.

Applicant denies that he slammed the car door on Lori's ankle. He alleges that when she continued to argue with him, he pushed her out the trailer and closed the door. He further asserts that he did not hurt Lori in any way and that he did not step outside his trailer until Lori, Duane and Ross drove up after midnight. He speculates that Lori fabricated the door slamming incident to "get back at [him]."

After reviewing the record, we are not persuaded that applicant slammed the car door on Lori's ankle. The allegation was apparently made by Lori when she was first interviewed by police. A few hours after applicant's assault, the police requested and obtained Lori's consent for a release of her medical records and to have an examination for possible injuries. (Ex. 13-7). However, after a preliminary examination, Lori left the hospital before x-rays could be performed. (Ex. 13-8). The record does not include a report from that examination. Hence, there is no medical evidence to confirm that Lori's ankle was injured on the night of the assault.

Furthermore, Lori later gave a contradictory statement to police when she reported that she twisted her ankle when applicant pushed her out of the trailer; she did not report having her ankle slammed in the car door. (Ex. 13-22). Finally, a few weeks after applicant's assault, Lori called the district attorney's victim assistant and gave yet another contradictory statement. She reported that she kicked a couch and inquired whether there was a program to help pay her medical bills. (Ex. 20-3). This last statement is consistent with applicant's allegation that Lori injured her ankle when she accidentally kicked his couch about 10 days before his assault. (Ex. 16).

Duane and Ross also stated that applicant slammed the door on Lori Kennedy's ankle; however, we find their statements to be unreliable for the following reason. Duane stated that when Ross and Lori returned to Young's residence, Ross told him that applicant had slammed the door on Lori's ankle. (Ex. 13-12). However, Young, who was present when Ross spoke to Duane, recalled that Ross told Duane that Lori "had been pushed down." (Ex. 13-14). Young did not recall anything being said about Lori's ankle. Thus, there is no evidence corroborating the statements by Duane Kennedy and Ross. Therefore, a preponderance of the evidence establishes that applicant did not slam the car door on Lori's leg, but rather, he pushed her out of his trailer.

Nevertheless, we find sufficient evidence that applicant's conduct contributed, in part, to his injuries. Applicant and Lori have a history of domestic disturbances, as verified by neighbors and applicant's brother. (Ex. 13-6, 13-8). Further, applicant, Lori, Duane and Young were all intoxicated at the time of the assault. Applicant admitted to drinking about a case of beer that day. (Ex. 3-22). Applicant concedes that during an argument with Lori, he pushed her out of his trailer. (Ex. 16). Although it is not clear how much force he used, it is apparent that sufficient force was used to remove Lori from the premises.

In addition, although applicant alleged that he was assaulted as soon as he answered the knock at his door, that allegation was contradicted by other witnesses. Lori reported that when she, Duane and Ross arrived at applicant's trailer, applicant opened the door and started down the steps. (Ex. 13-22). Her statement is corroborated by a disinterested neighbor who stated that, when he was awakened by arguing, he looked out his window and saw applicant standing on the steps of his trailer. (Ex. 13-19). We find, therefore, that applicant did not avoid a physical confrontation with Duane and Ross. Under these circumstances, we conclude that applicant's conduct in pushing Lori and later confronting Duane and Ross in a state of intoxication contributed to his assault.

We find the circumstances of this case to be somewhat similar to those in Billy Jack Kuykendall, 39 Van Natta 1120 (1987). In Kuykendall, the Department reduced the applicant's benefits on the ground that the applicant's conduct leading to a "bar fight" contributed to his injuries. Although the suspect initiated the confrontation, the applicant in Kuykendall exacerbated the situation by leaving the bar in order to fight the suspect. Once outside the bar, the applicant struck the suspect, and was then shot by the suspect. The Department, therefore, justifiably reduced the applicant's benefits. Kuykendall, supra.

Like the applicant in Kuykendall, applicant's conduct contributed to his injuries. However, we are not persuaded that applicant is entirely precluded from receiving benefits. The assailants, Duane and Ross, initiated the confrontation, beat applicant with a pipe or bat, and then stabbed him. Because they initiated and then escalated a violent confrontation, we conclude that applicant's actions in responding to the situation were not sufficiently substantial to preclude him entirely from receiving compensation. See ORS 147.015(5); OAR 137-76-010(7), 8; Billy Jack Kuykendall, supra.

Under the circumstances, we find applicant eligible to receive an award of compensation under the Act. However, considering the circumstances described above, particularly applicant's intoxication, we conclude that a 25 percent reduction in benefits is appropriate. See ORS 147.125(3).

ORDER

The January 6, 1993 Findings of Fact, Conclusions and Order of the Department of Justice Crime Victims' Compensation Fund, as reconsidered March 2, 1993, is modified. Applicant's claim for benefits is remanded to the Department with instructions to accept and process the claim in accordance with law. Applicant's benefits shall be limited to 75 percent of his medical and hospital expenses and loss of earnings, up to the statutory maximum.

December 27, 1993

Cite as 45 Van Natta 2420 (1993)

In the Matter of the Compensation of
JAMES P. EDDINS, Claimant
WCB Case No. 91-12743
ORDER ON REMAND (REMANDING)
Malagon, et al., Claimant Attorneys
Paul Louis Roess, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

This matter is before the Board on remand from the Court of Appeals. Eddins v. Morse Brothers, Inc., 123 Or App 632 (1993). The court has reversed our prior order, which held that the Hearings Division lacked jurisdiction to consider an "invalid" Order on Reconsideration because the order had issued without consideration of a medical arbiter's report. Reasoning that the Hearings Division had authority to consider a reconsideration order whether "invalid" or "valid," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A June 17, 1991 Determination Order closed claimant's injury claim with an award of 6 percent scheduled permanent disability for the left index finger. Claimant requested reconsideration, objecting to the impairment findings used to close the claim. The August 29, 1991 Order on Reconsideration, which issued without prior appointment of a medical arbiter, affirmed the Determination Order in all respects. After the issuance of the Order on Reconsideration, a medical arbiter's examination was performed. Claimant requested a hearing.

The Referee found the Order on Reconsideration invalid because the order issued without consideration of a medical arbiter's report under ORS 656.268(7). Therefore, the Referee concluded that the Hearings Division lacked jurisdiction to consider the merits of the reconsideration order.

In our prior order, we affirmed the Referee's order dismissing claimant's request for hearing for lack of jurisdiction. We relied on our decision in Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

In Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the court reversed the reasoning we used in deciding Olga I. Soto, supra. Noting that ORS 656.268(6)(b) allows any party to request a hearing under ORS 656.283 concerning objections to a reconsideration order, the court held that a "valid" order on reconsideration is not a jurisdictional prerequisite for a hearing on that order. Reasoning that no statute divests the Board of its review obligations where an "invalid" order on reconsideration occurs, the court remanded for reconsideration. In so doing, the court further instructed: "Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board." Pacheco-Gonzalez v. SAIF, 123 Or App at 316.

Here, relying on its decision in Pacheco-Gonzalez v. SAIF, supra, the court has remanded our prior order for reconsideration. Accordingly, we proceed with our reconsideration.

Although the Referee admitted some exhibits into the record, the "post-reconsideration order" medical arbiter's report was not admitted. Moreover, no testimony was presented based on the Referee's conclusion that the Hearings Division lacked jurisdiction over the Order on Reconsideration. As reasoned by the court, Pacheco-Gonzalez v. SAIF, *supra* at 316, the Referee did have jurisdiction over the Order on Reconsideration and the "post-reconsideration" medical arbiter's report should have been considered at hearing.

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). Under the circumstances of this case, we find the record insufficiently developed. Moreover, in light of the Referee's evidentiary rulings, and the Pacheco-Gonzalez court's subsequent holding, we find a compelling reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Betty S. Tee, 45 Van Natta 289 (1993). Consequently, we remand this matter to the Referee for further evidence taking.¹ See Rosa M. Pacheco-Gonzalez, 45 Van Natta 2276 (1993); Nancy M. Buckles, 45 Van Natta 2077 (1993).

Accordingly, the Referee's order dated December 4, 1991 is vacated. The matter is remanded to Referee Brazeau for further proceedings consistent with this order. Such proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7). Once these further proceedings are completed, the Referee shall issue a final appealable order.

IT IS SO ORDERED.

¹ In light of ORS 656.268(7) and the court's ruling, the additional medical evidence will consist of the medical arbiter's report. Any lay testimony will consist of evidence concerning claimant's disability as of the date of issuance of the Order on Reconsideration. ORS 656.283(7); Safeway Stores, Inc. v. Smith, 122 Or App 160, 163 (1993).

December 27, 1993

Cite as 45 Van Natta 2421 (1993)

In the Matter of the Compensation of
FRANCIS J. MERCK, Claimant
WCB Case No. 92-14042
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial of his claim for a consequential psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a 52-year-old journeyman carpenter, compensably injured his neck, back, elbow and wrist on June 2, 1988, when he fell from a ladder. On December 27, 1990, Dr. Brett, claimant's attending physician, performed a decompressive laminectomy at C5, C6 and C7 and a bilateral foraminotomy at C5-6 and C6-7. On June 17, 1991, Dr. Brett performed an anterior cervical discectomy and fusion at C5-6 and C6-7.

On November 27, 1991, Drs. Ploss, M.D., and Duvall, psychologist, performed a disability prevention evaluation. Dr. Duvall diagnosed somatoform pain disorder and alcohol abuse. (Ex. 39).

On January 23, 1992, Dr. Brett performed a closing examination and declared claimant medically stationary. (Ex. 48).

On February 11, 1992, the SAIF Corporation issued a Notice of Closure awarding claimant temporary disability and 15 percent (48 degrees) unscheduled permanent disability for his neck. Claimant requested reconsideration, contending that his claim had been prematurely closed and requesting a medical arbiter panel.

On April 29, 1992, an Order on Reconsideration issued increasing claimant's unscheduled permanent disability award to a total of 29 percent (92.8 degrees) and affirming the remainder of the Notice of Closure. Claimant requested a hearing, on which action was deferred until compensability of this psychological claim was decided.

Claimant returned to work as a carpenter in the summer of 1992. He worked 300 hours, but was unable to do the job. In October 1992, he returned to Dr. Brett complaining of pain into his arms and legs. Dr. Brett concluded that claimant's symptoms were not a result of claimant's work injury or post-operative condition. He also reported that claimant was seeing a psychiatrist at the request of his attorney.

On December 7, 1992, Dr. Glass performed a psychiatric evaluation at the request of SAIF. He diagnosed somatoform pain disorder, alcohol dependence and alcohol abuse. (Ex. 67-A).

On December 21, 1992, Dr. Grewe, neurosurgeon, examined claimant in regard to his complaints of pain radiating from his neck into his arms bilaterally and low back pain radiating into his legs and feet bilaterally. (Ex. 69C).

On January 11, 1993, SAIF issued a denial of claimant's psychological condition diagnosed as somatoform pain disorder and alcoholism with associated symptoms of depression and dysthemic moods. (Ex. 69A).

On January 27, 1993, Dr. Dixon, psychiatrist, performed a psychiatric evaluation. He diagnosed depression, alcohol dependence and general anxiety disorder. (Ex. 71).

On February 13, 1993, Dr. Klecan, psychiatrist, performed a records review for SAIF. (Ex. 70).

Claimant has always been a heavy drinker of alcohol. During the last year, his alcohol intake increased to more than two 12-packs of beer a day.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not met his burden of proving that his psychological condition was compensably related to his accepted neck injury. Claimant argues that his current condition, diagnosed as depression and alcoholism by Dr. Dixon, is compensably related to his accepted neck and back condition. We agree with the Referee's conclusion, but for different reasons.

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 to establish compensability. ORS 656.005(7)(a)(A); Kephart v. Green River Lumber, 118 Or App 76, 79 (1993); Albany General Hospital v. Gasperino, 113 Or app 411 (1992).

The Referee concluded that claimant was not clinically depressed or anxious, and, therefore, does not have a psychological condition that is related to his injury. She also concluded that the compensable injury is not the major contributing cause of his diagnosed somatoform pain disorder or alcohol abuse or a worsening of those conditions.

Drs. Glass and Duvall reported that claimant complained of pain in his arms, shoulders and neck, and was frustrated and discouraged at not being able to return to carpentry, his lifetime work. They also reported loss of appetite, loss of weight, loss of concentration, loss of motivation, insomnia, fatigue, loss of enjoyment, and an increase in alcohol intake.

Drs. Glass and Duvall diagnosed somatoform pain disorder, a condition in which a person's complaints of pain and disability are out of proportion to the physical findings. Dr. Duvall attributed this condition to claimant's uncertainty over his physical abilities and his vocational future. Dr. Duvall also diagnosed mild to moderate alcohol abuse, based on claimant's report that he drank eight beers once or twice a week. However, because he did not discuss the relationship of his findings to claimant's compensable injury, we do not rely on his report for our causation analysis.

Claimant reported to Dr. Glass that he had always been a heavy drinker, although his after-work drinking had not interfered with his employment. He also reported that, in the past year, his drinking had increased to more than two 12-packs of beer a day "in order to get to sleep." Dr. Glass opined that most if not all of claimant's depressive symptoms, namely his loss of appetite, concentration and enjoyment, and insomnia and fatigue, are the result of his excessive use of alcohol. (Ex. 67A-11, Tr. 10 and Tr. 97-109). Furthermore, Dr. Glass explained that one of the features of alcohol dependency is the drinker's need to rationalize his desire to drink. He opined that claimant was using his preoccupation with his physical symptoms, including his pain and symptoms of depression as justification or rationalization for his drinking. (Ex. 67A-13, Tr. 80-82). In addition, he opined that claimant's excessive alcohol use interfered with his ability to adjust to his vocational situation. (Tr. 79). Finally, he opined that claimant's industrial injury was not the major contributing cause of his increased intake of alcohol. (Tr. 82 and 83).

We are more persuaded by Dr. Glass' well-reasoned opinion than that of Dr. Dixon, who attributed claimant's symptoms to injury-related depression. See *Somers v. SAIF*, 77 Or App 259 (1986). Although Dr. Dixon agreed that claimant's symptoms could be the result of his alcohol abuse, he did not explain why he attributed them to depression rather than claimant's excessive alcohol intake.

Consequently, we conclude that claimant has failed to prove that his symptoms of depression, his alcohol abuse or his pain symptoms are compensable consequences of his industrial injury.

ORDER

The Referee's order dated April 29, 1993 is affirmed.

December 27, 1993

Cite as 45 Van Natta 2423 (1993)

In the Matter of the Compensation of
LEE A. MIZE, Claimant
WCB Case Nos. 92-16242 & 92-14460
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Referee Baker's order which upheld the SAIF Corporation's denial of her injury claim for a cervical-thoracic strain and jaw strain, and an alleged "de facto" denial of a left temporomandibular joint (TMJ) condition. In her reply brief, claimant contends that the Referee erred in awarding a 25 percent penalty based on compensation which was "delayed" due to the insurer's unreasonable failure to timely accept her July 28, 1992 left shoulder injury claim. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

TMJ Condition/Jaw Strain

We adopt the Referee's conclusion with regard to this condition.

Cervical-thoracic Condition

We adopt the Referee's conclusion with the following supplementation.

Claimant treated with Dr. Balmer, M.D. for a compensable back injury that occurred on August 16, 1991. (Ex. 1). On August 21, 1991 Balmer noted that claimant had "recurrent pain and numbness in the [left] arm and pain through her shoulder into her left neck and into the left side of her head * * *." On September 13, 1991, Dr. Balmer reported that claimant's August 1991 injury was not improving, but was actually getting worse. (Ex. 1-5).

Claimant was again injured on July 28, 1992 when a patient kicked her in the chest and left shoulder. On August 15, 1992, claimant was examined by the Medical Consultants Northwest. (Ex. 7). At that time, her symptoms included blackouts, headaches from the left neck to the left side of the head, "ringing" pain in the left neck, burning and sharp left shoulder pain, left back pain from the shoulder down and left arm numbness. (Ex. 7-2, 3). Five days later, on August 20, 1992, claimant asserted that she had sustained another work injury involving her neck and jaw.

In light of the medical evidence, which establishes that claimant was experiencing similar symptoms prior to the alleged August 20, 1992 injury, we are persuaded that claimant did not suffer a new cervical-thoracic injury on August 20, 1992. We agree with the Referee that claimant had been treating, and continued to treat for neck, upper back and shoulder conditions prior to her August 1992 work incident.

Penalty

Claimant contends that the Referee incorrectly awarded a 25 percent penalty, pursuant to ORS 656.262(10), based on all compensation that had been "delayed" due to SAIF's unreasonable failure to timely accept claimant's July 28, 1992 left shoulder injury claim. Noting that claimant did not raise this penalty issue in her appellant's brief, SAIF argues that claimant has untimely asserted the penalty issue in her reply brief.

We need not resolve this procedural issue because we agree with the Referee's penalty assessment. Since SAIF did not timely respond to claimant's left shoulder injury claim, the Referee properly assessed a penalty equal to 25 percent of the compensation "delayed" as a result of SAIF's unreasonable conduct. Since SAIF's unreasonable conduct was an untimely acceptance, we interpret the Referee's penalty assessment to encompass all compensation "then due" at the time of SAIF's acceptance. See ORS 656.262 (10).

ORDER

The Referee's order dated April 1, 1993 is affirmed.

December 27, 1993

Cite as 45 Van Natta 2424 (1993)

In the Matter of the Compensation of

WAYNE A. MOLTRUM, Claimant

WCB Case No. 90-14909

ORDER ON REVIEW

Allen T. Murphy, Jr., Claimant Attorney

Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Referee Hazelett's order which, on reconsideration, assessed an attorney fee, when a prior order on the merits had declined to do so and claimant requested reconsideration of that order more than 30 days after it became final. On review, the issue is jurisdiction. We vacate.

FINDINGS OF FACT

SAIF denied claimant's head and brain injury claim on subjectivity grounds. After a September 1992 hearing, a November 9, 1992 Opinion and Order held that claimant was a subject worker when he was injured, but his attorney was not entitled to an attorney fee under ORS 656.386(1). A December 28, 1992 Order on Reconsideration republished the November order and indicated that the parties' appeal rights extended 30 days from December 28, 1992.

On March 19, 1993, claimant filed a request for an assessed attorney fee for services associated with the September 1992 hearing. On April 30, 1993, the Referee issued a "Supplementary Order" which awarded claimant an assessed attorney fee.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that the Referee lacked jurisdiction to alter or supplement his December 28, 1992 order. We agree.

Inasmuch as the December 28, 1992 order was neither appealed, abated, stayed, republished nor withdrawn within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3). Pursuant to that order, the referee held that claimant's counsel was not entitled to an attorney fee. Because claimant did not request reconsideration and the referee's order was not withdrawn or appealed before the expiration of the statutory 30-day period, the December 28, 1992 order has become final. Therefore, the Referee lacked authority to alter his prior holding regarding fee entitlement. See Renee A. Anderson, 42 Van Natta 157 (1990); Gabino R. Orozco, 41 Van Natta 599,775 (1989). Accordingly, we vacate the Referee's "Supplementary Order" which purports to assess an attorney fee.

ORDER

The Referee's "Supplementary Order" dated April 30, 1993 is vacated.

December 27, 1993

Cite as 45 Van Natta 2425 (1993)

In the Matter of the Compensation of
MARION U. STUBBS, Claimant
WCB Case No. 93-04257
ORDER OF DISMISSAL
Bischoff & Strooband, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

The insurer requested review of Referee Brown's order that set aside a Medical Director's order which held that a surgery was not appropriate medical treatment. Prior to conducting our review, the parties announced that they had settled their dispute. The parties have now submitted a proposed "Stipulation and Order of Dismissal," which is designed to resolve all issues raised or raisable in this matter, in lieu of the Referee's order. Specifically, claimant agrees that the Referee's order shall be vacated and the Medical Director's order "reinstated and affirmed."

We have approved the parties' agreement, thereby fully and finally resolving this dispute, in lieu of the Referee's order. In granting this approval, we take administrative notice that the parties have also submitted a proposed disputed claim settlement which resolves claimant's request for review of Referee Howell's order that upheld the insurer's aggravation denial. (WCB Case No. 90-15801).

Here, in return for \$500 (less a \$125 attorney fee), claimant stipulates that the Medical Director's order will be reinstated and affirmed. The stipulation neither identifies, nor are we able to ascertain, what type of compensation the \$500 represents. Furthermore, unless the \$500 represents either compensation or disputed claim settlement proceeds, we are without authority to grant an attorney fee from such proceeds.

Inasmuch as this stipulation was submitted in conjunction with the parties' disputed claim settlement in the other case pending Board review and since there is some question regarding whether the identity of the stipulation's consideration and attorney fee are appropriate, we have considered the \$500 (less a \$125 attorney fee) as part of the disputed claim settlement proceeds. In reaching this conclusion, we have determined that our interpretation of the proposed agreements achieves the parties' intentions to resolve their disputes and is consistent with all applicable statutory and administrative requirements.

Accordingly, pursuant to the parties' approved stipulation and our aforementioned interpretation, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT R. THOMAS, Claimant
WCB Case No. 93-00437
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of that portion of Referee Neal's order which declined to award a penalty and attorney fee for the insurer's allegedly untimely determination of claimant's vocational eligibility. On review, the issues are penalties and attorney fees.

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

Assuming without deciding that the insurer was untimely in determining claimant's vocational eligibility, claimant has not been found entitled to vocational assistance. Accordingly, there are no amounts "then due" on which to assess a penalty. ORS 656.262(10). Further, because there has been no resistance to the payment of compensation, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1). Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated April 14, 1993 is affirmed.

December 28, 1993

Cite as 45 Van Natta 2426 (1993)

In the Matter of the Compensation of
GEORGE HAMES, JR., Claimant
WCB Case No. 92-13573
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Nichols' order that upheld the self-insured employer's partial denial of claimant's injury claim for a right ulnar nerve 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 compensably dislocated his right shoulder in a fall at work. The injury was treated by immobilization which resulted in adhesive capsulitis (frozen shoulder). Claimant was prescribed physical therapy to improve his range of shoulder motion. After a few months of physical therapy, claimant began having persistent numbness in the small fingers of his right hand. Electrodiagnostic studies revealed possible mild carpal tunnel syndrome on the right and slowing of the ulnar nerve at the right elbow. Claimant was diagnosed with an ulnar nerve entrapment syndrome at the right elbow.

Dr. McWeeney requested authorization for an ulnar nerve transposition surgery. In response, the employer denied the right hand and elbow condition as not being related to the original injury.

Aggressive physical therapy, appropriately prescribed for claimant's compensable right shoulder condition, was the major contributing cause of the onset of claimant's right ulnar nerve condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, under ORS 656.005(7)(a)(A), claimant must prove that his compensable shoulder injury was the major contributing cause of his ulnar nerve condition. Claimant concedes that the "major contributing cause" test applies. Therefore, we adopt the Referee's conclusion that claimant must satisfy the "major contributing cause" test under ORS 656.005(7)(a)(A).

The Referee also concluded, however, that claimant had failed to meet his burden of proof. We disagree and conclude, instead, that claimant has met his burden of proof.

Because the causation issue presents a complicated question, and there was a substantial delay between the shoulder injury and the onset of the ulnar nerve problems, we conclude that expert medical evidence is required to meet claimant's burden of proof. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). However, medical experts need not use "magic words" to satisfy the "major contributing cause" test. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

We find that the physical therapy, which was prescribed for claimant's adhesive capsulitis, was the major contributing cause of his ulnar nerve condition. Dr. McWeeney, claimant's attending orthopedist, opined that the physical therapy was the major cause of the ulnar nerve condition. (Ex. 25-27). He explained that the physical therapy required to treat adhesive capsulitis is very aggressive and forceful, involving stretching, yanking, pulling and leaning on the arm. (Ex. 25-30). Dr. McWeeney also relied on claimant's history that: (1) claimant sustained no intervening injury since the compensable injury; and (2) the onset of the tingling sensation in the right hand coincided with the physical therapy. (Ex. 25-26).

We conclude that the record supports the accuracy of claimant's history. Claimant's testimony that he sustained no intervening injury is uncontroverted. (Tr. 8). A physical therapy chart note dated July 8, 1992, documented claimant's report of the "onset of daily hand tingling depending on position of right upper extremity." (Ex. 12-14). Dr. McWeeney interpreted that report as supporting a causal connection between the therapy and tingling sensation. (Ex. 25-26).

The employer argues that Dr. McWeeney's opinion is based on incomplete history because he was not aware that claimant was jet skiing during the same period as the physical therapy. We disagree. At his deposition, Dr. McWeeney was asked to assume that claimant jet skied for a couple of hours every weekend but that he actually rode the jet ski for no more than 10 minutes at a time. (Ex. 25-21). Those facts were established by claimant's uncontroverted testimony. (Tr. 15-16). After assuming those facts, Dr. McWeeney opined that the jet skiing was not a likely cause of the ulnar nerve condition. (Ex. 25-21). Accordingly, we find that Dr. McWeeney's opinion was based on complete history.

The employer contends that, even if the physical therapy was the major contributing cause of the ulnar nerve condition, the medical evidence does not establish that the shoulder injury itself was the major cause of the ulnar nerve condition. In this regard, the employer notes that both Dr. McWeeney and Dr. Utterback, the examining orthopedist, opined that the shoulder injury did not cause the ulnar nerve condition. (See Exs. 18-3, 25-31).

At first glance, the doctors' opinions appear to support the employer's contention. However, upon closer examination, we find that both doctors' opinions were premised on the wrong causation theory. Claimant's theory of causation relates the ulnar nerve condition indirectly to the shoulder injury; that is, the ulnar nerve condition was caused by the physical therapy which was required to treat the adhesive capsulitis resulting from the compensable shoulder dislocation. By contrast, Drs. McWeeney and Utterback rendered their opinions based on the theory that the shoulder injury directly caused the ulnar nerve condition; that is, the trauma of the dislocation caused the ulnar nerve condition.

Dr. Utterback wrote, in relevant part:

"No mention is made of ulnar nerve dysesthesia or hypesthesia in any of the supplied information until 8/26/92. This includes multiple physical therapy visits, evaluation by two orthopedic surgeons, and evaluation by an emergency room doctor. The time span then is approximately 4.5 months between supposed injury to the

structure, and report of symptoms. One would expect symptoms to develop much sooner than this if the two were directly related, and it should be noted that most of the ulnar nerve entrapment syndromes either are caused by long term overuse with one activity or another, or occur spontaneously. I suspect that very few can be documented to occur from a distinct traumatic episode that does not involve a fracture. At any rate, I believe the probability of the ulnar nerve entrapment syndrome arising from a fall onto an outstretched right hand on 4/18/92, is remote. (Ex. 18-3) (Emphases supplied.)

The emphasized portions of Dr. Utterback's report clearly indicate that he was addressing only a direct causal relationship between the shoulder injury and the ulnar nerve condition. He did not address the indirect relationship asserted by claimant.

Dr. McWeeney's opinion also addressed a direct causal relationship. In one report, he wrote, in part: "...I can't understand how [the ulnar nerve lesion] can directly relate to the injury." (Ex. 23A). At his deposition, Dr. McWeeney again referred to a direct causal relationship:

"Q. * * * And your opinion has pretty consistently been that [the ulnar nerve condition is] not a result of the shoulder dislocation?

A. I don't think so, because I saw him three months after he dislocated his shoulder, and I think that it probably would have been apparent by now---by then if it had been the result of that injury." (Ex. 25-17).

Like Dr. Utterback, Dr. McWeeney emphasized the delay in the onset of symptoms as a persuasive factor in his causation opinion. However, as Dr. Utterback's opinion makes clear, the delay between the shoulder injury and the onset of ulnar nerve symptoms is significant in determining the direct causal relationship between the shoulder injury and ulnar nerve symptoms. That delay would not disprove an indirect causal relationship, with symptoms developing after months of physical therapy necessitated by the shoulder injury.

When viewed in their proper context, the opinions of Drs. McWeeney and Utterback do not disprove claimant's theory that the ulnar nerve condition was indirectly caused, in major part, by the shoulder injury. Rather, we conclude that the medical record as a whole establishes claimant's causation theory.

The record shows that claimant's shoulder dislocation was treated by a shoulder immobilizer. (Exs. 1, 2, 5). There is no indication in the record, nor any allegation by the employer, that the immobilization was unreasonable, unnecessary or otherwise inappropriate treatment for the shoulder injury. Rather, the contrary is the case. The record further shows that, as a result of the shoulder dislocation and immobilization required for the dislocation, claimant developed adhesive capsulitis (frozen shoulder). (Exs. 14, 16A, 25-32). The adhesive capsulitis, in turn, was treated with physical therapy to improve the range of shoulder motion. Again, all of the medical evidence indicates that the physical therapy was appropriate treatment for the adhesive capsulitis. (Exs. 16A, 18-2, 25-32).

Based on the medical record, therefore, we find that the sole cause of claimant's need for physical therapy was the compensable shoulder injury. Because we have found that the physical therapy was the major contributing cause of the ulnar nerve condition, we conclude that the compensable shoulder injury was the major contributing cause of the ulnar nerve condition.¹ Accordingly, the right ulnar nerve condition is compensable.

¹ We emphasize that not all conditions resulting, in part, from treatment for a compensable injury/condition are compensable under the "major contributing cause" standard. We have previously concluded, for example, that injuries sustained by a claimant as a result of a motor vehicle accident while returning home from physical therapy for a compensable condition were not compensable consequential conditions. Judy R. Hicks, 44 Van Natta 204, aff'd Hicks v. Spectra Physics, 117 Or App 293 (1992). On the other hand, we have concluded that a gastrointestinal condition caused, in major part, by medications prescribed for a compensable injury was a compensable consequential condition. Rosa L. Sulfridge, 45 Van Natta 1152 (1993). We believe the instant case is more similar to the facts of Sulfridge than those of Hicks. Our conclusion in this case is further supported by the absence of any evidence that the treatment prescribed for claimant's compensable injury was unreasonable, unnecessary or otherwise inappropriate.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of his ulnar nerve 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 the compensability of the ulnar nerve condition is \$3,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 3, 1993 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's partial denial of claimant's claim for a right ulnar nerve condition is reversed. That denial is set aside, and the claim is remanded to the employer for processing according to law. For services at hearing and on review concerning the ulnar nerve condition, claimant's counsel is awarded a \$3,000 attorney fee, payable by the employer. The remainder of the order is affirmed.

December 28, 1993

Cite as 45 Van Natta 2429 (1993)

In the Matter of the Compensation of
GARY L. HARRIS, Claimant
WCB Case Nos. 91-09781 & 90-22646
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Pamela A. Schultz, Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Bill Gurlock Towing (Gurlock), requests review of that portion of Referee Crumme's order which: (1) set aside its denial of claimant's right ear hearing loss claim; and (2) upheld Redmond Heavy Hauling's (Redmond) denial of the same condition. Liberty, on behalf of Redmond, cross-requests review of that portion of the Referee's order which: (1) set aside its denial of claimant's left ear hearing loss claim; and (2) upheld Gurlock's denial of the same condition. Claimant filed a motion to dismiss Gurlock's request for Board review and, alternatively, moves to strike Gurlock's December 1, 1992 brief as untimely. On review, the issues are dismissal, motion to strike, compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact through finding number 15.

CONCLUSIONS OF LAW AND OPINION

Dismissal

Claimant seeks dismissal of Gurlock's request for Board review as defective because it only partially appealed the Opinion and Order. Yet, the Board reviews the Referee's entire order, not just a limited portion as requested by one of the parties. Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992); Destael v. Nicolai Company, 80 Or App 596, 600-01 (1986); William E. Wood, 40 Van Natta 999, 1001 (1988). Accordingly, the motion to dismiss is denied.

Motion to Strike

Claimant requests that we strike Gurlock's December 1, 1992 brief as untimely. Furthermore, claimant contends that Gurlock's brief makes an argument concerning timeliness of claim filing which Gurlock specifically waived at hearing. (Tr. 3, 4). We deny the motion.

As the appellant, Gurlock's brief was due November 18, 1992. Gurlock did not file a brief within that period. Instead, its brief was filed within 14 days of Redmond's cross-appellant's brief, which was filed on November 17, 1992. Specifically, Gurlock filed its first brief on December 1, 1992.

Thus, although untimely as an appellant's brief, Gurlock's brief was timely filed as a cross-respondent/reply brief. OAR 438-11-020(2). However, the arguments in Gurlock's brief will only be considered insofar as they reply to those set forth in Redmond's brief. See George T. Cooper, 44 Van Natta 493 (1992).

Compensability

Claimant began working as a tow truck driver for Gurlock in 1987. On April 19, 1990, during his work for Gurlock, claimant was injured when struck on his right forehead by a metal bar. While on week-long vacations from Gurlock in May 1990 and August 1990, claimant worked as a tow truck driver for Redmond. On August 2, 1990, during the course of work for Redmond, claimant was again struck by a metal bar on the right side of the head.

Claimant's initial hearing test on December 22, 1989 indicated moderate to severe hearing loss in the high frequencies. (Ex. 1). After considering claimant's overall pattern of hearing loss, Dr. Hodgson stated that the pattern was suggestive of noise damage, and that the most likely explanation was noise exposure over many years. (Ex. 29). Based on claimant's employment history and pattern of hearing loss, Dr. Hodgson stated that employment exposures were the major contributing cause of claimant's bilateral hearing loss present in December 1989. (Ex. 37). Dr. Hodgson further stated that claimant's 70-hour employment at Redmond in August 1990 was not a significant contributing factor in claimant's hearing loss. (Ex. 29-2).

Dr. Bakos, the only other doctor to address causation of claimant's hearing loss, explained that the type of hearing loss experienced by claimant is not caused by head trauma. Rather, he attributed the loss to exposure to loud noises. (Ex. 33). Because the evidence supports hearing loss due to a gradual onset, rather than being due to a specific injury, we analyze the condition as an occupational disease. Valtinson v. SAIF, 56 Or App 184 (1982). In order to prove compensability of his bilateral hearing loss as an occupational disease, claimant must show that his work exposure is the major contributing cause of hearing loss. ORS 656.802; Aetna Casualty v. Aschbacher, 107 Or App 494, 502 (1991). The Referee concluded that claimant's work exposure was the major contributing cause of claimant's hearing loss. Based on Dr. Bakos' opinion, we agree.

Responsibility

ORS 656.308(1) applies to occupational disease claims as well as injury claims. Liberty Northwest Insurance Corporation v. Senters, 119 Or App 314 (1993); Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991). The statute, however, addresses only shifting of responsibility, not its initial assignment. Fred A. Nutter, 44 Van Natta 854 (1992). Consequently, because there is no accepted hearing loss claim in this case, we do not apply ORS 656.308. Instead, we apply the last injurious exposure rule.

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Bazar, 293 Or 239, 248 (1982).

The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983). Once liability is initially fixed, responsibility may not be shifted forward to a subsequent employer unless that employer's work conditions contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Bazar, *supra*; Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795, *rev den* 300 Or 162 (1985).

Here, claimant did not lose time from work due to his hearing loss condition. Thus, the "date of disability" is the time claimant first sought medical treatment for the hearing loss, and responsibility is initially assigned to the carrier on the risk at that time. Claimant first sought treatment for ringing in his ears and possible hearing loss on December 22, 1989, while Gurlock was on the risk. (Tr. 20, 21). Accordingly, responsibility is initially assigned to Gurlock.

Because claimant's employment with Redmond was subsequent to the "date of disability" fixed during employment with Gurlock, Gurlock can shift responsibility to Redmond only by proving that employment conditions at Redmond actually contributed to a worsening of the condition. Oregon Boiler Works v. Lott, 115 Or App 70 (1992). We find no evidence that supports shifting responsibility for claimant's bilateral hearing loss, caused by industrial exposure, to Redmond. Accordingly, responsibility for claimant's bilateral hearing loss remains with Gurlock.

In lieu of the Referee's attorney fee awards, we grant claimant an attorney fee for services at hearing and on review for prevailing over Gurlock's denial of claimant's bilateral hearing loss claim. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that reasonable fee for claimant's attorney's services at hearing and on review concerning claimant's bilateral hearing loss as an occupational disease claim is \$3,300, to be paid by Gurlock. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's brief on Board review), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 21, 1992 is reversed in part and affirmed in part. That portion of the order which set aside Liberty/Redmond's denial of claimant's injury claim for left ear hearing loss is reversed. Redmond's denial is reinstated and upheld. That portion of the order which set aside Liberty/Gurlock's denial of claimant's injury claim for right ear hearing loss is reversed. Gurlock's denial is reinstated and upheld. Gurlock's denial of claimant's occupational disease claim for bilateral hearing loss is set aside. The claim is remanded to Gurlock for processing according to law. In lieu of the Referee's attorney fee awards, for services at hearing and on Board review, claimant's attorney is awarded an assessed attorney fee of \$3,300, payable by Gurlock. The remainder of the Referee's order is affirmed.

December 28, 1993

Cite as 45 Van Natta 2431 (1993)

In the Matter of the Compensation of
KENNETH L. ORR, Claimant
WCB Case No. 91-16201
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn, Westerband, and Haynes.

The insurer requests review of that portion of Referee T. Lavere Johnson's order which found claimant permanently and totally disabled. On review, the issue is permanent total disability.

We affirm and adopt the Referee's order.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 16, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$800, payable by the insurer.

Board Member Haynes Dissenting:

Because I do not believe that claimant is permanently and totally incapacitated from performing gainful employment, I dissent.

It is undisputed that claimant is not PTD from a medical standpoint alone. Furthermore, suitable jobs were identified for claimant that took into consideration his physical abilities and other nonmedical factors. In fact, claimant received a bona fide job offer for a position he was capable of performing, considering the limitations resulting from his compensable injury.

Claimant, however, informed the employer that he could not begin working at the job because he had carpal tunnel syndrome (CTS). (Ex. 97-11). Claimant's CTS was not disabling prior to his compensable injury. Accordingly, it cannot be taken into account in determining whether claimant is permanently and totally disabled. Elder v. Rosboro Lumber Co., 106 Or. App 16 (1991).

Claimant refused to begin a bona fide job that was within his physical and mental capabilities because he determined, on his own, that he could not work because of his CTS, a condition that was not disabling at the time of his injury. Elder v. Rosboro Lumber Co., *supra*. I find that very persuasive evidence that claimant is not permanently and totally disabled as a result of his employment.

December 28, 1993

Cite as 45 Van Natta 2432 (1993)

In the Matter of the Compensation of
BILLIE L. THOMAS, Claimant
 WCB Case No. 92-07105
 ORDER ON REVIEW
 W. Daniel Bates, Jr., Claimant Attorney
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

Claimant requests review of Referee Livesley's order which upheld the insurer's denial of her occupational disease claim for a bilateral upper extremity condition. In her brief, claimant requests remand for cross-examination of Dr. Ronan, and for testimony of new witnesses to rebut "surprise" testimony by a defense witness. On review, the issues are remand and compensability.

We affirm and adopt the Referee's order with the following supplementation, but with exception of the Referee's discussion entitled "Credibility" beginning on page 3 of his order.

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).

Claimant argues that the case should be remanded for a deposition of Dr. Ronan concerning his opinion on the issue of medical causation. We disagree.

OAR 438-06-091 provides in part:

"The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. The referee may continue a hearing for further proceedings:

"(3) Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence * * *."

In an early examination of claimant, Dr. Ronan stated that claimant's condition was work related. Later, he stated that he had seen claimant only once and did not have enough information to give an opinion as to the major contributing cause. (Ex. 13). On September 21, 1992, Exhibit 13 was provided to claimant as discovery. The insurer sent the exhibit to the Referee for inclusion in the record on February 3, 1993. On February 10, 1993, claimant requested cross-examination of Dr. Ronan, and a deposition was scheduled for March 5, 1993.

The hearing was held on February 23, 1993. The Referee declined to hold the record open for Dr. Ronan's deposition. He concluded that claimant had not shown due diligence in obtaining Dr. Ronan's deposition because claimant had received Dr. Ronan's report five months before hearing. We agree with the Referee and conclude that he did not abuse his discretion in declining to hold the record open for Dr. Ronan's deposition.

Claimant further argues that remand is appropriate for taking rebuttal evidence because the insurer introduced a "surprise" lay witness. We disagree.

The Referee concluded that the medical evidence failed to show that claimant's work exposure was the major contributing cause of her upper extremity condition. Because we agree with the Referee's conclusion, it follows that claimant's motion for remand for the taking of lay witness testimony is moot.

ORDER

The Referee's order dated February 25, 1993 is affirmed.

December 29, 1993

Cite as 45 Van Natta 2433 (1993)

In the Matter of the Compensation of
SYLVIA ARANDA, Claimant
WCB Case Nos. 92-02441 & 91-14774
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Hall and Westerband.

Claimant requests review of those portions of Referee Podnar's order that: (1) found that claimant's headache, neck and upper extremity conditions were not work related; and (2) upheld denials of compensability and responsibility for those conditions by the SAIF Corporation and Liberty Northwest Insurance Corporation. On review, SAIF contends that, if claimant's condition is compensable, it is not the responsible insurer. Liberty Northwest contends that SAIF is the responsible insurer. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was employed as a cannery worker by the same employer from June 1986 to September 1989 and from June 24, 1991 to September 1991. The employer's insurance coverage shifted from Liberty Northwest to SAIF on July 1, 1991.

On September 24, 1989, claimant compensably injured her low back. After two weeks of physical therapy, she was released to work with restrictions. She was not accepted for employment with the restrictions. She returned to her previous level of employment.

She then sought chiropractic treatment for worsened right low back pain, right thorocolumbar pain and muscle spasm. On February 21, 1990, she sought treatment from Dr. Nash, neurosurgeon. Her chief complaints were low back pain, right gluteal pain, right leg pain and right foot numbness. She also complained of posterior cervical pain, intermittent right shoulder pain, interscapular pain, and cervico-occipital headaches. A CT scan and MRI revealed a disc bulge at L4-5. Dr. Nash treated her conservatively for her chief complaints only. (Exs. 6, 7 and 35).

By September 1990, claimant's complaints included headache, neckache, and muscle tension. (Ex. 12). She was not treated for these complaints.

Claimant was enrolled in a work hardening program. At the end of the program, she was evaluated as capable of performing light work, with limitations on walking, standing and lifting. (Ex. 13).

On May 6, 1991, Dr. Nash released claimant to a light-sedentary job, with standing limited to 30 minutes, alternating with sitting. He also limited her lifting to no more than 15 pounds, no lifting from floor level, and no repetitive climbing or crawling. (Ex. 17).

On June 11, 1991, claimant's low back injury claim was closed with awards of temporary and permanent partial disability. (Ex. 18).

On June 20, 1991, claimant returned to Dr. Nash, complaining of increased pain involving the right leg and low back, aggravated by walking. Dr. Nash referred claimant to Dr. Berkeley, neurosurgeon, for further evaluation. (Ex. 19).

On June 24, 1991, claimant returned to work four hours a day. She initially performed "manifest" duties, which consisted of constant walking while keeping a time tally of drums and pallets of berry product. No chair was provided. (Tr. 15, 16, 17 and 67). After three days, claimant was taken off work for a week. (Tr. 16). When she returned, she was assigned to work standing up at a conveyor belt, sorting berries. (Tr. 18, 61 and 93). She was permitted a ten-minute break each hour and was not provided with a means to sit. Other duties consisted of sweeping up outside, lining drums and washing plates. (Tr. 62 and 94).

Dr. Berkeley examined claimant on July 19, 1991. Claimant complained of low back, leg, neck, interscapular and right arm pain, which she attributed to the repetitive work on the production line and her other work activities which required bending and flexing of the trunk, arms and neck. (Exs. 21 and 22). Dr. Berkeley recommended that claimant avoid production line work and prescribed anti-inflammatory medications. (Ex. 21).

Dr. Nash examined claimant on August 27, 1991. He reported tenderness at C5-6, hypertonicity of the right trapezius muscle, and tenderness in the right supraclavicular region. He diagnosed claimant with cervical myofascial injury with signs and symptoms of a possible C6-7 nerve root involvement on the right. He recommended that claimant's work efforts should be limited to the light-work category for four hours a day, with lifting restrictions of no more than 12 pounds. (Exs. 13, 22 and 23). He also recommended that claimant should be enrolled in a Back-In-Action group to maximize her functional capacity at the cervical and lumbar level and he requested authorization for an MRI at the cervical level. (Exs. 22 and 25).

Claimant continued to work until September 1991, when she was laid off.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that SAIF's denial of claimant's claim for a neck, shoulder and upper extremity condition should be upheld. On review, claimant argues that this condition should be found compensable as an occupational disease. We agree.

ORS 656.802 provides:

"(1) 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 subjected or exposed other than during a period of regular actual employment therein, * * * including:

"(c) Any series of traumatic events or occurrences and which requires medical services or results in disability or death.

"(2) The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings."

The Referee concluded that claimant failed to establish that her work consisted of a series of traumatic events and that the medical evidence was not supported by objective findings. We disagree.

Dr. Nash, claimant's treating neurosurgeon, released claimant to a light-sedentary job, with standing limited to 30 minutes, alternating with sitting, lifting no more than 15 pounds, no lifting from floor level, and no repetitive climbing or crawling. When claimant returned to work on a four-hour-a-day schedule on June 24, 1991, she initially performed "manifest" duties, which required constant walking to tally drums and pallets of berry product. No chair was provided. After three days, claimant was taken off work for a week. When she returned, she was assigned to work standing up at a conveyor belt, sorting berries. She was permitted a ten-minute break each hour and was not provided with a means to sit. Other duties consisted of sweeping up outside, lining drums and washing plates.

When Dr. Berkeley, neurosurgeon, evaluated claimant on July 19, 1991, she complained of neck, interscapular and right arm pain, in addition to low back and leg pain, which she attributed to the repetitive work on the production line, and other work activities that required bending and flexing of her trunk, arms and neck. Dr. Berkeley found localized tenderness in the right trapezius but no neurological deficits in the arms. He recommended that claimant should avoid repetitive production line work if such work aggravated her symptoms. He also recommended anti-inflammatory medications.

When Dr. Nash examined claimant in August 1991, he reported that claimant had tenderness at C5-6, hypertonicity of the right trapezius muscle, and tenderness in the right supraclavicular region. He diagnosed a cervical myofascial injury with signs and symptoms of possible C6-7 nerve root involvement on the right. He limited claimant's work to the light-work job as delineated in the work hardening program report. That job consisted of manifesting, labeling and monitoring product production and limited lifting to 12 pounds. He also recommended that claimant be enrolled in a Back-In-Action group to maximize her functional capacity at the cervical and lumbar level. He also requested authorization for an MRI at the cervical level.

We conclude that claimant performed repetitive physical work that involved her shoulders, neck and arms. This physical overuse of her upper body qualifies as a "series of traumatic events" as used in ORS 656.802(1)(c). Ronald V. Dickson, 42 Van Natta 1102 (1990), aff'd Dickson v. Carolina Casualty, 108 Or App 499 (1991). In addition, the medical findings of muscular tenderness and hypertonicity in claimant's shoulders and arms is sufficient to establish existence of the disease. See ORS 656.005(19); Georgia Pacific v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

Claimant has established that her occupational disease should be analyzed under ORS 656.802(1)(c). Thus, she must prove that her employment conditions were the major contributing cause of the disease or its worsening. Id. The causation of a disease is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967). We generally give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to give greater weight to the opinion of Dr. Nash, who had been treating claimant both before and after she returned to work in June 1991. Furthermore, he had an accurate history of claimant's work activities during the period she returned to work.

Dr. Nash diagnosed claimant's condition as a cervical myofascial "injury," with possible C6-7 nerve root involvement on the right and opined that the major contributing cause of her condition was the work activities that she returned to in June 1991. Dr. Nash was aware of the work claimant performed and that it did not conform to the work to which she was released.

We are less persuaded by the opinion of Drs. Peterson, neurologist, and Fuller, orthopedic surgeon, who examined claimant on April 16, 1992, in that they did not have an accurate description of claimant's work activities after she returned to work in June 1991. They were not aware of the specific restrictions placed on claimant by Dr. Nash and erroneously relied on the work hardening summary as a description of the work that claimant actually performed.

We conclude that claimant has established that her work conditions were the major contributing cause of her myofascial pain condition in her neck, shoulders and arms. ORS 656.802.

Responsibility

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which has not been previously accepted. See Fred A. Nutter, 44 Van Natta 854 (1992). When, as here, a worker has not been disabled by an occupational disease, the triggering event for assigning responsibility is the time when the worker first seeks medical treatment for the condition. Progress Quarries v. Vandering, 80 Or App 160, 163 (1986). We treat Dr. Berkeley's examination on July 19, 1991 to evaluate claimant's neck, shoulders and arms condition as the triggering event for the onset of disability.

If a worker's disability results from exposure to potentially causal conditions and the onset of disability is during a later employment, the last injurious exposure rule assigns responsibility to the last employer whose work could have contributed to claimant's disability. Boise-Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984); Inkley v. Forest Fiber Products Company, 288 Or 337, 345 (1980). Nevertheless, any employer against whom a claim is made can avoid responsibility by presenting evidence to prove that the cause of the worker's disability is another employment, a cause unrelated to the employment, or that the disability is not related to a work exposure in its employment. Boise Cascade Corp. v. Starbuck, *supra*; Bracke v. Bazar, 293 Or 239 (1982); Castle & Cooke v. Alcantar, 112 Or App 392 (1992).

Here, SAIF contends that claimant first sought treatment for her cervical, right shoulder, scapular and headache pain in February 1990, when Liberty Northwest was on the risk. We disagree.

Although claimant mentioned pain in those locations for the first time in February 1990, Dr. Nash stated that those complaints were nominal in comparison to her chief complaints of low back, right gluteal and right leg pain. He made no specific examination of the cervical area and no treatment was directed at claimant's cervical, upper extremity and headache complaints. (Exs. 6, 8, 9, 10, and 35). On September 12, 1990, Dr. Berkeley also noted headache and neckache, but made no further comment regarding those complaints, instead focusing on claimant's low back and leg pain. (Ex. 12). Furthermore, even though claimant was taken off work three days after she returned to work on June 24, 1991, there is no medical evidence that she was treated at that time for her cervical, upper extremity and headache condition. We conclude that claimant first sought treatment for her cervical, right shoulder, scapular and headache condition on July 19, 1991, when SAIF was on the risk. Thus, initial responsibility is assigned to SAIF. Boise Cascade Corp. v. Starbuck, *supra*; Inkley v. Forest Fiber Products Company, *supra*.

SAIF contends that claimant's disability is unrelated to her employment. As noted in the previous section on compensability, we do not find the opinion by Drs. Peterson and Fuller persuasive. Accordingly, we conclude that responsibility for claimant's neck, shoulder, scapular and headache condition remains with SAIF. Boise Cascade Corp. v. Starbuck, *supra*; Bracke v. Bazar, *supra*; Castle & Cooke v. Alcantar, *supra*.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$3,500, 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 issue, and the value of the interest involved.

ORDER

The Referee's order dated March 5, 1993 is reversed in part and affirmed in part. The SAIF Corporation's denials are 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, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
TARI A. BRILL, Claimant
WCB Case No. 93-01060
ORDER ON REVIEW
Schneider, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Haynes and Westerband.

The insurer requests review of Referee Tenenbaum's order that awarded claimant 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (hand), whereas an Order on Reconsideration had awarded 5 percent (2.4 degrees) for the thumb and 24 percent (5.28 degrees) for the left middle finger. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSION OF LAW AND OPINION

Claimant injured parts of her left fingers when she caught them in a router at work. A July 30, 1992 Determination Order did not award any permanent disability. However, a January 6, 1993 Order on Reconsideration awarded 24 percent scheduled permanent disability for loss of use of the left middle finger. This award was based on decreased sensation and a partial tuft amputation of the finger. The order also awarded 5 percent left-thumb impairment for loss of opposition. See OAR 436-35-040 (1) and (3).

Citing OAR 436-35-070, the Referee converted the impairment values for claimant's left thumb and left middle finger to hand values and then added those two values for a hand loss of 6 percent. The Referee also granted claimant a 5 percent award for a chronic condition in her left hand under OAR 436-35-010(6). Combining the 6 percent and 5 percent figures, the Referee granted 11 percent scheduled permanent disability for loss of use or function of the left hand.

On review, the insurer contends that claimant is not entitled to a "chronic condition" award. Moreover, the insurer asserts that, since claimant's thumb award was granted for loss of opposition with the left middle finger, claimant was not entitled to convert her award to the hand. We agree.

Claimant only sustained impairment in the left middle finger according to the medical arbiter, Dr. Gritzka. Although the medical reports from claimant's treating physician (Dr. Gordon) suggest that claimant has no permanent impairment, we find Dr. Gritzka's thorough and well-reasoned arbiter's report to be more persuasive. See Noemith Giron, 45 Van Natta 93 (1993). Furthermore, the insurer does not contest the award of disability in the Order on Reconsideration for claimant's left middle finger.

According to the evaluator's worksheet for the Order on Reconsideration, claimant received a 5 percent award for loss of opposition in the left thumb because of the tuft amputation of the left middle finger. OAR 436-35-040(5) expressly provides that conversion to a hand value can occur only when more than one digit has impairment without considering opposition. Consequently, claimant is not entitled to have her finger and thumb impairments converted to a hand award. See John R Coyle, 45 Van Natta 325 (1993).

Finally, assuming arguendo that Dr. Gritzka's report supports a conclusion that claimant suffers from a "chronic condition," we conclude that claimant was not entitled to a "chronic condition" award for the left hand. As previously reasoned, the applicable standards (OAR 436-35-040(5)) do not provide for conversion of thumb/finger impairment values into a hand value. In the absence of hand impairment, claimant does not qualify for a "chronic-condition" award in the left hand. See James E. Smith, 44 Van Natta 2556 (1992), recon den 45 Van Natta 300 (1993) (The claimant was not entitled to a hand "chronic condition" award when finger impairment could not be converted to a hand value).

ORDER

The Referee's order dated May 4, 1993 is reversed. The Order on Reconsideration is reinstated and affirmed.

December 29, 1993

Cite as 45 Van Natta 2438 (1993)

In the Matter of the Compensation of

LOIS J. SCHOCH, Claimant

WCB Case No. 92-09982

ORDER OF ABATEMENT**Pozzi, et al., Claimant Attorneys****Lundeen, et al., Defense Attorneys**

On December 3, 1993, we issued an Order on Review vacating Referee Holtan's order that affirmed a Director's order under ORS 656.327(2) which held that a proposed surgery was inappropriate medical treatment. Relying on Jefferson v. Sam's Cafe, 123 Or App 464 (1993), we held that the Hearings Division retained original jurisdiction to consider the propriety of the proposed surgery. Finding that neither testimony was offered nor that additional "post-Director" evidence was allowed into the record, we further determined that the record was insufficiently developed and that there was a compelling reason to remand to the Referee for additional evidence.

Claimant has submitted a response to our order. Noting that additional testimonial and documentary evidence was presented (but subsequently excluded by the Referee), claimant asks that we correct this misstatement in our order.

Because the aforementioned excluded evidence is already present in the record and since such evidence may be reviewed by the Board, claimant's request raises a question as to whether remand is necessary. See Eugene H. Wilkinson, 42 Van Natta 2551 (1990); Herbert D. Rustrum, 37 Van Natta 1291 (1985).

Consequently, in order to further consider this matter, we withdraw our December 3, 1993 order. In addition, we grant the parties an opportunity to submit their respective positions concerning whether remand is warranted. To be considered, each parties' submission 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
JEANETTE E. BOLLINGBERG, Claimant
WCB Case No. 91-05451
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) dismissed her request for hearing to the extent it pertained to the self-insured employer's "de facto" denial of medical services; (2) upheld the self-insured employer's "de facto" denial of her aggravation claim for a bilateral arm condition; and (3) declined to assess a penalty-related attorney fee for the employer's allegedly unreasonable failure to process her claim for medical services. On review, the issues are jurisdiction, aggravation and attorney fees. We affirm in part and remand in part.

FINDINGS OF FACT

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

Claimant requested a hearing alleging that the employer had "de facto" denied the following claims: (1) physical therapy services; (2) mileage reimbursement stemming from the physical therapy; (3) proposed carpal tunnel surgery; and (4) aggravation. Although the employer did not issue a formal denial, its response to claimant's request for hearing indicated that it denied the proposed surgery on the basis that it was not compensably related to claimant's work activities and alleged that the proposed surgery and other medical services in question were palliative.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Based on our decision in Stanley Meyers, 43 Van Natta 2643 (1991), the Referee found that the Hearings Division did not have original jurisdiction over the issue of whether the proposed surgery, the physical therapy services and the related mileage reimbursement were reasonable, necessary, and curative for the treatment of claimant's compensable condition. Because the surgery is proposed and the physical therapy services and related mileage reimbursement have already been rendered, we discuss them separately.

Proposed Surgery

ORS 656.327(1) provides for review by the Director to determine if medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services[.]" Subsequent to the Referee's order, in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), the Court of Appeals considered the Director's jurisdiction to review proposed medical treatment under the statute. Reasoning that the statute expressly applied only to treatment that the claimant "is receiving" at the time Director review is requested, the court held that the process of review by the Director set forth in ORS 656.327(1) did not apply to requests for future medical treatment. Moreover, the court determined that the Hearings Division and Board had jurisdiction to resolve disputes concerning proposed medical treatment. Id. at 466-67.

Here, the dispute pertains to the propriety of a proposed surgery. Based on Jefferson v. Sam's Cafe, supra, the Hearings Division has jurisdiction to resolve the dispute concerning the proposed surgery.

Physical Therapy/Mileage Reimbursement

While the Hearings Division and the Board have sole jurisdiction with regard to review of proposed medical treatment, medical treatment that a claimant "is receiving" falls under ORS 656.327(1). Since the disputed physical therapy services and related mileage reimbursement concern medical services that have already been performed, this dispute falls under ORS 656.327(1). Theodore v. Safeway Stores, Inc., 125 Or App 172 (1993) (where a claimant had already received the disputed medical treatment at the time the carrier asserted the treatment was palliative, the Director has jurisdiction only if a party wishes to have the matter reviewed by the Director).

As noted above, the Referee relied on our decision in Stanley Meyers, supra in finding that the Hearings Division lacked original jurisdiction to decide this dispute. Subsequent to the Referee's order, the court reversed our decision in Meyers. See Meyers v. Darigold, Inc., 123 Or App 217 (1993).

In Meyers, the court held that the 1990 amendments to ORS 656.327(1) do not require the parties or the Director to invoke the Director review process. Rather, the court determined that if a party or the Director "wishes review of the treatment by the director," and gives notice, the statute provides the procedure for a proceeding, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. Without a "wish" for Director review and a notice filed with the Director, the court further concluded that there is no "proceeding" before the Director. Reasoning that the Director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create the jurisdiction occur, the court held that those conditions did not occur in Stanley Meyers. Accordingly, the court found that the medical treatment dispute remained within the Board's jurisdiction.

Here, there is no evidence that either the parties or the Director "wished" for Director review or filed notice with the Director for such a review. Instead, claimant filed a request for hearing from SAIF's "de facto" denial of his physical therapy and related mileage reimbursement. Under such circumstances, we conclude that the Director did not have exclusive jurisdiction over this matter and that the Referee was authorized to consider the dispute. See Meyers v. Darigold, Inc., supra.

Finally, the employer's response to claimant's hearing request indicated that the employer was contending that all the disputed medical services were palliative. In Theodore v. Safeway Stores, Inc., supra, the court held that disputes concerning whether disputed medical treatment is palliative or curative is treated the same as other medical services disputes for jurisdictional purposes. That is, if the dispute involves proposed treatment, it is within the jurisdiction of the Hearings Division and the Board under ORS 656.283. Jefferson, supra. However, if the dispute involves treatment that a worker "is receiving", jurisdiction is dependent on whether a party "wished" for Director's review under ORS 656.327(1). Meyers, supra.

Insofar as the employer is denying claimant's proposed surgery on the basis that it is palliative, that dispute is within the jurisdiction of the Hearings Division and the Board. Similarly, since there is no evidence that either the parties or the Director "wished" for Director review or filed notice with the Director for such a review concerning the performed physical therapy services and incurred mileage expenses, the Referee is authorized to consider that dispute.

Although testimonial and documentary evidence was presented, such evidence was almost entirely directed to the aggravation issue. Such submissions were likely limited due to the Referee's statements at the hearing that the Hearings Division probably did not have jurisdiction over any of the medical services issues. In any event, the record concerning these medical services issues is essentially nonexistent.

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). While a mere change in the law does not automatically merit remand, given the posture of this case and the court's recent holdings, we find a compelling reason to remand in this instance. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Consequently, we conclude that the record is incompletely and insufficiently developed. See ORS 656.295(5). Therefore, we remand this case to the Hearings Division for further proceedings.

Aggravation

We adopt the Referee's conclusions and reasoning concerning the aggravation issue with the following supplementation.

While we agree with the Referee that, on this record, claimant has not established a compensable aggravation of her bilateral carpal tunnel syndrome condition, we note that claimant has advanced her aggravation claim irrespective of the disputed proposed carpal tunnel surgery. In this regard, our agreement with the Referee's 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. See Deborah G. Portenier, 45 Van Natta 1593 (1993). Accordingly, we affirm that portion of the Referee's order.

Attorney Fees

Claimant contends that he is entitled to an assessed attorney fee pursuant to ORS 656.382(1) for the employer's allegedly unreasonable failure to pay her medical services bills or seek Director's review of the disputed medical services bills.

Inasmuch as it has not yet been decided whether the employer is liable for the disputed billings, we have no basis to decide whether the employer has unreasonably resisted compensation, in this case the disputed medical billings. Since we are remanding this matter to the Referee for a resolution of the disputed medical billings, we find it appropriate to remand this matter as well.

Accordingly, the Referee's order dated May 29, 1992 is vacated in part and affirmed in part. We remand to Referee Michael Johnson to conduct further proceedings in any manner which, in the Referee's discretion, achieves substantial justice in that each party is permitted to present evidence concerning their respective position regarding the medical services, travel expense, and penalty-related attorney fee disputes. Thereafter, the Referee shall issue a final, appealable order on those issues. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

December 30, 1993

Cite as 45 Van Natta 2441 (1993)

In the Matter of the Compensation of
MERRY E. FRANKLIN, Claimant
WCB Case No. 92-14761
ORDER ON REVIEW (REMANDING TO DIRECTOR)
Willner & Heiling, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Referee Galton's order that affirmed a Director's order which found that claimant was not entitled to vocational assistance. On review, the issue is whether the Director's order should be affirmed. We remand to the Director.

FINDINGS OF FACT

Claimant worked as an intern juvenile officer from 1986 through 1988. She worked as a Greyhound bus driver from 1988 until March 1990, when she was locked out of her employment during a strike. Claimant earned an average of \$630 per week while working as a bus driver for Greyhound.

From April 1990 through November 1990, claimant received \$1700 in union strike benefits.

In December 1990, claimant went to work for OHSU as a temporary shuttle bus driver. She was injured during work on December 28, 1990.

The SAIF Corporation, as insurer for OHSU, sent claimant a Notice of Ineligibility, which claimant appealed to the Director. The Director found that, because claimant had been locked out of her employment, her past 52 weeks of wages had to be calculated using her strike benefits, rather than the wage of \$630 per week that she had been previously receiving prior to the lockout. The Director's order found that a "suitable wage for claimant is \$4.75" per hour. The Director's order further found that, although claimant's injury would prevent her from returning to her prior job at Greyhound, claimant had not established a "substantial handicap to employment," sufficient to receive vocational assistance.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to establish a basis for modification of the Director's order pursuant to ORS 656.283(2). The Referee, therefore, affirmed the Director's order.

Subsequent to the Referee's order, the Supreme Court reversed the Court of Appeals' holding in Colclasure v. Washington County School Dist. No. 48-J, 117 Or App 128 (1992). Colclasure v. Washington County School Dist. No. 48-J, 317 Or 526 (1993). The Court of Appeals had affirmed our order on review which found that, when determining whether a Director's order regarding vocational assistance should be modified, the referee was not permitted to make his own record or findings of fact. Richard A. Colclasure, 42 Van Natta 2454 (1990). In reversing the Court of Appeals and the Board's decisions, the Supreme Court held that, in a case involving vocational assistance where the Director informally investigates and issues an order, the referee's role is to conduct a hearing at which the parties develop a record. The Court also held that, on the basis of the record developed at hearing, the referee finds the facts from which to conclude whether the director's decision survives review. Finally, the Court concluded that the Board reviews under ORS 656.283(2) upon the record developed before the referee. Colclasure, supra.

In the present case, the parties agreed that the case should be decided on the record, without a hearing. Additionally, the dispute pertains solely to the legal application of the administrative rules, rather than to the factual findings made by the Director or the Referee. Accordingly, we find no compelling reason to remand this case to the Referee in light of Colclasure, supra. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Moreover, in light of the parties' prior stipulation and their respective positions, we consider the record sufficiently developed to conduct our review. ORS 656.295(5).

At hearing and on review, claimant objects to the Director's conclusion that she is not entitled to vocational assistance because she has not established a substantial handicap to employment.¹ ORS 656.340 provides that a worker has a substantial handicap to employment when she lacks the necessary skills and knowledge to be employed in suitable employment. Among other things, in order for employment to be suitable, it must produce a wage within 20 percent of the wage currently being paid for employment which is the regular employment for the worker. ORS 656.340(6)(b)(B)(iii).

The Director's rules provide a method for calculation of a base wage, in order to determine a suitable wage for purposes of the statute. OAR 436-120-025 provides that:

"(1) For the purpose of establishing a base wage from which to calculate a suitable wage when the worker's job at the time of injury is other than a full-time permanent job, the following standards apply:

(a) Volunteer employment. A volunteer's wage is the computed wage established to calculate temporary total disability payments and the employer's workers' compensation premium under OAR 436-60. When the worker's customary employment is other than the volunteer job, and the worker cannot return to that customary employment, the base wage is the computed wage calculated at a rate based on the time worked in the worker's customary employment.

(b) Seasonal and temporary employment. When the worker's customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected, the wage is established by including earned wages and unemployment insurance benefits for the 52 weeks preceding the injury. The combined income for the preceding 52 weeks is calculated at a full-time rate to establish the base wage.

(c) Part-time employment, two jobs. When the worker is employed in two part-time jobs and the worker is unable to return to either job, the base wage is the wage rate with the employer at the time of injury, calculated at a rate based on the combined amount of time worked in both jobs.

¹ Although it is not dispositive in this case due to our finding that the administrative rules were incorrectly applied, we note our disagreement with that portion of the Director's order which found that there is no provision "either in the vocational rules or in related case law" to presume continuous earning during a lockout. The court has affirmed the Board's order holding that, so long as a claimant is unable to perform her regular work, and her modified job remains unavailable as a result of the conduct of the employer (i.e., a lockout), the claimant is entitled to temporary disability benefits. Kati A. Hanks, 44 Van Natta 881 (1992), aff'd Safeway Stores Inc. v. Hanks, 122 Or App 582 (1993).

"(2) The Director may prescribe additional standards for establishing a base wage from which the wage described in OAR 436-120-005(6)(a) can be determined."

Here, the Director concluded that the appropriate rule for purposes of calculating claimant's base wage was OAR 436-120-025(1)(b). For the following reasons, we conclude that the Director's decision violates the provisions of OAR 436-120-025 and ORS 656.340. See ORS 656.283(2)(a).

OAR 436-120-025(1)(b) specifically applies to workers whose customary employment pattern is periods of seasonal or temporary employment followed by periods in which unemployment insurance benefits are collected. Although "customary" is not defined in the statute or rules, the dictionary defines "customary" as "usual," or "according to custom." Webster's Dictionary (1989 Edition).

Yet, the record does not establish that claimant's usual or "customary" employment "pattern" is seasonal or temporary. Rather, the record shows that claimant worked as an intern juvenile officer from 1986 through 1988. She worked as a full time Greyhound bus driver from June 1988 until the lockout in March 1990. Accordingly, the only evidence in the record of temporary work is the job at injury which was taken by claimant when she was locked out of her work as a Greyhound bus driver. Considering that claimant was performing her temporary duties during the lockout from her regular Greyhound job, the record does not establish that claimant's "customary" employment "pattern" is seasonal or temporary employment followed by periods of unemployment benefits.

Under the circumstances, we find that the Director's application of OAR 436-120-025(1)(b) is a violation of that rule in that the rule does not apply to claimant's situation. Accordingly, our next inquiry is whether or not an applicable rule exists which can be applied to the facts of this case.

After reviewing the record, we find that neither OAR 436-120-025(1)(a), which pertains to volunteer employment, nor OAR 436-120-025(1)(c), which pertains to part-time employment involving two jobs, applies to claimant's case. Moreover, we have above determined that OAR 436-120-025(1)(b), which applies when the worker's customary employment is temporary or seasonal, does not apply to the facts of this case. Therefore, because none of the subsections provided under OAR 436-120-025(1) apply to claimant's case, the calculation of claimant's base wage can only fall within section 2 of the rule. That section provides that the Director may prescribe additional standards for establishing a base wage from which the wage described in OAR 436-120-005(6)(a) can be determined. OAR 436-120-025(2).

We are without authority to prescribe such a standard or to promulgate a rule pertaining to claimant's case. However, the court has recently held that in cases in which only the Director can grant the relief requested, by necessary implication, the Board has the power to remand the case to the Director. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993) (Where the Director has not promulgated a temporary rule or made findings that existing "standards" adequately address claimant's disability, the Board has the power to remand the matter to the Director).²

Consequently, because only the Director may promulgate a rule or an additional standard for establishing a base wage in claimant's case, we remand this matter to the Director to prescribe such a standard. Following promulgation of such a rule, the Director shall issue an order pursuant to ORS 656.283(2) addressing claimant's request for vocational assistance.

ORDER

The Referee's order dated February 5, 1993 is vacated. The Director's Review and Order dated November 13, 1992 is also vacated. This matter is remanded to the Director for further action and proceedings consistent with this order.

² We acknowledge that Gallino, supra, involved a case under the "standards," and ORS 656.726(3)(f)(C). However, the court in Gallino also stated that, because "only the director" could grant the relief requested, the Board, by necessary implication, had the power to remand the case to the Director. Gallino, 124 Or App 538, 542. Similarly, in the present case, promulgation of an administrative rule pertaining to vocational assistance is a matter within the Director's authority. Moreover, we conclude that, even if Gallino is not applicable in this vocational case, we would nevertheless instruct the parties to seek promulgation of such a rule. Therefore, we find that regardless of the method of disposition of this case, the issue would first be brought before the Director.

In the Matter of the Compensation of
WILLIAM E. HOLLIDAY, Claimant
WCB Case Nos. 92-08737 & 92-03430
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Westerland and Haynes.

The SAIF Corporation requests review of those portions of Referee McCullough's order which: (1) set aside its denial of claimant's current low back condition claim as related to claimant's 1991 low back strain injury claim; (2) set aside its denial of claimant's occupational disease claim for his low back degenerative condition; and (3) upheld its denial of claimant's current low back condition as related to claimant's 1982 claim. On review, the issues are compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the same employer since 1976. He has an accepted July 27, 1982 lumbosacral strain injury claim and an accepted December 31, 1991 lumbar strain injury claim, both with SAIF. SAIF conceded at hearing that the 1982 injury had worsened claimant's degenerative disc disease.

On February 11, 1992, SAIF (for the 1991 claim) disclaimed responsibility for claimant's current low back condition on the ground that the 1982 injury claim was responsible for claimant's continuing need for treatment and disability. Subsequently, SAIF also denied the compensability of claimant's occupational disease claim for degenerative disease of the low back.

The Referee found that the December 31, 1991 lumbar strain injury continued to be a material contributing cause of claimant's low back condition. Relying on our decision in John L. Law, 44 Van Natta 1091 (1992), the Referee concluded that even if claimant's 1982 injury claim was the major contributing cause of his current condition, that under ORS 656.308, responsibility remained with the 1991 injury claim.

In Peggy Holmes, 45 Van Natta 278 (1993), we concluded that, in cases involving the same employer/insurer, we would continue to conform the test for distinguishing new injuries from aggravations with current responsibility law. The Holmes holding has also been applied in single employer/insurer cases where neither compensability nor responsibility is at issue. See Luella M. Best, 45 Van Natta 1638 (1993).

Here, although the same employer/insurer is involved, the issue is which of claimant's two compensable claims is responsible for claimant's current condition under ORS 656.005(7)(a)(B). Accordingly, in accordance with Holmes, we apply the following reasoning.

Subsequent to the Referee's order, the Supreme Court held, in SAIF v. Drews, 318 Or 1 (1993), that ORS 656.005(7)(a)(B) did apply in the responsibility context to determine whether or not a worker sustained a "new compensable injury" under ORS 656.308. The Court reasoned that such a determination is made regardless of whether the preexisting condition was compensable.

SAIF conceded at hearing that the 1982 injury worsened claimant's degenerative disc disease. We interpret SAIF's concession as accepting the degenerative disc disease as a compensable component of the 1982 injury claim, so that the "resultant condition" is a lumbosacral strain combined with the degenerative disc disease. As such, SAIF argues that, under ORS 656.005(7)(a)(B), the condition resulting from the 1982 injury remains the major contributing cause of claimant's current low back condition.

Claimant does not dispute that the 1991 injury claim is not the major contributing cause of claimant's resultant/current low back condition. Rather, he contends that his work activities after the 1982 injury are the major contributing cause of his current low back condition, including his degenerative disc disease; and, therefore, his condition is compensable as a new occupational disease claim.

The Referee found that claimant's current low back condition, including the degenerative disc disease, was compensable as a new occupational disease claim. See ORS 656.802(1). The Referee determined that claimant's work activities subsequent to the 1982 injury caused a further worsening of the degenerative disc disease than that caused or worsened by the 1982 injury. We disagree.

The preponderance of the medical evidence fails to establish that the underlying degenerative disc disease has worsened as a result of claimant's subsequent work activities. Dr. Brown, who performed the 1992 MRI, reported that claimant's lumbar degenerative disc disease had not significantly changed from the 1986 CT scan. Based on this report, the doctors for Medical Consultants Northwest reported that there had been a symptomatic worsening, but no objective evidence of a worsening of claimant's degenerative disc disease. They opined that claimant's 1982 injury and his work activities were the major contributing cause of his current condition. Dr. Rosenbaum, who examined the actual 1986 CT scan and 1992 MRI, opined that the degenerative disc disease had not pathologically worsened. Claimant's treating physician, Dr. Belza, reported that comparing the 1986 CT scan with the 1992 MRI would be meaningless because of technological changes. Dr. Belza, however, believed that claimant's degenerative back condition had changed since 1986 (CT scan).

Dr. Belza has rendered various opinions regarding claimant's degenerative condition. Dr. Belza initially opined that claimant's work activities were the major contributing cause of claimant's degenerative disc disease and that the degenerative disease was the cause of his current symptoms. Dr. Belza subsequently opined that the December 1991 injury exacerbated claimant's preexisting condition resulting in a worsening of symptoms. He has also opined that the December 1991 injury was both a material and a major contributing cause of claimant's current condition and ongoing symptoms. Moreover, other than merely disagreeing with Dr. Rosenbaum that there has been no change in claimant's degenerative disc disease, Dr. Belza did not address whether or not claimant's degenerative disc disease had pathologically worsened. A symptomatic worsening is insufficient. Given Dr. Belza's inconsistent opinions and failure to address the relevant issue, we find his opinion unpersuasive.

Consequently, because there has been no pathological worsening of the underlying degenerative disc disease as a result of claimant's "post-1982" work activities, claimant has failed to establish a compensable occupational disease. ORS 656.802(1); Weller v. Union Carbide, 288 Or 27 (1979). Therefore, responsibility for his current low back condition, including the degenerative disc disease, remains with the 1982 injury claim (D590930).

ORDER

The Referee's order dated January 19, 1993 is reversed in part and affirmed in part. The SAIF Corporation's October 6, 1992 denial, in connection with claimant's December 31, 1991 claim (Claim No. 7129010), is reinstated and upheld. SAIF's "de facto" denial of claimant's occupational disease claim is reinstated and upheld. SAIF's denials in connection with claimant's 1982 injury claim are set aside and the claim is remanded to SAIF for processing in accordance with law. SAIF is responsible for the Referee's \$2,500 assessed attorney fee under the 1982 claim. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of

GENE G. MARTIN, Claimant

WCB Case Nos. 92-06438 & 92-05056

ORDER ON RECONSIDERATION

Karen M. Werner, Claimant Attorney

Employers Defense Counsel, Defense Attorneys

The insurer requests reconsideration of that portion of our October 28, 1993 Order on Review which assessed a penalty based on the full amount of permanent disability benefits awarded by the Order on Reconsideration. In our order, we assessed a penalty and related attorney fee for the insurer's unreasonable refusal to pay those benefits.

The insurer seeks reconsideration of our determination of the amounts "then due" upon which to assess a penalty. It contends that it is entitled to offset overpaid temporary disability benefits against the permanent disability awarded by the Order on Reconsideration before calculation of the assessed penalty. We agree.

Claimant's claim was initially closed by a December 24, 1991 Determination Order, which awarded temporary disability but no permanent disability. By letter dated January 17, 1992, the insurer informed claimant that temporary disability benefits had been overpaid in the amount of \$2,219.37 and that it would recover the overpayment from future permanent disability awards. The March 6, 1992 Order on Reconsideration awarded 5 percent scheduled permanent disability (\$4,575) and authorized an offset of overpaid temporary disability benefits from unpaid permanent disability benefits. On April 9, 1992 (more than 30 days later), the insurer filed a request for hearing challenging the Order on Reconsideration. Prior to the filing of its hearing request, the insurer paid no portion of the permanent disability award.

In our October 1993 order, we held that during the delay period, between the date the permanent disability payment became untimely (April 5, 1992) and the filing of the request for hearing (April 9, 1992), the permanent disability benefits were "then due." See also George Violet, 42 Van Natta 2647 (1990) (the entire amount of permanent disability award came due on date of issuance of the determination order, regardless of its method of payment). However, the question remains what amount of compensation was due and owing at the time of the insurer's delay.

The insurer's late request for hearing is akin to a failure to timely pay permanent disability compensation due under an Order on Reconsideration. The "amounts then due" upon which to assess a penalty would be unpaid permanent disability compensation, which had been reduced by any authorized offset. See Roy W. Smee, 40 Van Natta 1254, 1258 (1988).

Here, the Order on Reconsideration had authorized an offset of overpaid temporary disability benefits against unpaid permanent disability benefits. Thus, the amount of unpaid compensation due and owing under the Order on Reconsideration equals \$2,355.13 (\$4,575 scheduled permanent disability - \$2,219.87 overpayment). Therefore, the "amounts then due" upon which to assess a penalty for the insurer's untimely request for hearing was \$2,355.13 rather than the amount of the permanent disability award before the offset. Our October 28, 1993 order is modified accordingly.

On reconsideration, as supplemented and modified herein, we adhere to and republish our October 28, 1993 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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Cite as 318 Or 1 (1993)

October 28, 1993

IN THE SUPREME COURT OF THE STATE OF OREGON
 In the Matter of the Compensation of Rosalie S. Drews, Claimant.

SAIF CORPORATION and MARQUIS HOMES, INC., Petitioners on Review,
 v.
 ROSALIE S. DREWS and WAUSAU INSURANCE COMPANIES, Respondents on Review.
 (WCB 90-05597, 90-15186; CA A73419; SC S40093)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 2, 1993.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for petitioners on review. With him on the petition were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Karsten H. Rasmussen, of Rasmussen & Henry, Eugene; and David O. Horne, Beaverton, argued the cause for respondents on review. Karen M. Werner, Cheshire, and Eveleen Henry, of Rasmussen & Henry, Eugene, filed the response.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

*Judicial review from the Workers' Compensation Board. 117 Or App 596, 845 P2d 217 (1993).

318 Or 3> In this workers' compensation case, SAIF Corporation (SAIF) petitions for review of a Court of Appeals' decision affirming an order of the Workers' Compensation Board (Board) that held SAIF responsible for workers' compensation benefit payments for claimant's 1989 injury. *SAIF v. Drews*, 117 Or App 596, 845 P2d 217 (1993). The case involves two successive compensable injuries to the same part of claimant's body. Claimant was employed by a different employer at the time of each injury. The case turns on the interpretation of ORS 656.308(1), in the context of assigning responsibility among successive employers for multiple compensable injuries.

The issues are: Which employer is responsible for the second injury? Does a second injury in a case such as this fall within the revised successive responsibility statutes enacted by the legislature in 1990? We answer the second question in the affirmative, which means that the answer to the first question is that, in this case, the insurance carrier for the first employer remains responsible. For the reasons explained below, we reverse the Court of Appeals' decision and the Board's order -- both of which assigned responsibility to SAIF, the last carrier on the risk -- and remand the case to the Board for further proceedings.

In 1986, while employed by Wausau Insurance Companies' insured, claimant injured her low back and left leg. Wausau accepted the claim and paid benefits to claimant. In 1989, while employed by SAIF's insured, claimant again injured her low back and left leg. Wausau denied the claim on the ground that, although claimant's low-back condition had worsened, she had suffered a new injury and, therefore, SAIF was responsible. SAIF also denied the claim, asserting that Wausau remained responsible. Claimant appealed both denials.

ORS 656.308(1), enacted in 1990,¹ makes the following provisions for determination of responsibility among successive employers:

¹ On May 7, 1990, the Oregon legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law, ORS ch 656. The present wording of ORS 656.308(1) was enacted as part of that revision. Or Laws 1990 (Special Session), ch 2, 49.

318 Or 4 > "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."

ORS 656.003 provides: "Except where the context otherwise requires, the definitions given in this chapter govern its construction." ORS 656.005(7)(a) provides the following definition:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(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." (Emphasis added.)

The limitations set forth in subparagraphs (A) and (B) were added by the 1990 amendments to the definition of "compensable injury" in ORS 656.005. Or Laws 1990 (Special Session), ch 2, 3.

In November 1990, a referee determined that the 1990 amendments to the Workers' Compensation Law applied to the issue of which of claimant's employers were responsible for the costs of her 1989 injury. After reviewing ORS 656.308(1) and 656.005(7)(a)(B), the referee concluded that claimant's <318 Or 4/5> 1989 injury was not "the major contributing cause" of claimant's disability or need for treatment and, therefore, that the responsibility for compensation for the 1989 injury did not shift to her subsequent employer under ORS 656.308(1). Accordingly, the referee affirmed SAIF's denial, set aside Wausau's denial, and ordered Wausau to process the claim. Wausau sought Board review.

The Board agreed with the referee that the 1990 amendments applied to the claim. The Board concluded, however, that claimant's 1989 injury was "a material contributing cause" of her disability or need for treatment and that "the major contributing cause" limitation contained in ORS 656.005(7)(a)(B) does not apply, because it should be applied only after an initial determination has been made that the injury is compensable. Instead, the Board looked to the provisions of ORS 656.308(1) and the Board's previous interpretations of that statute. The Board held that Wausau, as the last carrier against whom claimant had an accepted low-back injury claim, must demonstrate that there has been a "new compensable injury involving the same condition" under ORS 656.308(1) and that it need only show that the 1989 injury was "a material contributing cause" of disability or need for treatment. The Board concluded that, in the present case, Wausau had sustained its burden and, thus, the responsibility for claimant's condition shifted to the subsequent employer and to SAIF, because claimant's 1989 injury was "a material contributing cause" of her disability or need for treatment. The Board's analysis did not address the policy considerations underlying the legislature's 1990 amendments and did not discuss any legislative history. SAIF petitioned for judicial review.

In the Court of Appeals, SAIF contended that the Board erred in finding SAIF responsible for claimant's 1989 injury, because the 1989 injury was not the major contributing cause of her disability or need for treatment. SAIF argued that the Board misinterpreted the 1990 amendments. The Court of Appeals agreed with the Board's analysis and affirmed its order. *SAIF v. Drews, supra*. The Court of Appeals' opinion did not address the legislature's intent in amending the statutes in 1990. We allowed SAIF's petition for review to consider the interrelationship of ORS 656.308(1) and ORS 656.005(7)(a)(B), an issue not addressed previously by this court.

318 Or 6> On review, SAIF contends that the Court of Appeals wrongly ignored the 1990 statutory changes and the policy choices that those changes represented. Specifically, SAIF argues that the Court of Appeals impermissibly inserted a word in ORS 656.005(7)(a)(B) by adding a requirement in that statute that the "preexisting disease or condition" to which the statute refers be *noncompensable*. The effect of that judicial insertion was to make ORS 656.005(7)(a)(B) inapplicable to this case, because the earlier injury in this case was *compensable*. SAIF asserts that the Court of Appeals' insertion of the word "noncompensable" violated ORS 174.010.²

In interpreting a statute, this court's task is to discern the intent of the legislature. ORS 174.020. To determine legislative intent, the court first examines the text and context of the statute. See *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, ___ P2d ___ (1993) (explaining methodology). If, after doing so, using aids to statutory construction that bear directly on the interpretation of the text of the statute within its context, the legislative intent is unclear, the court considers legislative history. *Id.* at 611-12. If, after consideration of text, context, and legislative history, the intent of the legislature remains unclear, the court may then resort to general maxims of statutory construction to aid in resolving the remaining uncertainty. *Id.* at 612.

It is not clear from the text or context of the 1990 amendments whether the legislature intended the "major contributing cause" limitation on the definition of "compensable injury" found in ORS 656.005(7)(a)(B) to apply to employer responsibility determinations under ORS 656.308(1). Accordingly, we turn to the legislative history of the 1990 amendments in an attempt to discern the legislative intent.

In 1990, a special session of the legislature was held, primarily to amend Oregon's workers' compensation laws. <318 Or 6/7> During that session, ORS 656.005(7)(a) was amended to add the limitations on the definition of "compensable injury" now found in subparagraphs (A) and (B), and a new provision was enacted, ORS 656.308(1), to govern the shifting of responsibility among employers. Or Laws 1990 (Special Session), ch 2, 3, 49.

On the House floor, Representative Mannix explained the operation of the provision for shifting of responsibility among employers in this way:

"We've had a problem with Oregon in regard to responsibility for claims. The shifting of responsibility from one employer or insurer to another. This bill * * * addresses responsibility as to industrial injuries and provides the worker and employer some assurance that when a worker has an industrial injury the responsibility for that injury remains with the first employer and another employer can take on that worker without worrying about having bought, in effect, some baggage of a previous injury unless the worker has an actual new compensable injury with a new employer. Then there will be a new claim. We toughened up on the standards there in terms of shifting responsibility." House Special Session, May 7, 1990, Tape 2, Side A.

Representative Mannix's statements indicate that the 1990 amendments were intended to make it more difficult to shift responsibility to a subsequent employer.³ Those statements support SAIF's contention that "the major contributing cause" limitation found in ORS 656.005(7)(a)(B) was meant to apply to employer-responsibility determinations.

² ORS 174.010 provides:

"In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all."

³ Under this court's pre-1990 decisions discussing shifting responsibility among employers, the judicially adopted doctrine of "last injurious exposure" indicated that "the last employer who materially contributes to a worker's disabling condition is liable for compensation for the entire cumulative disability." *Bracke v. Bazar*, 293 Or 239, 244, 646 P2d 1330 (1982). See *Rimft v. SAIF*, 303 Or 493, 499-500, 739 P2d 12 (1987) (recognizing that "last injurious exposure" rule may produce arbitrary results); *Boise Cascade Corp. v. Starbuck*, 296 Or 238; 242, 675 P2d 1044 (1984) ("last injurious exposure" rule may apply in injury cases as well as occupational disease cases). One of the purposes of the 1990 amendments was to overturn this line of cases and make it more difficult to transfer responsibility for a condition or disability to a subsequent employer.

In response to an employer's concerns about hiring a worker who had experienced a compensable injury while working for an earlier employer, Representative Mannix <318 Or 7/8> made the following statements during a public hearing of the Joint Interim Special Committee on Workers' Compensation:

"I think it's important as a matter of this record to say that actually there's more to this than meets the eye, and it's good to have it on the record. Although I don't think [section] 49 goes far enough, let's state for the record that it says here, first of all, *this will do away with the current court interpretations of what is a new injury for responsibility purposes*. Do you hear that, judges on the Court of Appeals, members of the Board, when you read the transcript of this hearing? This does away with what they've been saying, which is if the subsequent employment contributed however slightly to the causation of the disabling condition, then all of that -- I won't even go into all the standards that are there and you know that they are there. This says that there's going to have to be a new compensable injury and *this bill defines compensable injury and so if there isn't a new compensable injury under the definition of the law, then responsibility remains with the first employer*." Joint Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 18, Side A (emphasis added).

Those statements also support the conclusion that the definition of compensable injury as limited by ORS 656.005(7)(a)(B) was meant to apply in the context of shifting responsibility to a subsequent employer.⁴ Our review of the relevant legislative history persuades us that the Board's and the Court of Appeals' implicit holding that ORS 656.005(7)(a)(B) is not applicable in this context is erroneous.

As we interpret ORS 656.308(1) and 656.005(7)(a) together, they work in this case as follows: "Compensable injury" encompasses an application of the criteria found in ORS 656.005(7)(a), including the limitations found in subparagraphs (A) and (B) of that statute, in making an initial determination of compensability. If the accidental injury <318 Or 8/9> described in paragraph (a) combines with a preexisting condition, a determination is made under subparagraph (B) whether the accidental injury described in paragraph (a) is "the major contributing cause of the disability or need for treatment." That determination is made under subparagraph (B) whether or not the preexisting condition was compensable.

If the preexisting condition was compensable, then the provisions of ORS 656.308(1) apply to determine whether responsibility shifts to the subsequent employer. If the accidental injury described in ORS 656.006(7)(a) was found not to be "the major contributing cause" under subparagraph (B); then the first sentence of ORS 656.308(1) applies, because the claimant has not sustained a "new compensable injury involving the same condition" and, thus, the first employer remains responsible. If the accidental injury described in paragraph (a) of ORS 656.005(7) was found to be "the major contributing cause" under subparagraph (B), then the second sentence of ORS 656.308(1) applies, because a new compensable injury has occurred, and responsibility shifts to the subsequent employer. Thus, the provisions of both ORS 656.005(7)(a)(B) and 656.308(1) can be applied, giving effect to both provisions, while carrying out the intent of the legislature to shift the burden to a subsequent employer only if a new injury is "the major contributing cause" of the need for treatment.

We conclude that the legislature intended the "major contributing cause" requirement of ORS 656.005(7)(a)(B) to apply to the shifting of responsibility among employers under ORS 656.308(1), whether or not the earlier condition to which subparagraph (B) refers was compensable. Accordingly, we reverse the contrary decisions of the Court of Appeals and the Board.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

⁴ See also Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 4, Side A (Ross Dwinnel, co-chair of committee that drafted 1990 amendments, agreed with Representative Mannix that the new provisions on shifting of employer responsibility eliminated prior judicial standards for responsibility shifts); Joint Interim Special Committee on Workers' Compensation, May 4, Tape 18, Side A (Representative Edmundson understood new provisions to require that the initial employer remains responsible unless a new injury qualifies as compensable under definition of compensable injury).

Cite as 318 Or 33 (1993)

November 18, 1993

IN THE SUPREME COURT OF THE STATE OF OREGON

ALSEA VENEER, INC., an Oregon corporation; MO'S ENTERPRISES, INC., an Oregon corporation; THOMPSON'S SANITARY SERVICE, INC., an Oregon corporation; WILLAMETTE VALLEY SHADE, INC., an Oregon corporation; PRODUCTION PARTS, INC., an Oregon corporation; NOBEL & BITTNER PLUG COMPANY, INC., an Oregon corporation; GREEN TRANSFER & STORAGE COMPANY, an Oregon corporation, on their own behalf and on behalf of those similarly situated; DONALD M. DRAKE CO., an Oregon corporation; KAUFMAN CRUSHING, INC., an Oregon corporation; MT. HOOD MEADOWS, OREG., LTD., an Oregon corporation; ROAD & DRIVEWAY PAVING, an Oregon corporation; STAFF JENNINGS, INC., an Oregon corporation; GRIFFITH RUBBER MILLS, an Oregon corporation; STANLEY INVESTMENT AND MANAGEMENT, INC., an Oregon corporation; HARSCH INVESTMENT CORP., an Oregon corporation; BARRETT MOBILE HOME TRANSPORT, INC., an Oregon corporation; OREGON MANUFACTURED HOUSING ASSOCIATION, an Oregon corporation; and H.T. REA FARMING CORP., an Oregon corporation, Petitioners on Review/Respondents on Review,

v.

STATE OF OREGON, ANTHONY MEEKER, Treasurer of State of Oregon, OREGON DEPARTMENT OF REVENUE and its Director, RICHARD MUNN, and STATE ACCIDENT INSURANCE FUND CORPORATION, Respondents on Review/ Petitioners on Review.

ABC ROOFING CO., INC., an Oregon corporation, for itself individually and for all other persons similarly situated; ABBOTT & SIMPSON ROOFING & SHEET METAL, INC., an Oregon corporation; ASSOCIATED OREGON LOGGERS, an Oregon nonprofit corporation; BATTLES CONSTRUCTION COMPANY, INC., an Oregon corporation; BAUGHAM AND SON, INC., an Oregon corporation; BEAVER PLUMBING & HEATING, INC., an Oregon corporation; BROSTERHOUS CONSTRUCTION CO., an Oregon corporation; CHAMBERS PLUMBING AND HEATING, INC., an Oregon corporation; CLARK ELECTRIC INC., an Oregon corporation; IRVING L. WELLS, JOHN M. HANSEN and DENNIS M. BAKER, an Oregon Partnership dba Clow Roofing & Siding Co.; J.C. COMPTON COMPANY, an Oregon corporation; DEHAAS & ASSOCIATES, INC., an Oregon corporation; DONALD M. DRAKE COMPANY, INC., an Oregon corporation; DURBIN CONSTRUCTION CO., an Oregon corporation; FLOYD GRAHM CONSTRUCTION CO., an Oregon corporation; S & B JAMES CONSTRUCTION CO., an Oregon corporation; RAY D. KALAL dba Ray D. Kalal - Grading Contractor; NEIL KELLY CO., INC., an Oregon corporation; MORRIS P. KIELTY GENERAL CONTRACTOR, INC., an Oregon corporation; L.P. COMPANY, an Oregon corporation; MEADE & GREENLEE, INC., an Oregon corporation; MORRISON ELECTRIC COMPANY, an Oregon corporation; MORSE BROS., INC., an Oregon corporation; OREGON-COLUMBIA CHAPTER, THE ASSOCIATED GENERAL CONTRACTORS OF AMERICA, INC., an Oregon nonprofit corporation; OREGON CONCRETE & AGGREGATE PRODUCERS ASSOCIATION, INC., an Oregon nonprofit corporation; BILL PAGE CONSTRUCTION, INC., an Oregon corporation; V. M. PHILIP & SON, INCORPORATED, an Oregon corporation; PIONEER MASONRY RESTORATION CO., INC., an Oregon corporation; PIONEER WATERPROOFING COMPANY, INC., an Oregon corporation; REIMERS & JOLIEVETTE, INC., an Oregon corporation; RIVER BEND SAND & GRAVEL CO., an Oregon corporation, dba Salem Road & Driveway Co.; SALEM WOOD PRODUCTS, INC., an Oregon corporation; SLAYDEN HOLM, INC., an Oregon corporation; SPRICK ROOFING CO., INC., an Oregon corporation; TEMP-CONTROL MECHANICAL CORP., an Oregon corporation; TIGARD ELECTRIC, INC., an Oregon corporation; VALLEY CONCRETE & GRAVEL CO., INC., an Oregon corporation; FRED JOYNER and SHERRY JOYNER, dba Dial One Kwik Klip Maintenance and Perfection Bark Blowing; and ROSE CITY ELECTRIC, INC., an Oregon corporation, Petitioners on Review/Respondents on Review,

v.

STATE OF OREGON, and State of Oregon by and through ANTHONY MEEKER, in his capacity as Treasurer of the State of Oregon, and ANTHONY MEEKER, in his capacity as Treasurer of the State of Oregon; STATE OF OREGON by and through the Oregon Department of Revenue, and its Director, Richard Munn, and STATE ACCIDENT INSURANCE FUND CORPORATION, a public corporation, Respondents on Review/Petitioners on Review.

On review from the Court of Appeals.*

Argued and submitted September 1, 1993.

Jacob Tanzer, of Ball, Janik & Novack, Portland, argued the cause and filed the petition and response for petitioners on review/respondents on review Alsea Veneer, Inc., et al., and ABC Roofing Co., Inc., et al. With him on the response were Bruce W. DeKock, of Ball, Janik & Novack, Portland; Bruce M. Hall, Portland; and Bruce C. Hamlin and Charles F. Hudson, of Lane Powell Spears Lubersky, Portland.

William F. Gary, Special Assistant Attorney General, of Harrang Long Watkinson Laird & Rubenstein, P.C., Eugene, argued the cause and filed the petition and response for respondents on review/petitioners on review State of Oregon, et al. With him on the petition and response were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem, and Sharon A. Rudnick, Special Assistant Attorney General, Eugene.

Phil Goldsmith, of Stoll Stoll Berne & Lokting, Portland, and Cecil B. Strange, Portland, filed a brief on behalf of amicus curiae Oregon Trial Lawyers Association.

Before Carson, Chief Justice, and Peterson, Gillette, Van Hoomissen, Fadeley, and Unis, Justices.

PETERSON, J.

The decision of the Court of Appeals is affirmed in part and reversed in part. The judgments of the circuit court are reversed, and the cases are remanded to the circuit court for further proceedings consistent with this opinion.

*Appeal from Marion County Circuit Court, Rodney W. Miller, Judge. 117 Or App 42, 843 P2d 492 (1992).

318 Or 38 > This is Round 3 of a dispute stemming from an act of a special session of the 1982 Legislative Assembly when, in breach of a contract and in violation of Article I, section 21, of the Oregon Constitution, it amended ORS 656.634¹ and ordered that \$81 million be transferred from the Industrial Accident Fund (IAF) to the General Fund. Round 1 was decided in the state's favor in 1983 when this court held, in a declaratory judgment action brought by the Attorney General, that the State Accident Insurance Fund Corporation (SAIF) lacked authority to hire, without obtaining prior authorization from the Attorney General, a private law firm to bring an action to determine the legality of the 1982 legislative action. This court affirmed a trial court ruling that SAIF was among the entities required by statute to use the services of the Attorney General and, therefore, that SAIF's employment of outside counsel was impermissible, without first having obtained the authorization of the Attorney General to do so. *Frohnmayr v. SAIF*, 294 Or 570, 660 P2d 1061 (1983).

Round 2 was decided by this court in 1988. In *Eckles v. State of Oregon*, 306 Or 380, 402-03, 760 P2d 846 (1988), an action brought by a SAIF insured (SAIF was not a party), this court held: (1) that, "[b]y directing the State Treasurer to transfer \$81 million from the IAF to the General Fund, section two of the Transfer Act breached the state's contract with employers insured with SAIF"; and (2) that section four of the Transfer Act violated Article I, section 21, the impairment of contract provision of the Oregon Constitution.

Before September 3, 1982, ORS 656.634 provided:

"(1) The Industrial Accident Fund is a trust fund exclusively for the uses and purposes declared in ORS 656.001 to 656.794, except that this provision shall not be deemed to amend or impair the force or effect of any law of this state specifically authorizing the investment of moneys from the fund.

318 Or 39 > "(2) The State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund."

¹ Unless otherwise stated, all statutory references in this opinion are to the statutes in existence immediately following the 1982 Special Session of the Oregon Legislature.

Eckles v. State of Oregon, supra, held that ORS 656.634 "expressed a contractual promise of the state to employers who insured with SAIF that the state would not transfer IAF funds to the General Fund," 306 Or at 393, and that the 1982 amendment of ORS 656.634² violated Article I, section 21, of the Oregon Constitution (which prohibits the state from passing laws that impair the obligation of contracts). *Id.* at 399. The legislation requiring the \$81 million transfer breached that promise. *Id.* at 402.

Round 3 (this case) began after *Eckles* was decided, when various employers insured by SAIF filed two actions: The plaintiffs sought damages and equitable relief requiring that the state be required to return the \$81 million to SAIF and that SAIF be required to administer the \$81 million for workers' compensation purposes, including the possible payment of dividends or reduction of premiums, as SAIF would have done had the money not been taken in 1982. The actions were consolidated in the trial court.

In all, there are over 38,000 employers having potential claims against the state. There are essentially three classes of employers: employers with retrospectively rated policies; employers with group policies; and employers with standard policies. Plaintiffs in the cases at bar include employers who are representative of all classes of employers <318 Or 39/40> insured by SAIF at the time of the 1982 legislation. Among other relief, plaintiffs sought:

1. Class certification of the three classes under ORCP 32.
2. Damages.
3. As equitable relief, that the State of Oregon be ordered to retransfer the \$81 million, with interest, to the IAF, and that SAIF be ordered to administer the IAF as it would have administered it, had the \$81 million not been taken out of the IAF. (We will refer to such claims as the "equitable claims.")

The trial court: (1) denied plaintiffs' request for class certification under ORCP 32 C(2); (2) dismissed a number of plaintiffs' claims for failure to state a claim; (3) granted summary judgment on some of the other claims; (4) denied plaintiffs' claims for equitable relief; and (5) dismissed SAIF as a defendant. The modified claims for damages of three plaintiffs were submitted to a jury, which found for defendants. Plaintiffs appealed to the Court of Appeals.

The Court of Appeals reversed, holding that the trial court erred in all of its rulings except the ruling denying plaintiffs' request for equitable relief. *Alsea Veneer, Inc. v. State of Oregon*, 117 Or App 42, 49-56, 843 P2d 492 (1992). As for those claims, the Court of Appeals read *Eckles* to hold that specific performance of the contract was not an available remedy, *id.* at 49, and affirmed the trial court, saying:

"We affirm the trial court's dismissal of the equitable claims of the *Alsea* plaintiffs against the state. Those plaintiffs argue that a complete remedy must require the state to return \$81 million to IAF so that SAIF and its Board of Directors may declare dividends or reduce premiums for the year in question in a manner consistent with good faith. In *Eckles*, the Supreme Court rejected that contention, holding that, under Article I, section 21, the state is not obliged to return the funds. 306 Or at 401-03." *Id.* at 56.

Even though the Court of Appeals affirmed the dismissal of plaintiffs' equitable claims, it nonetheless appears to have ordered equitable relief. It concluded:

² In special session, the 1982 Legislative Assembly amended ORS 656.634(2) to read as follows:

"Subject to the right of the State of Oregon to direct legislatively the disposition of any surplus in excess of reserves and surplus deemed actuarially necessary according to recognized insurance principles, and necessary in addition thereto to assure continued fiscal soundness of the State Accident Insurance Fund Corporation both for current operations and for future capital needs, the State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund." Or Laws 1982 spec sess 3, ch 2, 4 (added language emphasized).

"The state contracted with SAIF policyholders through SAIF, and SAIF is therefore a necessary party. Additionally, <318 Or 40/41> SAIF's presence is necessary for plaintiffs to obtain complete relief on their only cognizable claim for damages for breach of contract by the state. Only SAIF can determine how the transfer of \$81 million from IAF affected its March, 1983, dividend declaration and the premiums that it charged plaintiffs. Plaintiffs are entitled to compel SAIF to determine how it would have exercised its discretion if it had had the extra \$81 million in 1983." *Ibid.* (emphasis added).

Plaintiffs filed a petition for review seeking reversal of the trial court and Court of Appeals' rulings concerning the equitable claims. Defendants sought review of the Court of Appeals' rulings adverse to them. We first will consider defendants' assertions that the Court of Appeals erred in certifying the class. Then we will consider the equitable issue raised by both plaintiffs and defendants: What equitable relief are plaintiffs entitled to on remand?³

On the issue whether the Court of Appeals erred in reversing the trial court's denial of plaintiffs' motion to certify the class, we agree with the Court of Appeals' analysis as to that question and see no reason to discuss it further. See *Alsea Veneer, Inc. v. State of Oregon, supra*, 117 Or App at 52-55. The other issues raised by defendants are resolved by our decision on the equitable claims, an issue as to which we reach a different conclusion from that reached by the Court of Appeals.

In their Third Amended Complaint, the *Alsea* plaintiffs alleged:

"As a consequence of the enactment and application of the Transfer Act, plaintiffs have suffered irreparable harm to their contractual relationships with the State of Oregon and with SAIF. Plaintiffs have lost potential dividends and/or prospective reductions of insurance premiums which would have been available but for defendants' unlawful acts, and <318 Or 41/42> must proceed under ORCP 32]. Plaintiffs have an inadequate remedy at law. Plaintiffs are therefore entitled to an injunction requiring the State Defendants to return to the IAF a sum equal to all losses suffered by the IAF because of the transfer. Plaintiffs are also entitled to an injunction directing defendants to declare dividends and/or reduce employer premiums from any funds returned to the IAF in a manner consistent with their statutory and contractual obligations to those employers which, but for the transfer, would have received dividends or reduced premiums."

That complaint also contained a Fifth Claim for Relief entitled "Derivative Action Against Defendants," which alleged:

"Prior to the breach by defendants of their contractual promises not to transfer or permit to be transferred IAF funds to the general fund, defendant SAIF in *SAIF v. Oregon*, Marion County Circuit Court No. 13647, sought to restrain State Defendants from causing such transfer. However, as a result of *Frohnmayr v. SAIF*, 294 Or 570 (1983), SAIF was disabled from prosecuting said action. To this date, and despite the Supreme Court decision in *Eckles, supra*, SAIF has been unable or unwilling to require the return to itself of the funds so transferred. While demand that SAIF take such action has been timely made upon SAIF by plaintiffs, such demand is in any event rendered

³ Concerning equitable relief, in their petition for review, defendants assert:

"The Court of Appeals erred in concluding that SAIF Corporation should be compelled on remand to determine how it would have exercised its discretion if it had an additional \$81 million in 1983."

In their petition for review, plaintiffs assert:

"This court, on review, should correct the error by addressing plaintiffs' claim for equitable relief on its contract and trust claims, clarifying its holding in *Eckles* and mandating the state to pay \$81 million plus interest to the IAF for the purpose of distribution as it would have been distributed for 1982."

futile by the continued acquiescence by SAIF in State Defendants' legal position that SAIF may not seek the return of IAF funds."⁴

The IAF "is a trust fund exclusively for the uses and purposes declared in [ORS 656.001 to 656.990]." ORS 656.634. The promise to the various classes of employers, as stated in ORS 656.634(1), was to use all IAF funds for <318 Or 42/43> workers' compensation purposes and for no other purpose. The state breached that promise in 1982.

IAF funds are administered by SAIF for a number of purposes, only one of which is the declaration of dividends. We cannot here decide what precise uses SAIF would have put the \$81 million to, had the money not been taken. It might have been used for one or a combination of the following: for refunds to participating employers/insureds, ORS 656.642(2)(b); for augmenting reserve accounts, ORS 656.635(1), 656.640; for loss payments, rehabilitation, safety programs, or SAIF administration; for dividends to SAIF employers/insureds; for reduction of future premiums; or for any other workers' compensation purpose. See, e.g., ORS 656.508(2) (SAIF, annually, may "readjust, increase or decrease the premium rates"). The point is that the employers were a party to a contract with the state, and the state's taking of the \$81 million deprived them of some or all of the multiple benefits that the \$81 million would have been put to, had the state not taken the money. Perhaps SAIF would have paid a greater dividend to some of or all the employers here represented. Then again, it might not have.

Defendants argue that plaintiffs should be limited to their remedies at law. We disagree. Equitable relief does not lie if there is an adequate remedy at law. *Johnson v. Steen*, 281 Or 361, 575 P2d 141 (1978). The remedy at law must be practical, efficient, and adequate, as full a remedy as that which can be obtained in equity. *N.Y. Life Ins. Co. v. Yamasaki*, 159 Or 123, 78 P2d 570 (1938). Equitable relief is appropriate here because the remedy in damages is not an adequate remedy. In addition to whatever dividend or reduced premium, if any, that SAIF would have declared to its policyholders but for the taking of the \$81 million, plaintiffs are entitled to the other benefits that that money would have provided.

A remedy at law -- an action for damages -- could not, as a practical matter, recompense plaintiffs for their losses aside from the dividends. Valuation of each plaintiff's share of the essentially intangible nondividend benefits would be extremely difficult. More importantly, what plaintiffs actually lost is something whose true value only equity <318 Or 43/44> can return to them -- a system with the additional economic flexibility that the \$81 million would give it.

In a practical sense, this case is like a shareholder's derivative action against a corporation that refuses to act. SAIF allegedly is unwilling to make any claim against the state. At least two actions necessarily are involved in affording relief to plaintiffs. One is to get the \$81 million back in SAIF's hands. The second is for the trial court to decree how SAIF shall administer the fund with the \$81 million in it. An equity court is better able to decide questions relating to the exercise of corporate discretion than is a jury. Indeed, this court has stated that equity can compel a corporation to declare a dividend. *Baillie v. Columbia Gold Min. Co.*, 86 Or 1, 16-18, 166 P 965, 167 P 1167 (1917); accord 11 Fletcher, *Cyclopedia of Private Corporations* 744, 5325 (1986). Only by ordering the return of the funds to SAIF, so that the court can decree an appropriate administration of the fund by SAIF, can full and complete relief be afforded to plaintiffs.

⁴ In their Court of Appeals brief, plaintiffs state:

"ORS 656.634(1) requires that the Fund be expended exclusively for purposes connected with ORS ch 656, i.e. for workers compensation purposes. That requirement is part of the state's contract and the policyholders are entitled to enforce it. A dividend is but one possible purpose under ORS ch 656. If the entire \$81 million is not distributed in dividends, then plaintiffs and other policyholders are entitled to invoke the assistance of equity to require that all undistributed funds be returned to the Fund to be applied exclusively for the uses and purposes declared in ORS 656.001 to 656.694."

"Plaintiffs are entitled to complete relief. A damages trial goes only to dividends. Plaintiffs are entitled under the contract to a broader scope of relief. They are entitled to the benefit of requiring undistributed funds to be expended for nondividend workers compensation purposes. If the court accepts defendants' theory that not all of the \$81 million would have been distributed, then only equitable remedies can provide complete relief."

The trial court and the Court of Appeals read *Eckles v. State of Oregon, supra*, to hold that specific performance of the contract, i.e., return of the \$81 million, was not an available remedy. We do not read *Eckles* as narrowly as did the Court of Appeals. *Eckles* rejected the plaintiff's claim for damages because the "[p]laintiff neither sought compensation nor produced any evidence that he had been damaged by the state's breach of contract." 306 Or at 402. The *Eckles* court also denied plaintiff's request for injunctive relief -- return of the \$81 million to the IAF -- saying:

"[Plaintiff] sought a declaratory judgment that the Transfer Act was 'null and void and unconstitutional' and a 'mandatory injunction' for the return to the IAF of the funds transferred. The state is not obliged by Article I, section 21, to return the funds to the IAF, but the circuit court erred in not awarding plaintiff a declaratory judgment that section four of the Transfer Act is unconstitutional insofar as it affects employers with SAIF insurance contracts that were in existence on or before the date of the enactment of the Transfer Act." *Id.* at 402-03.

Eckles does not foreclose equitable relief in this case. It was appropriate for this court there to state that "[t]he state is not obliged by Article I, section 21, to return the funds <318 Or 44/45> to the IAF," *id.* at 403, because specific performance was not at issue in *Eckles*. Indeed, specific performance was not sought. Therefore, *Eckles* was not the proper forum in which to consider or grant specific performance. It is also significant that neither SAIF nor any other employer was a party in *Eckles*. Here, all necessary parties are before this court. SAIF is a party, and all classes of employers insured with SAIF at the time in question also are before the court and represented here.

The relief to which plaintiffs are entitled is this. First, the State of Oregon must be ordered to repay the \$81 million, with interest, to the IAF. Second, plaintiffs are entitled to the additional relief that they can establish that they are entitled to under the equitable claims of their Third Amended Complaint, subject to any defenses that defendants may raise by answer.

As a practical matter, with respect to the second aspect of relief, the trial court, sitting in equity, eventually will be required to determine what would have happened, had the \$81 million transfer not occurred. The trial court will have to determine, after hearing, what the SAIF board would have done, in 1982 and thereafter, had the \$81 million been available to it. Then the trial court should enter an appropriate decree directing SAIF, as steward of the IAF, to act in accordance with that determination. That may or may not mean that dividends will be distributed to some or all classes of employers insured with SAIF. The relief may or may not include reduced premiums to one or more classes. The specific form of relief is for the trial court to select, based on the evidence presented and any defense asserted.

We note that SAIF, which strongly opposed the state's action in 1982, now resists the very relief that it so fervently sought in 1982. We emphasize that good faith must be exercised by SAIF in implementing any action decreed by the trial court. SAIF has no legal license to attempt once again to pass the money to the General Fund under the first clause of *current* ORS 656.634(2). See note 2, *ante*.⁵ The trial court <318 Or 45/46> erred in dismissing plaintiffs' equitable claims in their Third Amended Complaint. Those claims should be reinstated, and the case should proceed appropriately. Defendants should file an answer to the equitable claims and the class action should go forward.

The decision of the Court of Appeals is affirmed in part and reversed in part. The judgments of the circuit court are reversed, and the cases are remanded to the circuit court for further proceedings consistent with this opinion.

⁵ Defendants also assert that the jury's verdict should stand as to the claims that were decided there. For the reasons stated earlier, those claims should not have been permitted to go to the jury in the first place. The appropriate inquiry includes what dividends, if any, what premium reductions, if any, and the total panoply of other benefits, if any, that the various classes would have received. We are convinced, as was the Court of Appeals, that the posture in which the issues were presented to the jury for decision differs so greatly from the issues that should have been decided that the plaintiffs whose cases actually did go to a jury did not have a fair trial of their actual claims.

Cite as 318 Or 58 (1993)

November 18, 1993

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Mary E. Coleman, Claimant.

MARY E. COLEMAN, Petitioner on Review,

v.

LAMB-WESTON, INC., Respondent on Review.
(WCB 90-16879; CA A75971; SC S40433)

In Banc

On review from the Court of Appeals.*

Submitted on petition for review August 11, 1993.

Mary Ellen Coleman, petitioner on review *pro se*, filed the petition for review.

No appearance *contra*.

MEMORANDUM OPINION

The petition for review is allowed. The decision of the Court of Appeals is vacated, and the case is remanded to the Court of Appeals with instructions to dismiss the judicial review.

*Judicial review from the Workers' Compensation Board. 121 Or App 206, 856 P2d 344 (1993).

318 Or 59 > Neither this court nor the Court of Appeals had jurisdiction of this appeal, because the petition for judicial review was not timely served on the Workers' Compensation Board, as required by ORS 656.298(3). *Southwest Forest Industries v. Anders*, 299 Or 205, 218-19, 701 P2d 432 (1985). Accordingly, the petition for review is allowed, the decision of the Court of Appeals is vacated, and the case is remanded to the Court of Appeals with instructions to dismiss the petition for judicial review.

Cite as 123 Or App 217 (1993)

September 15, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Stanley Meyers, Claimant.

STANLEY MEYERS, Petitioner,

v.

DARIGOLD, INC. and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
 (90-09863; CA A72829)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted September 30, 1992; resubmitted in banc February 10, 1993.

Glen H. Downs, Portland, argued the cause for petitioner. With him on the brief were Gerald C. Doblle and Doblle & Associates, Portland.

M. Kathryn Olney, Senior Trial Counsel, Liberty Northwest Insurance Corp., Portland, argued the cause and filed the brief for respondents.

DURHAM, J.

Reversed and remanded for reconsideration.

Deits, J., dissenting.

123 Or App 219> Claimant seeks review of a Workers' Compensation Board order upholding employer's denial of his aggravation claim and holding that the Board lacked jurisdiction to review employer's partial denial of his claim for medical services. We review for errors of law, ORS 656.298(6); ORS 183.482(7), (8), and reverse.

Claimant, a warehouseman and laborer, suffered a compensable back injury in September, 1986. After the last arrangement of compensation in June, 1987, he continued working at his regular job. In January, 1989, he experienced the same back pains that he had experienced after the original injury. He returned to his treating physician who, on January 13, 1989, reported to employer that claimant's condition had worsened since the last arrangement of compensation. Claimant then consulted a chiropractor, who began to treat him once or twice a week. On April 24, 1990, employer denied payment of any chiropractic treatments in excess of the administrative guideline for such treatments. OAR 436-10-040(2).¹ On June 1, 1990, employer denied claimant's claim for an aggravation of the 1986 injury.

Claimant requested a hearing on both denials. The referee set aside employer's denial of the aggravation claim. She also set aside employer's partial denial of the medical services claim on the basis that employer had failed to submit the matter to the director for review under ORS 656.327. The Board reinstated the aggravation denial and vacated the order setting aside the denial of chiropractic treatment on the ground that it lacked jurisdiction to review the denial of medical services.

Claimant first assigns error to the Board's conclusion that it lacks jurisdiction to review employer's denial of the claim for medical treatment. ORS 656.327(1) provides:

123 Or App 220> "(a) If an injured worker, an insurer or self-insured employer or the director [of the Department of Insurance and Finance] believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services *and wishes review of the treatment by the director*, the injured worker, insurer or self-insured employer shall so notify the parties and the director.

¹ OAR 436-10-040(2) provides, in part:

"Frequency and extent of treatment shall not be more than the nature of the injury or process of a recovery requires * * *. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter."

"(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. 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. The decision of the board is not subject to review by any other court or administrative agency.

"(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section." (Emphasis supplied.)

The Board reasoned that a 1990 amendment to ORS 656.704(3) made review of treatment disputes by the director a mandatory rather than discretionary procedure.² ORS 656.704(3), with the 1990 amendment in italics, provides:

"For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and <123 Or App 220/221> review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. 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." Or Laws 1990 (Spec Sess), ch 2, 37.

The Board adopted that construction even though no party requested director review or gave a notice initiating the director's procedure under ORS 656.327(1)(a).

In construing the statute, we look primarily to the text and context of the statute to discover the legislature's intention. *Boone v. Wright*, 314 Or 135, 138, 836 P2d 727 (1992). We must adopt a construction that gives effect to every word of a statute, if possible. ORS 174.010.

ORS 656.327 does not require the parties or the director to invoke the director review process. ORS 656.327(1)(a) provides that a party who believes that a claimant is receiving inappropriate treatment "and wishes review of the treatment by the director" (emphasis supplied) shall notify the parties and the director. In the 1990 amendments, the legislature left untouched the parties' discretion to not request director review and to argue the claimant's entitlement to compensation for medical services before the Board.³

The legislature's purpose in defining "matters concerning a claim" in ORS 656.704(3) is to determine "the respective authority of the director and the board to conduct hearings, investigations and other proceedings under [this chapter] * * *." (Emphasis supplied.) Under ORS 656.327(1)(a), if no

² In *Lillie M. Willis*, 42 Van Natta 1923 (1990), the Board held that the Director review procedure in ORS 656.327(1) is discretionary with the parties and originates only if a party wants the Director to act:

"The language of this former statute is discretionary upon the parties. It contains two requirements: first there has to be one or more of the types of problems listed in the statute; and second, the parties have to want the Director to act. Once the matter has been submitted by one of the parties to the Director, then the provisions of ORS 656.327(2) take effect. At that point, the Director has sole jurisdiction over the matter and the insurer cannot deny the claim and the claimant cannot request a hearing. It is only at that point that the Hearings Division loses jurisdiction over the matter under ORS 656.283." (Emphasis supplied.)

³ The dissent contends that the parties' discretion under ORS 656.327 to seek director review was impliedly repealed by the 1990 amendment to ORS 656.704(3). The dissent focuses on the amendment but does not address the language in ORS 656.327 that the legislature left untouched. The dissent's interpretation fails to give effect to the unamended language, as required by ORS 174.010, and contradicts that language by, in effect, compelling the parties to seek review, whether or not they wish to do so. We find no persuasive indication that the legislature meant the amendment to ORS 656.704(3) to prevail over the language in ORS 656.327. See *Harris v. Craig*, 299 Or 12, 16 n 1, 697 P2d 189 (1985).

party or the director requests a medical treatment review by the director, no question of *respective* authority between the director and the Board arises. If a party or the director "wishes" for director review and gives <123 Or App 221/222> the notice, ORS 656.327(1) provides the procedure for a proceeding, within the meaning of ORS 656.704(3), for resolving the medical treatment dispute. If the parties or the director commence the director review proceeding, they must exhaust it and are barred from denying the claim or requesting a hearing before the Board until the director issues an order. ORS 656.327(1)(c), (2). Without a "wish" for the review and a notice filed with the director, there is no proceeding before the director. The director acquires exclusive jurisdiction over a medical treatment dispute only if the conditions necessary to create that jurisdiction occur. Those conditions did not occur here. The medical treatment dispute remained within the Board's jurisdiction.

The Board rewrote ORS 656.327 under the guise of interpretation in an attempt to harmonize its construction of the director's authority with the terms of the statute. The Board said:

"[The insurer's] failure to initiate review procedures or pay the bills within 90 days of receipt will, by that fact alone, ordinarily constitute the unreasonable resistance to the payment of compensation, for which penalties or attorney fees will be assessed.³

³ Furthermore, by failing to timely request Director review, the insurer may waive its right to seek director review, and be held bound to pay the bills. *See proposed* OAR 436-10-046(4)."

The Board held that employer was required either to "pay claimant's medical bills or initiate Director review of the dispute." That ignores employer's right under ORS 656.327(1)(a) to invoke director review only if it *wishes* to do so. The Board's effort to compel employers and insurers to invoke director review contradicts the statute. The Board's interpretation of its jurisdiction over the medical treatment dispute is erroneous as a matter of law.

Claimant assigns error to the Board's holding that he must prove a diminished capacity to work in order to recover on his aggravation claim. The Board found that claimant suffered a symptomatic worsening, but rejected his aggravation claim, because

123 Or App 223> "claimant's earning capacity was [not] diminished below what it was at the time his claim was last closed."

Claimant admits that he has continued to work full time. He argues that his ability to work is irrelevant, because he seeks compensation only for medical services, not disability compensation.

ORS 656.273 does not require claimant to prove a diminished capacity to work in this context. That statute provides, in part:

"(1) After the last award or arrangement of compensation, an injured worker is entitled to *additional compensation, including medical services*, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings.

* * * * *

"(2) To obtain additional medical services *or* disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer." (Emphasis supplied.)

The Board cited *Smith v. SAIF*, 302 Or 396, 730 P2d 30 (1986), for its proposition that lost earning capacity must be proven in all aggravation claims, including those limited to medical services. *Smith* does not support the Board. That case involved an aggravation claim for increased disability compensation. The Supreme Court held:

"[I]n a claim for increased compensation for *unscheduled disability* under ORS 656.273, the worker * * * must prove that his symptoms have increased or otherwise demonstrate that his underlying condition has worsened so that he is less able to work in the broad field of general occupations resulting in a loss of earning capacity." 302 Or at 401. (Emphasis supplied.)

Smith states:

"Of course, a worker is entitled to medical expenses under ORS 656.245⁴ without a showing of worsening of his <123 Or App 223/224> underlying condition. The entitlement to services under ORS 656.245 is not tied to a worsening but requires only that the need for medical services be a result of the injury." 302 Or at 402.

Because the Board disposed of the aggravation claim by holding that claimant was not more disabled from working, it did not determine whether the need for medical services was the result of the injury.⁵ *Smith v. SAIF, supra*, 302 Or at 402. On remand, the Board should address that question.

Claimant also assigns error to the order setting aside the referee's award of penalties and attorney fees on the denials. In light of our disposition of the issues discussed above, we do not address this assignment.

Reversed and remanded for reconsideration.

⁴ ORS 656.245 provides, in part:

"(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires * * *"

⁵ The dissent contends that the aggravation claim was properly denied because it did not include a claim under ORS 656.245 for additional medical services resulting from the original injury. We reject that argument. Because the claim was based on ORS 656.273, a citation to ORS 656.245 was unnecessary. We also note that the dissent's view was not a basis for the Board's order and was not argued to this court by employer.

DEITS, J., dissenting.

The majority begins its analysis with the proposition that, in construing a statute, we should give effect to every word of a statute. It then proceeds to ignore the words of the pertinent statutes, as well as the legislative intent in the adoption of the statutes and a well reasoned opinion of the Board interpreting the statutes.

As the majority correctly points out, the critical question is whether the process set out in ORS 656.327 for review by the Director of disputes concerning whether medical treatment is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" is exclusive or whether the Board also has jurisdiction of such disputes.¹ The majority concludes that the parties to such a dispute have the discretion to decide whether to seek <123 Or App 224/225> review by the Director or to seek a hearing before a referee and the Board.

Before the amendment to the Workers' Compensation Act in 1989, the majority's conclusion was correct and the Board had so interpreted the statutes. However, in 1989, the legislature amended ORS 656.704(3), which governs the respective jurisdiction of the Director and the Board. That subsection was amended to provide that "matters concerning a claim" over which the Board has review authority do not include "any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." That subsection now reads:

"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 worker's right to receive 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.)

¹ As the Board noted in its opinion, this case concerns jurisdiction to review the *appropriateness* of medical treatment. It does not concern jurisdiction involving cases where the dispute relates to the extent of the causal relationship in fact and law between the claimant's medical condition and the claimant's compensable injury or occupational disease.

As the Board correctly explains in its order in this case, the language added to ORS 656.704(3) in 1989 changed the authority of the Board regarding review of disputes concerning medical treatment or fees:

"Under amended ORS 656.704(3), 'matters concerning a claim' over which the Board, and thus the Hearings Division, has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly 'excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services.' Accordingly, unlike the situation in *Lillie M. Willis, supra*, [42 Van Natta 1923 (1990)] original jurisdiction over a dispute concerning the frequency of medical treatment is no longer shared by the Director and the Hearings Division. Rather, because such disputes are no longer matters concerning a claim, original jurisdiction lies exclusively with the Director." (Footnote omitted.)

123 Or App 226> The Board noted that its reading of the statutes is consistent with the apparent purpose of the amendment to ORS 656.704(3) to remove questions concerning the reasonableness of medical treatment from the litigation process. As the Board explained:

"This conclusion is supported by the legislative history. The amendments to ORS 656.327 and 656.704 were proposed in Senate Bill 1197. In explaining the bill to the Special Committee of the legislature, a member of the Governor's Workers' Compensation Labor-Management Advisory Committee testified that the purpose of the amendments was to remove questions concerning the reasonableness and necessity of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee."

It is often unclear how procedures provided in different statutes are to relate to each other. In such cases, we often have to apply principles of statutory construction to decide how the statutes should be read together. This is a case, however, where the legislature directly states how these statutes are to relate to each other. It adopted specific language defining the respective jurisdiction of the Board and Director concerning disputes regarding medical treatment. ORS 656.704(3) specifically states that "matters concerning a claim" over which the Board has jurisdiction does not include proceedings for resolving disputes concerning medical treatment or fees when there is a procedure otherwise provided in chapter 656. ORS 656.327 sets out specific procedures to handle such disputes.

The majority decides that ORS 656.327(3) does not really mean what it says, that when the statute says that the Board does not have jurisdiction of disputes regarding medical treatment for which a procedure has already been provided in chapter 656, what it really means is that it is up to employers and workers to decide whether they want to have such disputes resolved by the Director or the Board. That simply is not what the statute says. The majority acknowledges that ORS 656.704 does concern the respective jurisdiction of the Board and the Director, but reasons that you do not get into a question of respective jurisdiction unless one of the parties invokes the Director's jurisdiction. That reasoning is quite circular and blatantly ignores the last sentence in **<123 Or App 226/227>** ORS 656.704(3) that says that when a dispute concerning medical treatment or fees is involved for which a procedure has been provided elsewhere in chapter 656, the Board does not have jurisdiction.

Further, the majority's interpretation is completely inconsistent with the purpose of the legislation to remove such disputes from the litigation process. The legislature has adopted a process for dealing with this type of dispute in ORS 656.327. The Worker's Compensation Department has also adopted extensive administrative rules further detailing the process to be followed by the director in resolving disputes concerning medical treatment and fees. These rules include detailed requirements as to the timing of requests for review and the process to be used in reviewing such disputes. Under the majority's reading of these statutes, an employer or a worker has the authority to decide that they simply do not feel like following those well defined procedures and to ask the Board to undertake the review.

The majority's result is not compelled by the language of the statutes; it is inconsistent with the purpose of the legislation. It allows the parties to avoid a detailed and well defined process for resolving these disputes before the Director if they wish to do so. I believe that the Board's reasoning was sound and that it was correct in concluding that it lacked authority to review the insurer's partial

denial of claimant's chiropractic treatments, because the statutes give jurisdiction of such matters to the Director.

The majority also concludes that the Board erred in upholding the denial of claimant's aggravation claim, because "ORS 656.273 does not require claimant to prove a diminished capacity to work" in order to receive additional medical services for his worsened condition. The majority holds that when the Board rejected the aggravation claim, it was then required to determine "whether the need for medical services was the result of the injury" under ORS 656.245.

The majority is correct that, under ORS 656.245, an employer is responsible for medical services for conditions resulting from the compensable injury, regardless of whether the claimant has suffered an aggravation, and that responsibility continues for the life of the claimant. See *Evans v. <123 Or App 227/228> SAIF*, 62 Or App 182, 660 P2d 185 (1983). However, the majority overlooks the fact that this aggravation claim is a separate claim from the claim for medical services discussed above. Claimant's request for a hearing on employer's June 1, 1990 denial involved only a claim for aggravation under ORS 656.273 and penalties and attorney fees. His claim for an aggravation did not include a claim under ORS 656.245 for additional medical services resulting from the original compensable injury. Because of that, *Smith v. SAIF*, 302 Or 396, 730 P2d 30 (1986), is not applicable. In my view, the aggravation issue was correctly decided, and the Board should not address it on remand. For all of the above reasons, I respectfully dissent.

Richardson, C.J., and Warren and Edmonds, jj., join in this dissent.

Cite as 123 Or App 249 (1993)

September 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John Papen, Claimant.

JOHN PAPEN, Petitioner,

v.

WILLAMINA LUMBER COMPANY and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(90-12952; CA A74507)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 10, 1992.

Stanley Fields, Salem, argued the cause for petitioner. With him on the brief was Law Office of Michael B. Dye, Salem.

James D. McVittie, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

123 Or App 251> Claimant seeks review of an order of the Workers' Compensation Board upholding a determination order that offset his preexisting hearing loss in its calculation of the permanent disability award. We affirm.

Claimant has worked continually in lumber mills since 1947, except for the time between 1949 and 1951 when he served in the military. He has a measurable and progressive hearing loss. Until 1980, claimant worked for Champion International, a plywood mill, where he was exposed to high levels of noise. He did not use hearing protection until 1975, when he began using it about 50 percent of the time. In 1976, claimant underwent an audiogram to measure his hearing loss. It revealed that he had 17 percent monaural hearing loss in his right ear and 34.5 percent in his left ear, for a combined binaural loss of 19.18 percent.

Claimant began working for Willamina Lumber Company (employer) in November, 1980. He filed a claim for hearing loss with Champion in February, 1988, which Champion denied. He requested

a hearing on Champion's denial and also filed a claim against employer. Champion moved to join employer, and an order of joinder was issued on November 20, 1989. Claimant underwent another audiogram in December, 1989, which revealed a 25 percent monaural hearing loss in his right ear and 40 percent in his left ear, for a combined binaural loss of 26.88 percent. In January, 1990, employer accepted claimant's hearing loss, and claimant withdrew his request for a hearing on Champion's denial. A February, 1990, determination order issued awarding claimant 5.81 percent or 11.16 degrees scheduled permanent disability. The award offset claimant's hearing loss measured in 1976, before he began working for employer. Claimant appealed, the referee upheld the order, and the Board affirmed the referee.

In upholding the determination order, the Board adopted the referee's opinion that

"the Evaluation Section properly applied OAR 436-35-250(2)(a). The rule is plain and unambiguous. It states that hearing loss existing before the compensable injury or exposure should be offset. Moreover, the rule is <123 Or App 251/252> entirely consistent with ORS 656.214(2), which requires a worker to prove that his scheduled permanent disability is 'due to the [compensable] injury.' See *Nomeland v. City of Portland*, [106 Or App 77, 806 P2d 175 (1991)].

"Furthermore, I need not reach claimant's argument that OAR 436-35-250(2)(a) should not be applied to preexisting work exposure. That is, on this record, claimant has not proven that his hearing loss prior to November, 1980, was caused or worsened by his work exposure. See *New ORS 656.802(2)* (1990 Oregon Laws (Special Session) Chapter 2, Section 43)."

Claimant assigns error to the Board's holding that his preexisting hearing loss may be offset against his present hearing loss in determining his permanent disability award. The pertinent statute is ORS 656.214:

"(2) 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 injured member due to the industrial injury.

"* * * * *

"(g) For partial or complete loss of hearing in both ears, that proportion of 192 degrees which the combined binaural hearing loss bears to normal combined binaural hearing. For the purpose of this paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. In the case of individuals with compensable hearing loss involving both ears, either the method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be used, depending upon which allows the greater award of disability." (Emphasis supplied.)

The version of OAR 436-35-250 in effect at the pertinent time read:

"(2) Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. The following will be offset against hearing loss in the claim:

"(a) Hearing loss which existed before this injury or exposure, if adequately documented by pre-employment audiogram."¹

¹ OAR 436-35-250 now provides, in part:

"(2) Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. The following will be offset against hearing loss in the claim:

"(a) Hearing loss which existed before this injury or exposure, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment[.]"

123 Or App 253 > We conclude that the Board's decision is consistent with the above rule as well as with the statute. The rule provides that an offset is allowed for hearing loss "which existed before this injury or exposure, if adequately documented by pre-employment audiogram." Here, the record demonstrates that claimant had diagnosed hearing loss before starting work with employer. The previous condition was measurably and distinctly different, as evidenced by the 1976 audiogram. Moreover, we conclude that the rule is consistent with the statute, which requires a claimant to prove that a scheduled disability is "due to the [compensable] injury." *Nomeland v. City of Portland, supra*.

Claimant argues that this is a case of incremental injuries at successive employments and that, under "the last injurious exposure rule," employer is responsible for his aggregate condition. *Bracke v. Bazar, 293 Or 239, 646 P2d 1330 (1982)*. The Board, however, found that "claimant has not proven that his hearing loss prior to November, 1980, was caused or worsened by his work exposure" (emphasis in original), and that finding is supported by substantial evidence in the record. Because the last injurious exposure rule is not applied to hold an employer responsible for a non-work-related disability that preexisted the injury, the Board did not err in concluding that employer was only responsible for that measured loss of hearing that occurred during claimant's employment with employer. *Nomeland v. City of Portland, supra, 106 Or App at 81*.

Claimant contends that the Board erred in finding the date of injury for his occupational disease to be April 1, 1987. Claimant argues, relying on *Johnson v. SAIF, 78 Or App 143, 146, 714 P2d 1098, rev den 301 Or 240 (1986)*, that, in an occupational disease case, the date of injury is the date of last exposure, which he contends was January, 1990. He also argues that, because he is entitled to a redetermination of his <123 Or App 253/254> award, his award is payable at the rate effective after May 7, 1990.

We do not agree with claimant's argument regarding the date of injury. The date of injury in an occupational disease case is either the date of disability or the date when medical treatment is first sought. *Medford Corp. v. Smith, 110 Or App 486, 488, 823 P2d 441 (1992)*. *Johnson v. SAIF, supra*, relied on by claimant, does not hold otherwise. As we explained in *Brown v. SAIF, 79 Or App 205, 209, 717 P2d 1289, rev den 301 Or 666 (1986)*, the holding in *Johnson* regarding the time of "injury" was limited to a determination of the applicability of a newly enacted statute:

"Although we equated 'injury' with exposure for the purpose of determining the applicability of the statute which was enacted after the exposure but before the disability, our decision was explicitly limited to ORS 656.202(2) and cannot be read to hold that, as a general rule, an occupational disease occurs at the time of the exposure which causes the disease. That reading is inconsistent with the wording of the occupational disease law. See, for example, ORS 656.807(1) and (4). Our decision in *Johnson* reflected our concern that using the date of disability to determine the law governing the claim would effect a retroactive application of the occupational disease law in the absence of an expression of legislative intent to make the law retroactive. 78 Or App at 148. *Johnson* does not offer any support for claimant's argument that exposure constitutes an 'injury' independently of the subsequent development of an occupational disease." (Emphasis supplied.)

If claimant's position were the rule, then he would be seeking compensation for exposure after the date he filed his claim, as he was still working for employer after 1989.

We also conclude that the Board's finding that April 1, 1987, was the date of injury is supported by substantial evidence. Claimant did not seek medical treatment until two months after filing his claim against employer. Therefore, we look to his date of disability, or the date he was entitled to compensation. Claimant stated on his 801 form that the date of his injury was April 1, 1987. In its notice of acceptance, employer accepted April 1, 1987, as the date of injury. Nothing in the record indicates that a different date is appropriate.

123 Or App 255 > We also hold that the 1990 amendment to ORS 656.214(2), which increased the rate of compensation, does not apply here because the applicable rate is determined by the date of injury, which the Board correctly determined to be in 1987. *SAIF v. Herron, 114 Or App 64, 72, 836 P2d 131, rev den 315 Or 271 (1992)*. The Board properly set compensation at the 1987 rate.

Affirmed.

Cite as 123 Or App 321 (1993)

September 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Rosa M. Pacheco-Gonzalez, Claimant.

ROSA M. PACHECO-GONZALEZ, Petitioner,

v.

SAIF CORPORATION and B. C. HOP FARMS, INC., Respondents.
 (WCB 91-11930; CA A76749)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 21, 1993.

Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief was Stanley Fields, Salem.

John T. Bagg, 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.

Reversed and remanded for reconsideration.

123 Or App 314> Claimant seeks review of a Worker's Compensation Board (Board) order holding that the Board lacks jurisdiction to conduct a hearing when a Department of Insurance and Finance (DIF) order on reconsideration is invalid, and also lacks authority to remand the case to DIF. We reverse.

Claimant suffered a compensable injury. She was declared medically stationary, with no award for permanent partial disability, by a notice of closure from DIF. On reconsideration, DIF affirmed the notice of closure. Because there was a dispute over the impairment findings used to close the claim, a medical arbiter's report was ordered pursuant to ORS 656.268(7).¹ However, the report was not considered by DIF because it arrived after the order on reconsideration was issued. The order on reconsideration stated:

"The Appellate Unit is unable to complete a substantive review of this reconsideration request within the time limits of the court injunction [imposed by *Benzinger v. Oregon Dept. of Ins. and Finance*, 107 Or App 449, 812 P2d 36 (1991)].^[2] Accordingly, we must affirm the prior determination order or notice of closure in its entirety. This will permit you to request a hearing on the claim closure and this Order on Reconsideration."

Claimant requested a hearing contesting the rating and impairment findings in the order on reconsideration. The referee dismissed claimant's request and the Board affirmed.

Claimant assigns error to the Board's conclusion that the referee lacks jurisdiction to hear a claim involving an invalid order on reconsideration. The Board found that the order was "invalid," because DIF did not review the medical arbiter's report pursuant to ORS 656.268(7).³ ORS 656.268(6)(b) provides, in part:

123 Or App 315> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 * * *."

¹ ORS 656.268(7) provides, in part:

"If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director."

² In *Benzinger*, we affirmed a trial court order compelling DIF to process orders on reconsideration within 15 days from the request, as required by ORS 656.268(6)(a) (*since amended* by Or Laws 1991, ch 502 1).

ORS 656.283(1) provides, in part:

"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."

Neither statute requires a "valid" order on reconsideration for the referee to have jurisdiction. No statute divests the Board of its obligations where an "invalid" order on reconsideration occurs. The purpose of the Workers' Compensation Law is to

"provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings." ORS 656.012(2)(b).

The Board's decision that the referee has no jurisdiction to hear appeals from "invalid" orders of DIF frustrates the intent of the statute and is in error. It leaves the claimant without recourse for review of what the Board terms an "invalid" order on reconsideration.

Because it may arise again on remand, we decide whether the Board may review a medical arbiter's report not reviewed by DIF and whether it has the authority to remand a case to DIF.⁴ The Board found that the referee could not <123 Or App 315/316> review the medical arbiter's report because it was received after the order on reconsideration was issued. The Board relied on ORS 656.268(7):

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

³ The Board relied on *Anaconda Company v. Department of Revenue*, 278 Or 723, 565 P2d 1084 (1977), which held that, when the Department of Revenue did not grant a taxpayer the statutorily-mandated pre-assessment hearing, the assessment order was invalid, as if it never existed. However, the court went on to say:

"Since the question always arises from a particular enactment, there can be no 'general rule' for concluding when failure to follow an obligatory procedure nevertheless does not invalidate an action."

"Similarly the nature and extent of the disadvantage sought to be avoided by the procedure can bear on the probable intent with respect to noncompliance." 278 Or at 727-28.

The legislature intended the workers' compensation system to provide a speedy procedure for delivery of benefits to injured workers. In this case, DIF followed the mandatory procedures: it ordered the medical arbiter's report and it completed the review within 15 days. The report came too late to affect the reconsideration, but it was available at the hearing. The late report does not exclude the claim from the provisions of ORS 656.268 and ORS 656.283.

⁴ The referee concluded:

"ORS 656.268(7) mandates that the findings of the medical arbiter be submitted to DIF for reconsideration and that no subsequent medical evidence can be considered by any reviewing body. Consequently, I conclude that I am unable to use the medical arbiter's report generated after the Order on Reconsideration to rate permanent partial disability."

On the issue of remand, the referee concluded that,

"although this matter remains under the jurisdiction [of] DIF's Appellate Review Unit pending completion of reconsideration as required by law, I have no authority to require that agency to act."

The Board adopted the referee's findings, but concluded that the referee lacked jurisdiction to review an invalid order because "the Director failed to appoint a medical arbiter and consider the arbiter's findings on reconsideration, the Referee properly found that the Order on Reconsideration is invalid. Consequently, the Referee lacked jurisdiction to consider claimant's request for hearing and properly dismissed the request for hearing."

The Board did not directly address whether the referee could review a medical arbiter's report not reviewed by DIF or whether it had the authority to remand a case to DIF.

The Board misinterpreted the statute. The statute prohibits the admission of evidence developed *after* the medical arbiter's report, not the medical arbiter's report. Even if the medical arbiter's report is not reviewed by DIF, it can and should have been considered by the referee and the Board. The legislature clarified its intent in 1991 by amending ORS 656.268(6)(a) to provide, in part:

"Any 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." Or Laws 1991, ch 502, 1.

Claimant also assigns error to the failure of the Board to remand her claim to DIF. ORS 656.283(7) provides, in part:

"If the referee finds that the claim has been closed prematurely, the referee shall issue an order *rescinding* the <123 Or App 316/317> determination order or notice of closure." (Emphasis supplied.)

Nowhere in the statute is there a provision for remanding a claim to DIF. The legislature and the courts have emphasized that speedy processing and resolution of claims is a primary goal. The time limit found in ORS 656.268(6)(a) (*since amended* by Or Laws 1991, ch 502, 1) was intended to speed the process. We intended to make it clear in *Benzinger v. Oregon Dept. of Ins. and Finance, supra*, that the reconsideration process before DIF was to be concluded within the statutory time limit. When the legislature amended ORS 656.268(6)(a) in 1991 to permit the referee to receive and consider the medical arbiter's report, it did not amend ORS 656.283(7) to authorize the remand of cases to DIF. The legislature clarified, with the amendment to ORS 656.268(6)(a), that the correct procedure is for the referee to hear the case. Claimant urges us to find that the referee's authority to remand cases is implied in the referee's review power of DIF orders on reconsideration. We reject that construction of the statute.

Reversed and remanded for reconsideration.

Cite as 123 Or App 326 (1993)

September 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert Proctor, Claimant.

ROBERT PROCTOR, Petitioner,

v.

SAIF CORPORATION and ADULT AND FAMILY SERVICES DIVISION, Respondents.
(90-04089; CA A70294)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 15, 1992.

Eileen G. Simpson, Eugene, argued the cause for petitioner. With her on the brief was Peter O. Hansen, Portland.

Michael 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.

DURHAM, J.

Reversed and remanded.

123 Or App 328 > Claimant seeks review of a Workers' Compensation Board order denying the compensability of his claim. The issues are whether he was a traveling employee and whether he was on a distinct departure on a personal errand at the time of injury. We review for errors of law, ORS 656.298(6); ORS 183.482(7), (8), and reverse and remand.

We take the facts from the Board's findings. Employer organized a conference in Corbett to teach its employees about alcohol and drug abuse so that they could better serve employer's clients. Attendance was optional, but it was a factor that employer considered in job evaluation. Employer compensated the employees for attending the seminar. Conference sessions were scheduled from 8:30

a.m. to 8:30 p.m. on January 23 and 24, 1990, and from 8:30 a.m. to 2:30 p.m. on January 25, 1990. Employer furnished meals before and after the sessions. Employer did not require employees to sleep and eat at the conference site, but encouraged them to stay at its expense because of the intensity of the program. Claimant, who lived 22 miles from Corbett, agreed to sleep and eat at the conference site.

The first 12-hour session was fatiguing. Employer encouraged, but did not require, participants to engage in some physical activity to relieve the stress, although it organized no recreational activities at the site. It also encouraged employees to see the beautiful sights off the grounds. Employees did not need permission to leave the conference site. Claimant tried to use the pool table and the ping-pong table, but they were occupied by others, and it was too dark to explore the conference center's walking trails. He wanted some physical activity, so he drove 15 miles to an athletic club, where he was a member, with the intention of working out and returning to the conference center. He ruptured an Achilles tendon while playing basketball. He obtained medical treatment and returned to his home in Portland. He went back to the conference the next day but was in too much pain to stay for the entire session. He did not attend the third day. Claimant filed a claim for his Achilles tendon injury.

The referee set aside SAIF's denial of the claim. He found that claimant was a traveling employee and that his <123 Or App 328/329> trip to the club was not a distinct departure on a personal errand. The Board accepted the referee's findings, but held that the injury was not compensable.

"We conclude that the 'traveling employee rule' is not applicable to the type of 'business' trip at issue here, where attendance at the seminar is voluntary and the employee is not required to stay the night. Moreover, assuming the rule was applicable, we would conclude that the basketball activity at the Cascade Athletic Club was a distinct departure on a personal mission."

The Board, instead, analyzed claimant's activity under the seven factors identified in *Mellis v. McEwen, Hanna, Givold*, 74 Or App 571, 573, 703 P2d 255, rev'd en 300 Or 249 (1985), for determining whether an injury is work related and held that the injury was not connected to work. The Board held that the trip to the conference center was within the course and scope of employment, but that the trip to the club to play basketball took claimant out of the course and scope.

On review, claimant challenges the Board's compensability determination, contending that he was a traveling employee and was not on a distinct departure on a personal errand. We agree that the Board's analysis is flawed. The Supreme Court in *SAIF v. Reel*, 303 Or 210, 216, 735 P2d 364 (1987), held that where travel is a part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of injury:

"The risk inherent in travel may arise out of the employment where such travel is a necessary incident of the employment. That is, when the travel is essentially part of the employment, the risk remains an incident to the employment even though the employee may not actually be working at the time of the injury."

As we noted in *PP&L v. Jacobson*, 121 Or App 260, 262, 854 P2d 999 (1993), the rule governing the compensability of injuries to traveling employees is stated in 1A Larson, *Workmen's Compensation Law* 5-275, 25.00 (1990):

"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 <123 Or App 329/330> 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."

The Board erred in holding that, although the trip to the conference was related to employment, the traveling employee rule is inapplicable because attendance was voluntary and claimant was not required to stay overnight. The rule does apply to employees who volunteer for work that entails travel. The issue is whether travel is purely a personal choice or preference and is, therefore, a self-created risk, or is an activity that accommodates or benefits the employer's business. The conference was an intensive course designed to improve employer's ability to serve its clients. Claimant's attendance was compensated and was a factor in his job evaluation. His travel to the conference accommodated employer's business purpose and was not a purely personal choice. His willingness to attend does not obviate the need to apply the rule.

The Board's second reason--that claimant was not required to stay overnight--was rejected in *PP&L v. Jacobson, supra*, 121 Or App at 262. In that case, we modified our prior conclusion that "the traveling employee rule is limited to employees who travel overnight," 121 Or App at 262, and applied the rule to a worker who was injured during his lunch hour while traveling for the employer's benefit. The rule's applicability does not depend on overnight travel. We conclude that, on the basis of the Board's findings, the traveling employee rule applies to claimant's travel to the conference.

A traveling employee is continuously within the course and scope of employment while away from home, except when engaged in a distinct departure on a personal errand. *Slaughter v. SAIF*, 60 Or App 610, 613, 654 P2d 1123 (1982). Whether a traveling employee's injury occurs on a distinct departure on a personal errand depends on whether the activity that results in injury is reasonably related to the travel status.¹ The Board <123 Or App 330/331> concluded, apparently as an alternative basis for its result, that claimant was on a distinct departure.

The Board construed the distinct departure on a personal errand exception too broadly. It reasoned that employer did not approve travel to the club and did not direct, encourage or acquiesce in the basketball activity. It noted that the seminar did not generate stress that required the specific activity of a basketball game at the club, and that claimant's job was not related to the club or the basketball game. It also noted that claimant had to leave the seminar site to get to the club, that the club was a five-minute trip from claimant's residence, and that he used the club for recreation, as he had on prior occasions.

Those statements do not describe a distinct departure on a personal errand. Employer need not approve a traveling employee's travel to or participation in an after-work relaxation activity. A traveling employee may satisfy a physical need for recreation even if the job does not cause stress, and even if the employee chooses an activity that is not related to work. As the cases show, most traveling employees relax through activities that have little relationship to work. In *Slaughter v. SAIF, supra*, we held that a long haul truck driver did not engage in a distinct departure on a personal errand when he chose to pass the time between trips by drinking in a local tavern, and was injured in a fight with other tavern customers. *Slaughter* distinguished *Hackney v. Tillamook Growers Coop.*, 39 Or App 655, 593 P2d 1195, *rev den* 286 Or 449 (1979), where we found that a traveling employee driver engaged in a distinct departure on a personal errand by disregarding a dispatcher's instructions to leave <123 Or App 331/332> Florida and drive to South Carolina, and, instead, remained for 5-1/2 hours in a motel bar, drinking and watching television. He broke his arm while arm wrestling. We said:

"*Hackney* is not controlling, because a 'personal errand' was found there, in large part because of *Hackney's* delay in leaving Florida. See *Hackney v. Tillamook Growers Coop., supra*, 39 Or App at 658-59. The perceived disregard of the dispatch direction made the personal errand 'distinct.'" *Slaughter v. SAIF, supra*, 60 Or App at 614.

¹ In *Slaughter v. SAIF, supra*, 60 Or App at 616, we said:

"We believe that the general rule of continuous coverage in *Simons[v. SWF Plywood Co.]*, 26 Or App 137, 143, 552 P2d 268 (1976), is best understood as a statement that injuries are compensable when resulting from activities reasonably related to the claimant's travel status."

We also said:

"Other jurisdictions have explained the limits on coverage for traveling employees in terms of reasonableness of the activity. One court states:

"Where an employee, as part of his duties, is directed to remain in a particular place or locality until directed otherwise or for a specified length of time, "the rule applied is simply that the employee is not expected to wait immobile, but may indulge in any *reasonable* activity at that place, and if he does so the risk inherent in such activity is an incident of his employment."

"* * * [T]he test as to whether specific activities are considered to be within the scope of employment or purely personal activities is the reasonableness of such activities. Such an employee may satisfy physical needs including relaxation." *Robards v. New York Div. Electric Products, Inc.*, 33 App Div 2d 1067, 307 NYS 2d 599, 600-01 (1970)." 60 Or App at 615. (Emphasis in original.)

In *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), the court found that a traveling employee's death in a bar following drinking and horseplay was work related because he was under stress, worked extended hours, had limited recreational and social choices open to him due to travel status and engaged in some supervisory activities on the night he died.

Those cases looked beyond the claimant's presence in a bar to find whether the claimant's or activity in the bar had a work connection, and whether the activity violated employer directives or was

"so inconsistent with the purpose of his trip * * * as to constitute an abandonment of his employment or such a deviation therefrom as should have caused us to conclude that he was no longer in the course of his employment." *Schreckengost v. Workmen's Comp. Appeal Bd.*, [43 Pa Cmwlth Ct 587, 403 A2d 165, 167 (1979)]." *Slaughter v. SAIF, supra*, 60 Or App at 615 n 4.

The order states no facts that could support a conclusion that claimant's activity was inconsistent with the business trip's purpose or the employer's directives. The order does not demonstrate how the club's proximity to claimant's residence is relevant to the determination of whether the basketball activity is reasonably related to his traveling employee status. The fact that claimant had used the club for recreation on prior occasions does not show a distinct departure. A traveling employee can seek relief from the stress of a 12-hour workday by attending a recreation facility through which the employee has obtained such relief in the past.

On the facts found by the Board, a correct interpretation of the "distinct departure on a personal errand" exception requires us to reverse. ORS 183.482(8)(a)(A). Claimant played basketball to exercise his body and relieve stress <123 Or App 332/333> created by the 12-hour seminar that day. Employer encouraged the employees to relieve stress with physical activity so that they would be better able to learn from and participate in the conference. It did not confine the employees to a particular activity or place. Claimant violated no employer directive in going to the club to play basketball. He chose to make that trip because he had little or no opportunity to engage in recreation at the conference site. Neither his manner of playing basketball nor conditions at the club created any unusual risk of injury.² The distance traveled by a traveling employee to obtain recreation may show a distinct departure, such as where the trip violates work requirements or lawful employer directives, or contradicts the asserted recreation objective, but the findings do not support such a conclusion here.

The Board's incorrect interpretation of the "distinct departure on a personal errand" exception is an error of law.

Reversed and remanded.

² Few would disagree with our view that a pick-up basketball game is more relaxing, healthier and less likely to result in injury than the drinking and fighting that we held in *Slaughter v. SAIF, supra*, were not a distinct departure on a personal errand.

Cite as 123 Or App 349 (1993)

September 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Pedro Mendoza, Claimant.

PEDRO MENDOZA, Petitioner,

v.

SAIF CORPORATION, JOSE AND JESUS FOREST, NW CONTRACTING AND WAUSAU
 INSURANCE COMPANY, Respondents.
 (90-12948; 90-12949; CA A73642)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 2, 1992.

Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief were Stanley Fields and the Law Office of Michael B. Dye, Salem.

Richard Rizk, Beaverton, argued the cause and filed the brief for respondents Wausau Insurance Company and NW Contracting.

Virginia L. Linder, Solicitor General, Salem, waived appearance for respondents SAIF Corporation and Jose and Jesus Forest.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

123 Or App 351 > Claimant seeks review of a final order of the Workers' Compensation Board. The Board found that claimant had not established good cause for an untimely filing of a request for hearing from a responsibility denial. We review for errors of law, ORS 183.482(8), and affirm.

The issue is whether claimant established good cause under ORS 656.319(1)(b),¹ by proving that his attorney gave two timely directives to his legal assistant to file a request for hearing, but she failed to do so. The Board found these facts: Claimant was consecutively employed by two employers. The first employer was insured by SAIF Corporation (SAIF) and the second employer was insured by Wausau Insurance Company (Wausau). Claimant filed an aggravation claim against SAIF and an industrial injury claim against Wausau. SAIF denied the aggravation claim, and Wausau denied responsibility for the new injury claim.

Wausau's responsibility denial, dated June 25, 1990, was received by claimant's attorney some time before July 25, 1990. Claimant's attorney had 60 days within which to request a hearing on the denial. ORS 656.319(1)(a). Claimant's attorney twice instructed his legal assistant to request a hearing and asked her to hand deliver the request. The legal assistant forgot to file the request for hearing and did not discover her error until after the 60-day period for filing had passed. Claimant's attorney filed a supplemental request for hearing on November 6, 1990, within the 180-day limit to file if a claimant proves good cause. ORS 656.319(1)(b).

Claimant has the burden to prove good cause for the untimely filing of the hearing request. ORS 656.319(1)(b). Good cause, as used in ORS 656.319(1)(b), means the same kind of "mistake, inadvertence, surprise or excusable <123 Or App 351/352> neglect" that permits relief from a default judgment under former ORS 18.160 and ORCP 71B(1). *Brown v. EBI Companies*, 289 Or 455, 458, 616 P2d 457 (1980); *Sekernestrovich v. SAIF*, 280 Or 723, 727, 573 P2d 275 (1977); *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986).

¹ ORS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

In *Sekermestrovich v. SAIF, supra*, the court held that the failure of an attorney to file a request for hearing did not constitute good cause under ORS 656.319(1)(b), unless the attorney's reason for failing to file would be good cause if attributed to the claimant. 280 Or at 727. See also *EBI Companies v. Lorence*, 72 Or App 75, 695 P2d 61, rev den 299 Or 118 (1985).² In *Brown v. EBI Companies, supra*, the issue was "whether the claimant is disqualified as a matter of law when neither she nor her attorney has carelessly neglected to make a timely request for hearing but the failure to do so is attributable to someone in the attorney's office." 289 Or at 458. In that case, the denial letter did not reach the claimant's attorney or his secretary "for some unexplained reason" in time to file a request for hearing. 289 Or at 459. The court held that a finding of good cause was not foreclosed under the circumstances and returned the case to the Board. The court noted:

"[O]nce 'good cause' under ORS 656.319(1)(b) is equated with the excuses stated in [former] ORS 18.160, it is at least within the range of discretion to relieve a claimant from a default caused by the mistake or neglect of an employee who is not charged with responsibility for recognizing and correctly handling the message that constitutes the legally crucial notice from which the time to respond is measured." 289 Or at 460.

In this case, the attorney and the legal assistant were responsible for filing the request for hearing. The Board correctly concluded: "[B]ecause failure to request a hearing by someone charged with that responsibility is not excusable <123 Or App 352/353> neglect, we hold that claimant has failed to establish good cause for his untimely request * * *." We find no error.

Claimant argues in his second assignment of error that he is not time barred under ORS 656.319(1), because Wausau denied only responsibility, not compensability of his claim. He relies on *Hanna v. McGrew Bros. Sawmill*, 44 Or App 189, 605 P2d 724, mod 45 Or App 757, 609 P2d 422 (1980). In *Hanna*, we held that the claimant's failure to timely file a request for hearing against one of two insurers did not bar his appeal, because compensability was not at issue, and because an ORS 656.307 order had issued. The case before us is distinguishable. SAIF denied compensability and an ORS 656.307 order never issued.

Affirmed.

² In *EBI Companies v. Lorence, supra*, we held that the negligence of the attorney's secretary in failing to return dictation concerning a request for hearing did not excuse the primary negligence of the attorney, where the attorney was aware of the exact date on which the request for hearing had to be filed and by reason of having dictated the request, forgot about the file and deadline. Under those circumstances the claimant did not establish good cause. 72 Or App at 78.

Cite as 123 Or App 358 (1993) September 22, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Olga I. Soto, Claimant.

OLGA I. SOTO, Petitioner - Cross-Respondent,

v.

SAIF CORPORATION and LITTLE LEARNING CENTER, Respondents - Cross-Petitioners.

(WCB 91-12369; CA A74702)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 21, 1993.

Edward J. Harri, Salem, argued the cause for petitioner - cross-respondent. With him on the briefs was Stanley Fields, Salem.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents - cross-petitioners. 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.

PER CURIAM

Reversed and remanded for reconsideration on petition and on cross-petition. *Pacheco-Gonzalez v. SAIF Corporation*, 123 Or App 312, ___ P2d ___ (1993).

Cite as 124 Or App 38 (1993)

October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joe Fernandez, Jr., Claimant.

JOE FERNANDEZ, JR., Petitioner,

v.

M & M REFORESTATION and SAIF CORPORATION, Respondents.
(90-18415; CA A73039)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 18, 1992.

Stanley Fields argued the cause for petitioner. With him on the brief was Law Offices of Michael B. Dye.

Jossi Davidson argued the cause for respondent M & M Reforestation. With him on the brief was Gracey & Davidson.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

124 Or App 40 > Claimant seeks review of an order of the Workers' Compensation Board holding that his aggravation claim was non-compensable. We review for substantial evidence and errors of law, ORS 656.304(6) and ORS 183.482(8), and affirm.

The facts, as found by the referee and adopted by the Board, are undisputed. On November 17, 1988, claimant injured his low back while working as a laborer for M & M Reforestation (employer) on a Christmas tree farm. On November 23, 1988, a CT scan of the lumbar spine revealed a disc bulge at L5-S1. A second CT scan in March, 1989, showed the left-sided bulge at L5-S1 and impingement of the left S1 nerve root.

On March 7, 1989, employer accepted claimant's claim for "pulled muscles" of the lumbosacral spine. Claimant completed a three-week therapy program and was considered medically stationary on June 20, 1989. His claim was closed on July 21, 1989 by a determination order awarding him 21 percent unscheduled permanent disability. On June 21, 1990, the parties stipulated that claimant suffered a worsening and reopened and re-closed the claim, awarding him an additional 5 percent unscheduled permanent disability.

In June, 1990, claimant began work as a laborer for a new employer, E. L. Woods, stapling cardboard boxes. On July 12, 1990, while off the job, claimant fell off of his moped. After the accident, his low back pain worsened and he experienced throbbing down his left leg. On August 23, 1990, an MRI scan revealed a worsened disc condition at L5-S1. Claimant has been unable to work since his fall due to his low back and left lower extremity pain. Surgery has been recommended. Claimant filed an aggravation claim with employer. SAIF denied the claim on behalf of employer, an alleged noncomplying employer.

The referee concluded that claimant's aggravation claim was compensable because, although claimant's off-the-job injury materially contributed to his worsened condition, his compensable injury remained the major contributing cause of his worsened condition. The Board adopted the <124 Or App 40/41> referee's findings of fact, but disagreed with the referee's conclusion that claimant's off-the-job injury was not the major cause of his worsened condition. It held that claimant's aggravation claim was not compensable. The Board explained its decision:

"We agree with the Referee that claimant's condition has worsened and we adopt the Referee's Opinion and Conclusions on the issue of claimant's worsened condition. However, inasmuch as the July 12, 1990 mo-ped [*sic*] injury, which did not occur in the course and scope of claimant's employment, contributed to his worsened condition, *he must also prove legal causation.*

"Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. See *Robert E. Leatherman*, 43 Van Natta 1677 (1991). However, if there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); *Elizabeth A. Bonar-Hanson*, 43 Van Natta 2578 (1991)." (Emphasis supplied.)

The Board went on to conclude that, read as a whole, the testimony of claimant's treating physician, Dr. Wright, established that the major cause of claimant's worsened condition was the moped accident.

As a threshold matter, claimant assigns as error the Board's allocation of the burden of proof. He argues that the Board required him to prove either that his off-the-job injury was not the major cause of his worsened condition or that his compensable injury was the major contributing cause of his worsened condition in order to establish compensability of his aggravation claim. Claimant relies on the Board's statement that "claimant must prove legal causation." Employer argues that the Board did not err, because ORS 656.266 places the burden of proving compensability on the worker.

ORS 656.266 provides that "[t]he burden of proving that an injury or occupational disease is compensable * * * is on the worker[.]" 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 <124 Or App 41/42> from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." (Emphasis supplied.)

Under that provision, claimant has a compensable aggravation if he proves that his compensable injury materially contributed to his worsened condition. See *Grable v. Weyerhaeuser Company*, 291 Or 387, 631 P2d 768 (1981). If claimant establishes that, his aggravation claim is compensable unless it is proven that an off-the-job injury is the major cause of his worsened condition.

In *Harris v. SAIF*, 292 Or 683, 690, 642 P2d 1147 (1982), the Supreme Court explained the general rule regarding the allocation of the burden of proof:

"The general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence was introduced on either side."

Applying that rule here, because claimant proved that his compensable injury materially contributed to his worsened condition, his aggravation claim would be compensable if there is no evidence of an off-the-job injury. Employer is the only party with an interest in establishing that an off-the-job injury was the major cause of claimant's worsened condition. As the proponent of that fact, employer has the burden to prove it. See *Harris v. SAIF*, *supra*, 292 Or at 690; ORS 183.450(2).

The Board considered the question of who has the burden of proof in these circumstances in a later decision, which is also presently before this court. *Roger D. Hart*, 44 Van Natta 2189 (1992). We find the Board's reasoning on that issue persuasive:

"ORS 656.266 generally places on the worker '[t]he burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom.' However, we believe that the appropriate analysis must begin with ORS 656.273(1), for the principal question here is not who has what burden of proof. ORS 656.273 is a substantive provision that governs aggravation claims. In plain words, it provides that an employer is authorized to deny an aggravation claim, and <124 Or App 42/43> this Board must uphold such a denial, 'if the major contributing cause of the worsened condition is an injury not occurring in the course and scope of employment.'

"Given the explicit nature of this statutory direction, we must reject the employer's argument that, under ORS 656.273(1), the claimant has the burden of proving that the off-the-job injury is not the major contributing cause or that the compensable injury is the major contributing cause. In doing so, we recognize that under ORS 656.266, generally the injured worker has the burden of proving compensability. We also recognize, however, that only the employer or insurer would have an interest in proposing that the major contributing cause of the worsened condition is an off-the-job injury; and to that extent, the effect, if not the purpose, of the explicit language of ORS 656.273(1) is to assign to the employer the burden of proving facts that only the employer would have reason to propose.

* * * * *

"Reading ORS 656.266 and *amended* ORS 656.273(1) together, we do not find any necessary or irreconcilable conflict between them. Rather, they can be read harmoniously, in a manner that carries out their respective purposes without doing damage to the language of either. We conclude that under ORS 656.266, claimant has the burden of proving that the compensable injury is a material contributing cause of the worsened condition. *Elizabeth A. Bonar-Hanson, supra*. If, pursuant to ORS 656.273(1), the employer denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the employer has the burden of proving it." (Emphasis in original; footnote omitted.)

We conclude that the Board did erroneously place the burden of proof upon claimant. However, in view of the Board's findings in the case, its allocation of the burden of proof was harmless. The Board interpreted the only medical evidence submitted, Wright's testimony, to support the conclusion that claimant's off-the-job injury was the major cause of his worsened condition and therefore held that his aggravation claim was not compensable under ORS 656.273(1). Accordingly, the Board's error in allocating the burden of proof under ORS 656.273(1) does not require reversal.

124 Or App 44 > Claimant next argues that the Board's determination that his off-the-job injury was the major cause of his worsened condition is not supported by substantial evidence. Essentially, claimant argues that the Board's reading of Wright's testimony was unreasonable. According to claimant, the Board "erred in its analysis by focusing upon an off-the-job injury and the effect that injury had upon a 'worsening' rather [than] upon the overall 'worsened condition' which the language of the statute requires."

The Board stated:

"Taken as a whole, we interpret Dr. Wright's opinion to mean that the major cause of claimant's worsened condition was the off-work mo-ped [*sic*] accident. Although Dr. Wright signed a concurrence letter contradicting his original opinion, we find the letter conclusory as there is no explanation for his change of opinion. Accordingly, we decline to rely upon the concurrence letter. Moreover, Dr. Wright's final statement on the subject of causation indicates that, as he originally stated, he believes that the mo-ped [*sic*] accident is the single incident which caused the worsening of claimant's low back condition, as evidenced by the MRI taken after the off-work accident." (Emphasis supplied.)

The Board did not focus on the cause of the worsening of claimant's injury, but rather on the major cause of his worsened condition. Further, although Wright's testimony was confusing, the Board's interpretation of the medical evidence was not unreasonable. For instance, in his deposition, Wright said:

"[Claimant] was in an equilibrium of some sort before I met him where he was working in some capacity, whether full-time, part-time, or full activity, but he was employable. *He had an injury, you know, second injury or new injury from this motorcycle accident that I considered an exacerbation of an underlying problem in his spine.*

"And subsequent to that we have discovered further evidence by MRI scan that the bulging disk is worse, as documented, to have deteriorated, based on his previous studies in November and March of 1989." (Emphasis supplied.)

We hold that the Board's conclusion that the major cause of claimant's worsened condition was his off-the-job injury is supported by substantial evidence.

Affirmed.

Cite as 124 Or App 90 (1993) October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joseph L. Gamble, Claimant.

JOSEPH L. GAMBLE, Petitioner,

v.

NELSON INTERNATIONAL and SAIF CORPORATION, Respondents.
(91-05124; CA A77464)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 23, 1993.

Gordon S. Gannicott waived oral argument for petitioner. With him on the briefs was Hollander, Lebenbaum & Gannicott.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

DE MUNIZ, J.

Affirmed.

Rossman, P.J., dissenting.

124 Or App 92 > Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in failing to assess attorney fees under ORS 656.386(1) for SAIF's withdrawal of its "disclaimer of responsibility" before a hearing had been held.

Claimant filed a claim for a back injury and received a "disclaimer of responsibility" from SAIF, pursuant to ORS 656.308(2),¹ in which SAIF contended that claimant's subsequent employer was responsible for the claim. Claimant <124 Or App 92/93> requested a hearing, and shortly before the hearing, SAIF withdrew its disclaimer. The only question on review is whether claimant's attorney is entitled to fees for having been instrumental in obtaining the withdrawal of the disclaimer.

¹ ORS 656.308(2) provides:

"No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating a paying agent under ORS 656.307. Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

OAR 438-05-053, which implements the statute, provides, in part:

"(1) If a self-insured employer or insurer intends to disclaim responsibility for a claim on the basis of injury or exposure with another employer, the self-insured employer or insurer shall, not later than 30 days after being named or joined in the claim, mail to the claimant a notice stating its intent to disclaim responsibility. The notice shall:

"(a) Identify the condition(s) for which responsibility is being disclaimed;

ORS 656.386(1) provides, in part:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. *If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed.*" (Emphasis supplied.)

There are two reasons why we conclude that the emphasized language does not authorize an insurer-paid attorney fee in <124 Or App 93/94> this case. Under the circumstances of this case, SAIF's "disclaimer" of responsibility, pursuant to ORS 656.308(2), is not a denial. Although SAIF could have chosen to deny the claim in the same document, *see* OAR 438-05-053, it did not. The disclaimer is not subject to the procedures of ORS 656.262(6). It serves only to notify the claimant that the claim may be compensable against another employer or insurer. We conclude that it does not trigger the provisions of ORS 656.319 regarding the request for hearing, and does not provide a basis for the assessment of attorney fees under ORS 656.386(1).

"(b) State the factual and legal reasons for the disclaimer of responsibility for compensation, and if the condition is also denied, for the denial;

"(c) Identify each injury or period of exposure which the self-insured employer or insurer claims is responsible for the claimant's condition, as follows:

"(i) The names and addresses of each allegedly responsible employer and of its insurer, if any;

"(ii) The specific date(s) of injury or exposure;

"(d) State whether the self-insured employer or insurer has requested the appointment of a paying agent pursuant to ORS 656.307.

"(2) The notice of intent to disclaim responsibility shall not be deemed a denial of the claim for purposes of ORS 656.319 unless the self-insured employer or insurer so states in the notice.

"(3) A notice of intent to disclaim responsibility that is not a denial of the claim shall include the following notice, in prominent or bold-face type, using the following paragraph divisions:

"THIS IS A NOTICE THAT WE BELIEVE ANOTHER EMPLOYER OR INSURER MAY BE RESPONSIBLE FOR YOUR CONDITION AND BENEFITS. YOU HAVE 60 DAYS FROM THE DATE OF THIS LETTER TO MAKE A WRITTEN CLAIM WITH THE EMPLOYER(S) OR INSURER(S) LISTED ABOVE.

"IF IN 60 DAYS YOU DO NOT MAKE A CLAIM WITH AN EMPLOYER OR INSURER WHO IS LATER FOUND RESPONSIBLE FOR YOUR CONDITION, YOU WILL LOSE YOUR BENEFITS. YOU MAY BE REPRESENTED BY AN ATTORNEY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES. IF YOU HAVE QUESTIONS YOU MAY CALL THE COMPLIANCE SECTION TOLL FREE IN OREGON AT 1-800-452-0288 OR IN SALEM OR FROM OUTSIDE OREGON AT (503) 378-4956."

"(4) A notice of intent to disclaim responsibility that is also a denial of compensation shall include the following notice, in prominent or bold-face type, using the following paragraph division:

"THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS. IF YOU THINK THIS DENIAL IS NOT RIGHT, YOU MUST DO TWO THINGS TO PROTECT YOUR RIGHTS:

"(1) WITHIN 60 DAYS OF THE DATE OF THIS LETTER, YOU MUST REQUEST A HEARING. * * *

"(2) WITHIN 60 DAYS MAKE A WRITTEN CLAIM WITH THE EMPLOYER(S) OR INSURER(S) LISTED IN THIS LETTER. IF IN 60 DAYS YOU DO NOT MAKE A CLAIM WITH AN EMPLOYER OR INSURER WHO IS LATER FOUND RESPONSIBLE FOR YOUR CONDITION YOU WILL LOSE YOUR BENEFITS."

Additionally, as the Supreme Court has held, an assessed fee is available under ORS 656.386(1) only if the claimant finally prevails "from an order or decision denying the claim for compensation." *Shoulders v. SAIF*, 300 Or 606, 611, 716 P2d 751 (1986). When the issue in the case does not concern the compensability of the claim, the statute is inapplicable. See *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988); *Multnomah County School Dist. v. Tigner*, 113 Or App 405, 408, 833 P2d 1294 (1992); *Mercer Industries v. Rose*, 103 Or App 96, 98, 795 P2d 615, *rev den* 311 Or 150 (1991). SAIF's disclaimer did not create an issue concerning the compensability of the claim.

In 1991, the legislature added the emphasized language to ORS 656.386(1), in response to our decision in *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *mod.* 108 Or App 230, 814 P2d 558 (1991), in which we had held that, in order to recover an assessed fee under ORS 656.386(1), the claimant must have prevailed after a hearing. We read the new language as making the statute applicable to cases in which a hearing is not held; however, we do not read it as a general expansion of the terms of the statute so as to provide a basis for an assessed fee in any case in which an attorney is instrumental in obtaining compensation for the claimant, even if the other requirements of the statute, as interpreted by the cases, have not been satisfied. See *SAIF v. Allen*, 124 Or App 183, ___ P2d ___ (1993).

In order to obtain an assessed fee under ORS 656.386(1), the claimant must still prevail from an order or decision denying a claim for compensation. Here, SAIF only disclaimed responsibility for the claim. Despite the fact that <124 Or App 94/95> claimant's attorney may have been instrumental in obtaining SAIF's withdrawal of its disclaimer, that is not a service for which an assessed fee is available under the statute.²

Affirmed.

² We note that ORS 656.307 contains a provision for assessed attorney fees in cases processed under that statute, when the claimant "actively and meaningfully participates" through an attorney. ORS 656.307(5).

ROSSMAN, P.J., dissenting.

Because SAIF sought to assert that an out-of-state employer was responsible for claimant's injury, SAIF's "disclaimer of responsibility" was, for all practical purposes, a denial of the claim, and I would hold that it triggered claimant's right to seek a hearing pursuant to ORS 656.319. Because claimant's only chance for compensation was from SAIF, when SAIF withdrew its disclaimer of responsibility, claimant prevailed. Claimant's attorney was instrumental in securing the withdrawal of SAIF's disclaimer of responsibility and in obtaining compensation for claimant, and I would hold that claimant is therefore entitled to insurer-paid attorney fees under ORS 656.386(1). See *SAIF v. Allen*, 124 Or App 183, ___ P2d ___ (1993).

Cite as 124 Or App 117 (1993)

October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Babette Stone, Claimant.

BABETTE STONE, Petitioner,

v.

WHITTIER WOOD PRODUCTS and SAIF CORPORATION, Respondents.
 (90-06254; CA A70323)

In Banc*

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed January 20, 1993. Opinion filed November 18, 1992. 116 Or App 427, 841 P2d 700.

Submitted in banc July 14, 1993.

Edward J. Harri for petition.

DURHAM, J.

Reconsideration allowed; opinion vacated; reversed and remanded.

Deits, J., dissenting.

*Landau, J., not participating.

124 Or App 119 > Claimant petitions for review of our opinion in *Stone v. Whittier Wood Products*, 116 Or App 427, 841 P2d 700 (1992). We treat it as a petition for reconsideration, ORAP 9.15(1), allow it, vacate our opinion and reverse.

We restate the pertinent facts. Claimant was discharged from her job on September 11, 1988. At that time, she was working in a light duty because of a February, 1989, injury at work. Employer had increased her wage at injury from \$6.97 per hour at the time of injury to \$7.48 per hour at the time of her discharge. The parties dispute the reason for the discharge. Employer claims that it fired claimant because of her absenteeism and violation of a last chance agreement regarding non-use of drugs and alcohol. Claimant argues that she was fired because she has, or employer believes she has, a physical or mental impairment, in violation of ORS 659.425(1).¹ She claims that she was entitled to temporary partial disability (TPD) after the discharge because the firing was unlawful, and her earning power at the time of discharge was not equal to or greater than her earning power at the time of injury.

We sustained the Board's denial of benefits, concluding that the Board was not required to determine whether her discharge violated ORS 659.425 before deciding her eligibility for TPD. 116 Or App at 430. Claimant does not petition for reconsideration of that holding. We incorporate and adopt our discussion and holding on that issue from our earlier opinion.

¹ ORS 659.425(1) provides, in part:

"For the purpose of ORS 659.400 to 659.460, it is an unlawful employment practice for any employer to refuse to hire, employ or promote, to bar or discharge from employment or to discriminate in compensation or in terms, conditions or privileges of employment because:

"(a) An individual has a physical or mental impairment which, with reasonable accommodation by the employer, does not prevent the performance of the work involved;

"(c) An individual is regarded as having a physical or mental impairment."

We also rejected claimant's earning power argument, holding that the Board properly considered her "actual wages at the time of the termination," 116 Or App at 431, and that, <124 Or App 119/120> under *Owsley v. Safeway Stores*, 91 Or App 475, 756 P2d 48 (1988), she was not entitled to TPD after her termination. She seeks reconsideration of that holding, contending that, in determining her right to TPD under ORS 656.212, the Board must consider her proportionate loss of earning power at any kind of work, not her loss in actual wages from the time of injury. She also argues that the Board rule on this subject, OAR 436-60-030(2),² is inconsistent with ORS 656.212. We allow reconsideration to address those arguments and conclude that she is correct.

ORS 656.212 provides:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of injury." (Emphasis supplied.)

Employer contends that we should follow our ruling in *Fink v. Metropolitan Public Defender*, 67 Or App 79, 83, 676 P2d 934 (1984), that "[e]arning power," as used in ORS 656.212, therefore, refers to a worker's pre-injury wages.³ Claimant contends that that ruling is inconsistent with the terms of ORS 656.212. In *Fink*, we said:

"ORS 656.212 provides:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury." * * *

"As the statute indicates, compensation for temporary partial disability is to be calculated on the basis of payments for temporary total disability, which are provided by ORS 656.210.

<124 Or App 121> "Because of the interrelationship of the statutes, we look to the function and purpose of ORS 656.210 for guidance in construing ORS 656.212. Under ORS 656.210, temporary total disability is computed on the basis of the claimant's actual wages at the time of the injury. ORS 656.210(1). The purpose of temporary total disability is to compensate a claimant for loss of income until the condition becomes medically stationary, not to compensate for the work-related injury and disability, which is a function of a permanent disability award. *Taylor v. SAIF*, 40 Or App 437, 440, 595 P2d 515, rev den 287 Or 477 (1979). Considering ORS 656.212 in the context of the statutory scheme, we conclude that it too is designed only to maintain a worker's income at or near the worker's pre-injury level of earnings. 'Earning power,' as used in ORS 656.212, therefore, refers to a worker's pre-injury wages. We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings." 67 Or App at 82. (Emphasis in original.)

² OAR 436-60-030(2) provides, in part:

"Temporary disability payments are not due if post-injury wages are equal or are greater than the wages earned at the time of injury."

³ The holding in *Fink v. Metropolitan Public Defender*, *supra*, was recited without analysis in dictum in *Owsley v. Safeway Stores*, *supra*, 91 Or App at 479.

We interpret a statute by examining its text and context. ORS 174.010; *Porter v. Hill*, 314 Or 86, 91, 838 P2d 45 (1992). We should give effect to every word, phrase, sentence and section, if possible. *Sanders v. Oregon Pacific States Ins. Co.*, 314 Or 521, 527, 840 P2d 87 (1992).

We note that *Fink* examined the context of ORS 656.212, but did not examine its words, particularly the references to "earning power." In *Fink*, we noted that TPD is calculated as a proportion of temporary total disability (TTD), which "is computed on the basis of the claimant's actual wages at the time of injury," under ORS 656.210(1). 67 Or App at 82. We proceeded from that statement to the conclusion that TPD was "designed only to maintain a worker's income at or near the worker's pre-injury level of earnings." We did not attempt to interpret the statutory phrase "which his loss of earning power at any kind of work bears to his earning power existing at the time of the occurrence of the injury." 67 Or App at 82. The failure to consider all of the statute's words was an error, because they are the primary manifestation of the legislature's intent.

The language of ORS 656.212 demonstrates that the legislature chose to measure TPD by determining the <124 Or App 121/122> proportionate loss of "earning power," rather than proportionate loss of pre-injury wages. Moreover, TPD is measured by the loss of earning power "at any kind of work," not only at the job held at injury. If the legislature had intended TPD to measure only the worker's proportionate decrease in pre-injury wages, it could have said so. It did not. The worker's decrease in wages may control the TPD calculus in most cases. However, the statute protects the parties' right to prove that actual wage loss does not reflect the proportionate loss of earning power at any kind of work.

The discussion in *Fink* about ORS 656.210, which we described as the context of ORS 656.212, does not logically compel the conclusion that we drew. Under ORS 656.210, TTD is calculated as a percentage of lost wages. As we said in *Fink*:

"The purpose of temporary total disability is to compensate a claimant for loss of income until the condition becomes medically stationary, not to compensate for the work-related injury and disability, which is a function of a permanent disability award." 67 Or App at 82.

However, in the context of TPD, the claimant is partially, not totally, disabled. The claimant is capable of earning a wage, but the extent of her disability, age, education and adaptability to perform a job may reduce or enhance the worker's earning power in any given case. The determination of the extent of a partially disabled worker's lost earning power is often a complex task. Nothing in ORS 656.212 or its context suggests that the legislature intended to avoid that task by using the amount of TTD payments under ORS 656.210 as the starting point for determining TPD. Moreover, the purpose of TPD as partial wage replacement, rather than as compensation for disability, does not relieve the Board of the duty to measure the extent of the disability by the proportionate loss of earning power at any kind of work. We now consider both the text and context of ORS 656.212 and conclude that the legislature did not intend to confine "earning power" to the wage at injury, and overrule *Fink v. Metropolitan Public Defender*, *supra*.

The Supreme Court's reasoning in *England v. Thunderbird*, 315 Or 633, 848 P2d 100 (1993), supports our conclusion. In *England*, the court invalidated a series of <124 Or App 122/123> Department of Insurance and Finance (DIF) rules relating to permanent partial disability that barred consideration of the worker's age, adaptability and education if the worker returned to work. 315 Or at 639. The applicable statute, ORS 656.214(5),⁴ required the Board to rate permanent partial disability by determining the "permanent loss of earning capacity due to the compensable injury" and, in making that determination, to consider "such factors as age, education, impairment and adaptability to perform a given job." As the court explained, the administrative rules rested on the false assumption that a worker who returns to the pre-injury job and, therefore, suffers no permanent loss of *earnings*, has not lost *earning capacity*. The court rejected that assumption:

⁴ The statute has since been amended. Or Laws 1990, ch 2, 7.

"[L]oss of earning capacity extends beyond the mere ability to retain the same job or earn the same wage to the ability to obtain and hold gainful employment in the broad field of general occupations." *Förmer* ORS 656.214(5). As the Court of Appeals has observed, the fact that one employer has been accommodating and the employee retains the same job or earns the same wage is "no indication that other potential employers would be as accommodating." *Howerton v. SAIF*, 70 Or App 99, 103, 688 P2d 422 (1984). That is, post-injury employment may establish *earnings*, but it does not necessarily establish *earning capacity*:

"Earning capacity must be considered in connection with a [worker's] handicap in obtaining and holding gainful employment in the broad field of general industrial occupations, and not just in relationship to his occupation at any given time. A [worker's] post-injury earnings is evidence which, depending upon the circumstances of an individual case, may be of great, little, or no importance in determining loss of earning capacity." *Smith v. SAIF*, 302 Or 396, 401-02, 730 P2d 30 (1986) (quoting *Ford v. SAIF*, 7 Or App 549, 552-53, 492 P2d 491 (1972)).

"Through statutory directive and historical interpretation, a person's post-injury earnings cannot solely determine the person's earning capacity." 315 Or at 639. (Emphasis in original.)

England v. Thunderbird is not directly controlling here, because it construed the statute that specified the <124 Or App 123/124> criteria for rating permanent, not temporary, partial disability. However, *England v. Thunderbird* is helpful, because it acknowledges the legislature's effort, which is evidenced in ORS 656.212, to require the Board to consider the worker's position in the job market, and not merely the reduction in wages, when it evaluates the loss from a partial disability. In restricting TPD, *i.e.*, the proportionate loss of earning power at any kind of work, to the actual wage loss, if any, on returning to work, our prior decision followed the same false assumption that *England v. Thunderbird* rejected in the PPD context.

To paraphrase *Howerton v. SAIF*, *supra*, 70 Or App at 103, the fact that one employer has been accommodating and has allowed claimant to retain her pre-injury wage even though she is disabled from performing her pre-injury work is "no indication that other potential employers would be as accommodating." The post-injury wage is evidence that, depending on the circumstances, may be of great, little, or no importance in determining whether the worker has a diminished "earning power at any kind of work" under ORS 656.212. See *Ford v. SAIF*, *supra*, 7 Or App at 552. The Board should determine the proportionate diminution in "earning power at any kind of work" by evaluating all of the relevant circumstances that affect the worker's ability to earn wages. One employer's willingness to pay the pre-injury wage does not necessarily establish that the claimant has no lost earning power "at any kind of work."

Applying the correct test here could make a substantial difference to claimant. After her surgery, employer restored her to a lower-paying job but voluntarily continued her pre-injury higher wage. She correctly notes that that was the equivalent of an employer-paid TPD program. When employer terminated her after a few months, she was still disabled from performing her pre-injury job, but the Board denied claimant any amount of TPD, to which she otherwise would have been entitled for up to two years.⁵ Other <124 Or App 124/125> employers might not be as accommodating as her employer at the time of injury. The Board should not terminate her statutory entitlement to two years of TPD because one employer was willing to re-employ her after surgery at her former wage.

Reconsideration allowed; opinion vacated; reversed and remanded.

⁵ The dissent argues that our holding conflicts with *Owsley v. Safeway Stores*, *supra*. Claimant contends that *Owsley* should be overruled. *Owsley* disqualified a worker for temporary benefits after a termination because the firing was unrelated to the injury and the worker was earning the same or higher wages, at the time of termination, than before the injury. Because the Board must determine on remand whether the partial disability caused a proportionate loss of earning power at any kind of work, we do not decide the applicability of *Owsley*, and do not address claimant's criticisms of it.

Deits, J., dissenting.

Claimant sought review of the Board's decision in this case arguing that our holding in *Safeway Stores v. Owsley*, 91 Or App 475, 756 P2d 48 (1988), was not applicable, because claimant's termination was unlawful. In our earlier opinion in this case, we rejected that argument and held that the Worker's Compensation Board was not the proper forum to determine the lawfulness of claimant's termination. The majority's opinion on reconsideration vacates the opinion without addressing that issue. I believe that it is necessary to our disposition of this case to decide that question. In my view, our previous analysis of that issue was correct, and I would not vacate that portion of the opinion.

The second argument made by claimant in her appeal, and the argument that she seeks our reconsideration of, is the question addressed by the majority on reconsideration. That question is whether the administrative rule, adopted by the Department of Insurance and Finance (DIF) and applied by the Board, that allows TPD to be calculated based on lost wages is consistent with ORS 656.212. The majority concludes that the agency's rule is invalid and that the board erred in applying it. I disagree.

At the outset, it is important to keep in mind that the purposes of awards of permanent and temporary disability benefits to a worker are different. Temporary disability benefits are paid for the purpose of compensating a worker for the temporary loss of income during a period of temporary disability due to an injury, while permanent disability benefits are paid to compensate a worker for the rest of their life for total or partial permanent impairment resulting from **<124 Or App 125/126>** an injury. I believe that in its adoption of the disputed rule here, OAR 436-060-030, DIF has acted consistently with the purpose of temporary disability awards and has not violated the terms of ORS 656.212.

As the majority notes, the governing statute is ORS 656.212 which provides:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

DIF's rule adopting a formula for the calculation of TPD provides in pertinent part:

"(1) The rate of temporary partial disability compensation due a worker shall be determined by:

"(a) Subtracting the post-injury wage earnings available from any kind of work; from

"(b) the wage earnings from the employment at the time of, and giving rise to the injuries; then

"(c) dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then

"(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.

"(2) *If the post-injury wage earnings are to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.*" (Emphasis supplied.) OAR 436-060-030.

In two previous decisions of this court, we have considered the application of ORS 656.212 and DIF's rule in calculating a claimant's TPD award. In *Fink v. Metropolitan Public Defender*, 67 Or App 79, 676 P2d 934, *rev den* 296 Or 829 (1984), we considered a prior version of OAR 436-60-030, then codified as OAR 436-54-225. That case involved a situation where a claimant was partially disabled and was not able to work as many hours per week as before the injury. Despite working fewer hours after the injury, however, the claimant's weekly wages were higher than at the time of the injury. We **<124 Or App 126/127>** concluded that, under the applicable rule, the claimant was not entitled to TPD because her actual earnings had not been diminished:

"We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings.

"The formula established by former OAR 436-54-225, for computing loss of earning power comports with our construction of ORS 656.212. The rule provided for an adjustment of the compensation to be paid for the difference between the wages the worker would have received for temporary total disability under ORS 656.210 [which is computed on the basis of the claimant's actual wages at the time of the injury]. If a claimant's post-injury wages exceed the claimant's pre-injury wages, the claimant suffers no loss of earning power and is not entitled to temporary partial disability benefits." (Emphasis supplied.) *Fink v. Metropolitan Public Defender, supra*, 67 Or App at 83.

Safeway Stores v. Owsley, supra, involved a similar issue. In that case, claimant was earning \$3.67 per hour at the time that she was injured. Claimant returned to work and began receiving TPD. However, she soon received an increase in her hourly pay due to a renegotiation of the union contract. She was eventually fired for reasons unrelated to her injury. At the time that she was fired, she was earning more per week than at the time of her injury. The employer refused to continue to pay her TPD after she was fired arguing that, under OAR 436-60-030, she had not lost earnings due to her injury. In deciding *Owsley*, we cited ORS 656.212 and OAR 436-60-030 and quoted with approval from our decision in *Fink*. We then concluded:

"Although *Fink* involved interim compensation, the same analysis is applicable here. Claimant's weekly wages were more during the period for which she seeks compensation than at the time of the injury. Therefore, she is not entitled to benefits for temporary partial disability. The Board's order determining otherwise and assessing a penalty and related attorney fees is therefore reversed, and employer's denial is reinstated.

"We reject claimant's contention that employer was required to begin paying temporary partial disability benefits <124 Or App 127/128> again after she was fired. See *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 744 P2d 295 (1987), *rev den* 305 Or 102 (1988); *Nix v. SAIF*, 80 Or App 656, 723 P2d 366, *rev den* 302 Or 156 (1986). Even 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." *Safeway Stores v. Owsley, supra* at 479-80.

The majority acknowledges that it departs from our holding in *Fink v. Metropolitan Public Defender, supra*, but asserts that its conclusion is compelled by the Supreme Court's recent decision in *England v. Thunderbird*, 315 Or 633, 848 P2d 100 (1993). I disagree. *England* involved the application of the statute governing awards of permanent disability, former ORS 656.214(5), and DIF's rules establishing formulas to calculate such awards. The Supreme Court concluded that DIF's rules were inconsistent with the statute. The language of the statute and rule involved here, however, are quite different than the language of the statute and rule considered in *England*. When the differing language of the statutes is considered, as well as the differing purposes of permanent and temporary disability benefits, I believe that the agency's formula for calculating TPD was not inconsistent with the statute.

The statute considered by the court in *England*, former ORS 656.214(5), provides in pertinent part:

"In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job." (Emphasis supplied.)

The rules that were challenged in *England* provided that, for workers who had returned to their usual and customary work, the factors of age, education and adaptability were not to be considered. The Supreme Court concluded that, because the statute explicitly directed the agency to consider the <124 Or App 128/129> factors of age, education and adaptability, DIF's rules providing that in certain circumstances these factors will not be considered were directly contrary to the statute and, therefore, invalid. Citing the specific factors included in the statute, the use of the term "earning capacity" and the definition of that term as the "ability to obtain and hold gainful employment in the broad field of general occupations," the court concluded that the legislature intended the Board to consider more than an injured person's post-injury wages in making a permanent disability award and that, accordingly, the rule was outside the agency's authority to interpret the statute.

Similarly, the question in this case is whether the agency's adoption of OAR 436-60-030, interpreting and implementing the inexact statutory terms of ORS 656.212, is consistent with the legislative intent in adopting the statute. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980). In *England*, DIF's rules clearly were inconsistent with the statutory directive to the agency. The statute explicitly directed the agency to consider particular factors in adopting the formula for calculation of permanent disability awards, and DIF's rules provided that, in certain circumstances, those factors would not be considered.

Here, by contrast, the statute does not include particular factors to be considered. The statute directs the agency to base the award on "loss of earning power at any kind of work," without further defining those terms. It is true that the statute at issue in *England*, ORS 656.214, uses the term "earning capacity" and the statute here, ORS 656.212, uses "earning power." These terms considered alone are similar. However, when the additional language included in ORS 656.214 is considered together with the differing purposes of these two statutes, I would conclude that it was within the agency's authority to decide that lost earning power may best be calculated by measuring lost wages. That is the reading of the statute that we have made in our previous decisions and, in my view, that holding is consistent with the statutory directive to the agency.

In reaching its conclusion, the majority expresses concern, relying on *Howerton v. SAIF*, 70 Or App 99, 688 P2d 422 (1984), that the fact that one employer is accommodating and continues to pay an injured worker at a higher salary <124 Or App 129/130> should not prevent a worker from being properly compensated for a disability. When we are dealing with an award of permanent disability, as we were in *Howerton v. SAIF*, *supra*, that concern makes sense. A permanent disability award is designed to compensate a worker for an injury for the rest of the worker's life. However, that concern is not so compelling when we are dealing with a temporary disability award that is designed to temporarily replace a worker's wages during the time of an injury. If the worker is being paid the same or a higher salary after an injury, the worker is not being harmed by not being paid additional temporary wage replacement.

The majority concludes its opinion by stating that:

"When employer terminated her after a few months, she was still disabled from performing her pre-injury job, but the Board denied claimant access to any amount of TPD, to which she otherwise would have been entitled for up to two years."

In making this statement, however, the majority again loses sight of our holding in *Owsley*. The majority forgets that, if claimant had not been fired, she would have continued to receive her full wages. It was not her injury that caused her to lose her entitlement to her wages, it was the fact that she was fired.

I would hold that DIF's rule was within its authority to implement the statute and that the Board's application of the rule here was proper. For all of the above reasons, I respectfully dissent.

Richardson, C.J., and Warren and Edmonds, JJ., join in this dissent.

Cite as 124 Or App 141 (1993)

October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Rodney T. Buckallew, Claimant.

PORTLAND ADVENTIST MEDICAL CENTER, Petitioner,

v.

RODNEY T. BUCKALLEW, Respondent.

(90-06594; CA A74163)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 9, 1993.

Patric J. Doherty argued the cause for petitioner. With him on the brief were Karli L. Olson and VavRosky, MacColl, Olson, Doherty & Miller, P.C.

Robert Wollheim argued the cause for respondent. With him on the brief was Welch, Bruun & Green.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

LANDAU, J.

Affirmed.

124 Or App 143 > Employer seeks review of an order of the Workers' Compensation Board that set aside its denial of claimant's occupational disease claim. At issue is whether diabetes-related neuropathy was merely a predisposition to or was a cause of claimant's Charcot's joint, a form of arthritis characterized by erosion and destruction of the joint surfaces and components. Employer disputes the Board's finding that claimant's neuropathy is not an idiopathic cause of his condition. It asserts that the incorrect finding led the Board into the legal error of not weighing claimant's neuropathy against his work activities to determine which was the greater factor. We review to determine whether the Board's findings are supported by substantial evidence. ORS 656.298(6); ORS 183.482(8); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). We affirm.

Claimant is a diabetic who suffers from neuropathy, a progressive loss of sensory perception, in his left foot. He worked for employer as a transportation orderly, escorting patients to and from radiology, helping technicians and working in the file room. His job involved a great deal of walking.

While he was at work on November 7, 1989, claimant experienced pain and swelling in his left calf, ankle and foot. He was unable to work for three days. He then worked until January 12, 1990, when he could no longer perform his duties. Claimant's condition was ultimately diagnosed as Charcot's joint and tendinitis. Employer accepted a claim for the initial swelling, but rejected all other claims for the ankle condition. Claimant requested a hearing on the denial.

The referee found that claimant's work activity was a material contributing cause of his tendinitis and that treatment of the tendinitis accelerated and worsened the progression of the Charcot's joint. It also found that "[c]laimant's diabetic neuropathy created a predisposition to development of Charcot's joint, but did not cause the condition." On review, the Board adopted the referee's findings and added that "repetitive microtrauma due to walking at work was the major contributing cause of claimant's Charcot's joint condition."

124 Or App 144 > Employer contends that the evidence shows that claimant's neuropathy was not merely a predisposition to Charcot's joint but was, instead, a cause of the disease. Because the Board erroneously excluded the neuropathy from its causation analysis, employer argues, its decision should be reversed and remanded. We disagree.

To establish that his Charcot's joint is compensable under ORS 656.802(1)(c) (*since amended* by Or Laws 1990 (Special Session), ch 2, 43), claimant must prove that his on-the-job walking constituted a "series of traumatic events or occurrences" that were the major contributing cause of his condition. *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 502, 812 P2d 844, *rev den* 312 Or 150 (1991). There is, however, a distinction between the cause of a disease and a predisposition to the development of that disease. As we explained in *Liberty Northwest Ins. Corp. v. Spurgeon*, 109 Or App 566, 569, 820 P2d 851 (1991), *rev den* 313 Or 210 (1992):

"An employer is responsible for a disease that a claimant who has a particular susceptibility or predisposition develops due in major part to conditions at work. The predisposition to disease is not a bar to compensability, if work causes the disease. In that sense, the employer takes that employee as it finds her. If, in contrast, a claimant develops a disease in major part because of factors personal to her that are independent of any activities or exposures either off or on the job, the claim is not compensable, even if work contributed to some degree to causing the disease."

Here, the Board's finding that claimant's neuropathy is but a predisposition to, and not a cause of, his Charcot's joint is borne out by the evidence.

Claimant's treating endocrinologist explained how Charcot's joint develops. Ordinarily, a person will avoid repetitive trauma that causes microfractures in the bones of the ankle, because a person has "a sense of where those joints are." However, a person who has a neuropathic joint has a "loss of position sense known as proprioception." Without proprioception, a person cannot feel the pain and, therefore, does nothing to avoid the trauma that leads to Charcot's joint. He referred to the neuropathy as a "pre-condition" to Charcot's joint, but clarified that this means that the neuropathy <124 Or App 144/145> creates a susceptibility to the disease. What causes the Charcot's disease is "repeated trauma."

The reviewing internist testified that claimant's condition was a function of a combination of neuropathy, tendinitis and work-related trauma. Neuropathy alone, he testified, was not the cause of claimant's condition; it only made claimant more susceptible to injury. He further stated that Charcot's joint can occur without neuropathy and that, although the genesis of claimant's condition was very difficult to describe, what caused claimant's condition was his "work situation."

Claimant's orthopedic surgeon testified that neuropathy is an "essential element" of Charcot's joint, but only in the sense that it creates conditions under which trauma can create the damage to the joint without notice.

In short, the evidence shows that neuropathy only causes loss of feeling. The loss of feeling, in turn, prevents the person with neuropathy from avoiding trauma. Once the joint has been injured, the risk of damage is increased. The loss of feeling does not itself create trauma; it is trauma that causes the Charcot's joint. All of the evidence shows that claimant's on-the-job walking caused trauma to his ankle, and employer does not argue that claimant suffered contributory trauma from any off-the-job activities. The Board's findings are supported by substantial evidence.

Employer's argument concerning attorney fees requires no discussion.

Affirmed.

Cite as 124 Or App 183 (1993)

October 20, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON,
In the Matter of the Compensation of Trina K. Allen, Claimant.

SAIF CORPORATION and ROSE'S RESTAURANT, Petitioners,

v.

TRINA K. ALLEN, Respondent.

(91-09837; CA-A76538)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 29, 1993.

David L. Runner, Assistant Attorney General, argued the cause for petitioners. On the brief were Charles S. Crookham, Attorney General, Virginia L. Linder, Solicitor General, and Julie K. Bolt, Special Assistant Attorney General.

Karen Stolzberg argued the cause for respondent. With her on the brief was Goldberg & Mechanic.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

Reversed as to assessment of attorney fees under ORS 656.386(1); otherwise affirmed.

De Muniz, J., concurring.

Rossman, P.J., dissenting.

124 Or App 185 > SAIF and Rose's Restaurant seek review of an order of the Workers' Compensation Board determining that claimant is entitled to attorney fees under ORS 656.386(1) for having prevailed on the question of entitlement to compensation for medical bills related to a compensable claim. We conclude that the Board erred in assessing attorney fees, and reverse in part.

Claimant sustained a compensable back injury in 1988 while working as a waitress for Nendel's. In 1989, she sustained another back injury while working for Rose's Restaurant, SAIF's insured. The insurers agreed that the injury was compensable, and in August, 1990, SAIF was assigned responsibility for claimant's upper back and cervical conditions. It paid some medical bills, but did not pay others until after claimant had requested a hearing regarding the nonpayment. At the hearing, the parties agreed that SAIF had paid the bills late and that claimant was entitled to a penalty under ORS 656.262(10), and a related attorney fee under ORS 656.382(1). The Board, in affirming the referee, also awarded attorney fees under ORS 656.386(1) on the basis of its conclusion that claimant's attorney had been "instrumental in obtaining compensation" for claimant.

The only issue is whether claimant was entitled to attorney fees under ORS 656.386(1), which provides:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. *If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed.* Attorney fees provided for in this section shall be paid by the insurer or self-insured employer." (Emphasis supplied.)

A claimant is entitled to attorney fees under ORS 656.386(1) only in an appeal "from an order or decision denying the claim for compensation." *Shoulders v. SAIF*, 300 Or 606, 611, 716 <124 Or App 185/186> P2d 751 (1986); *O'Neal v. Tewell*, 119 Or App 329, 850 P2d 1144 (1993). Here, the compensability of claimant's injury was never disputed. She sought a hearing regarding nonpayment of some medical bills. The Supreme Court has held that "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, ORS 656.386(1) is not the applicable attorney fee statute * * *." *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988). Because the compensability of claimant's injuries was not at issue in the hearing, her attorney was not entitled to an award of fees under ORS 656.386(1).

The unsettled question of statutory construction raised by this case is whether the emphasized language of the statute provides an independent basis for the assessment of attorney fees. The Board appears to believe that it does. We disagree. The legislature added the emphasized language to the statute in 1991, in response to our original decision in *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *mod* 108 Or App 230, 814 P2d 558 (1991), in which we held that, in order to recover an assessed fee under ORS 656.386(1), the claimant must have prevailed by a decision of the referee. We said that, if a matter was resolved by a stipulation of the parties or by a withdrawal of the denial, rather than by a decision of the referee, then the statute was inapplicable. Following that decision, the legislature amended the statute to specifically provide for an award of attorney fees to a claimant who prevails even if a hearing is not held, so long as the claimant's attorney is instrumental in having the claim determined to be compensable. The added language, read in the context of the statute, does not provide an independent basis for an award of attorney fees apart from the other requirements of the statute. It merely establishes that attorney fees may be assessed if a hearing is not held. The claimant must otherwise be entitled to them under the provisions of the statute and the cases interpreting it.

The Board erred in assessing attorney fees under ORS 656.386(1) in this case, because the subject of the hearing was not the compensability of claimant's injuries. The hearing involved a dispute about payment of medical bills.

124 Or App 187 > Reversed as to assessment of attorney fees under ORS 656.386(1); otherwise affirmed.

DE MUNIZ, J., concurring.

If I were writing on a clean slate, I would conclude that the referee and the Board were correct in awarding attorney fees under ORS 656.386(1) and a penalty under ORS 656.262(10). However, the Supreme Court has indicated that an insurer's failure to timely respond to a claim for compensation may not be construed as a *de facto* denial. If that is the case, then the lead opinion's conclusion that claimant is not entitled to attorney fees is correct, because an initial denial is a prerequisite to the recovery of attorney fees under ORS 656.386(1).

In my view, an insurer's failure to timely accept or deny a claim ought to be considered a denial, and that should entitle the claimant to attorney fees under ORS 656.386(1), which provides, in part:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed."

The first sentence of ORS 656.386(1) governs the award of attorney fees when either of Oregon's appellate courts review a claim for compensation. That sentence clearly makes "an order or decision denying the claim" a prerequisite to an award of attorney fees by the court.

The second sentence governs the award of attorney fees in cases decided by a referee or by the Board. That sentence begins with the words, "[i]n such rejected cases." That phrase establishes that a claimant who prevails in a <124 Or App 187/188 > hearing is entitled to attorney fees only if the claim has initially been rejected (*i.e.*, denied) by the insurer.¹

¹ The term "shall" in ORS 656.386(1) indicates that the referee's duty to allow attorney fees is nondiscretionary. *Dika v. Dept. of Ins. and Finance*, 312 Or 106, 109, 817 P2d 287 (1991); *Benzinger v. Oregon Dept. of Ins. and Finance*, 107 Or App 449, 451, 812 P2d 36 (1991).

Before 1990, ORS 656.386(1) did not contain any provision for the award of attorney fees in the absence of a hearing. Or Laws 1990, ch 2, 29; *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *mod* 108 Or App 230, 814 P2d 558 (1991). Now, an attorney fee is required if the claimant's "attorney is instrumental in obtaining compensation," even though no hearing is held. The purpose of the 1990 amendment is to assuage the effects of resistance to a valid claim that is resolved in favor of a claimant before a hearing is held. The third sentence in ORS 656.386(1) does not expressly state whether an initial denial is a prerequisite to the recovery of attorney fees when no hearing is held, but that requirement is implicit when the structure of ORS 656.386(1) is viewed as a whole.

The third sentence is important in cases like this one, where a recalcitrant insurer realizes that it has no chance of prevailing at a hearing, and it therefore capitulates. Here, SAIF failed to formally accept or deny the claim until claimant requested a hearing. Apparently, claimant's request for a hearing was necessary to get SAIF's attention, and SAIF paid the last of claimant's bills just before the hearing.

Even though SAIF conceded all issues of compensability, a hearing was still necessary for the purpose of determining attorney fees and penalties. The referee found that it was "doubtful that the bills would have been paid if it had not been for claimant's attorney's efforts." There is substantial evidence to support that finding, and the Board adopted it.

The majority and I part ways when it asserts that "the compensability of claimant's injury was not an issue in the hearing." 124 Or App at 186. The initial inquiry is whether SAIF made a "decision denying the claim for compensation." ORS 656.386(1). "Compensation" includes all <124 Or App 188/189> benefits, including medical services, provided for a compensable injury." ORS 656.005(8). "Claim" means a written request for compensation." ORS 656.005(6).

Everyone agrees that claimant suffered a compensable injury to her back while working for Rose's Restaurant. On March 14, 1991, claimant's attorney wrote to SAIF and sent it copies of unpaid medical bills. It cannot be gainsaid that her attorney's letter, accompanied by those bills, was a written request for compensation. SAIF was required to either accept or deny the claim, in writing, by June 12, 1991. ORS 656.262(6). It failed to do so.

SAIF contends:

"A *de facto* denial occurs only when the reason the benefits are not being paid is because the insurer is contesting their compensability and informally rejecting payment."

I wish I could disagree. An insurer should not be permitted to sit idly by and allow the statutorily mandated deadline to pass without giving claimant a definitive response or paying her claim in full.² In my opinion, SAIF's failure to do either was, in effect, a decision denying the March 14 claim for compensation.

However, the Supreme Court has indicated that "[a]n insurer's failure to respond to a claim [as required by ORS 656.262(6)] is neither acceptance [n]or denial." *Johnson v. Spectra Physics*, 303 Or 49, 58, 733 P2d 1367 (1987). The issue in that case was whether an insurer's inaction could be construed as acceptance of a claim. The conclusion that inaction does not constitute denial is therefore *dictum*. I question whether the Supreme Court really intended claimants to languish while insurers failed to obey the law that requires them to accept or deny claims in a timely fashion.

² SAIF did pay some of the bills in April and others in May. However, it did not pay the remaining bills until September.

ROSSMAN, P.J., dissenting.

Because the Board and referee got this one right, I dissent. SAIF readily admits that it did not pay all of claimant's medical bills in a timely fashion. This is definitely not the time for a claimant's attorney to be slumbering at the <124 Or App 189/190> switch. It was only after she filed a request for hearing that the bills were finally paid. ORS 656.386(1) plainly provides that a claimant is entitled to insurer-paid attorney fees if the "attorney is instrumental in obtaining compensation." The Board concluded that claimant's attorney was instrumental in obtaining compensation, and that conclusion is supported by substantial evidence in the record. Accordingly, we should affirm the Board's assessment of attorney fees.

Cite as 124 Or App 246 (1993) November 3, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, Petitioner,

v.

DON WHITAKER LOGGING, INC., Respondent.

(SH-91058; CA A76631)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 14, 1993.

Katherine H. Waldo, Assistant Attorney General, argued the cause for petitioner. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

George W. Goodman argued the cause for respondent. With him on the brief were Jerry K. Brown and Cummins, Brown, Goodman, Fish & Peterson, P.C.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

ROSSMAN, P.J.

Reversed and remanded.

De Muniz, J., concurring.

124 Or App 248 > The Oregon Occupational Safety and Health Division (OR-OSHA), seeks review of an order of a Workers' Compensation Board referee holding that a citation issued by OR-OSHA is invalid.

This is a case of first impression in which we are called upon to decide OR-OSHA's obligations with respect to notifying an employer of an investigation. Employer contends that it is entitled to notification and a presentation of the investigator's credentials before any investigation may begin. OR-OSHA contends that it may begin an off-premises investigation of an accident without first notifying the employer or presenting credentials.

The referee found that, on August 23, 1991, an OR-OSHA safety compliance officer (SCO) began an investigation of the circumstances of a logging accident that had occurred earlier that day on property being logged by employer. At the hospital, not on employer's premises, the SCO contacted and interviewed one or more of the employees involved in the accident. The referee found, further, that employer was not contacted by the SCO "for the purpose of presenting credentials" until the next day.

A citation was issued to employer as a result of the investigation. The referee held that, because the SCO had failed to show his credentials to employer before beginning his investigation, the investigation was commenced in violation of ORS 654.067¹ and, hence, the investigation and resulting citation were invalid.

¹ ORS 654.067 provides, in part:

"(1) In order to carry out the purposes of [the Oregon Safe Employment Act], the director, upon presenting appropriate credentials to the owner, employer or agent in charge, is authorized:

"(a) to enter without delay and at reasonable times any place of employment; and

"(b) to inspect and investigate during regular working hours and at other reasonable times, and within reasonable limits and in a reasonable manner, any such place of employment and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein and to question privately the owner, employer, agents or employees.

"(2) No person shall give an owner, employer, agent or employee advance notice of any inspection to be conducted under [the Oregon Safe Employment Act] of any place of employment without authority from the director.

"(3) Except in the case of an emergency, or of a place of employment open to the public, if the director is denied access to any place of employment for the purpose of an inspection and investigation, such inspection or investigation shall not be conducted without an inspection warrant obtained pursuant to ORS 654.202 to 654.216, or without such other authority as a court may grant in an appropriate civil proceeding. Nothing contained herein,

124 Or App 249 > OR-OSHA contends that ORS 654.067 applies only in the context of an on-site inspection and investigation and does not require a showing of credentials before an off-premises investigation. Employer contends that ORS 654.067(1) defines the scope and extent of OR-OSHA's power to enter, inspect and investigate the place of employment, and to question an employer or its employees, and requires that the questioning of an employee be conducted only upon presentation of credentials to the owner, employer or agent in charge.

We are persuaded that ORS 654.067 addresses only that aspect of the inspection or investigation that is made on the employer's premises. Subsection (1) discusses the director's right to enter, inspect and investigate the premises and question employees. Contrary to employer's suggestion, the reference in paragraph (1)(b) to questioning the "owner, employer, agents and employees," read in context, is intended to regulate questioning that takes place on the employer's premises, and does not restrict the SCO's authority to investigate off the premises.

Although there are administrative rules suggesting that a showing of credentials is a prerequisite to the inspection of a job site, OAR 437-01-055(2); OAR 437-01-075(4); OAR 437-01-080; there is no analogous rule or statute with respect to off-site investigations. Further, under ORS 654.062, the director has broad power to "make such inquiries, inspections and investigations as the director considers reasonable and appropriate." We will not impose limitations on the director's power to carry out its responsibilities under that statute beyond those imposed by the legislature. The evidence here supports only the finding <124 Or App 249/250> that the SCO began his investigation on August 23 by interviewing employees off the job site, and that before inspecting the premises the next day he met with employer and presented his credentials. The Board erred in dismissing the citation.

Reversed and remanded.

however, is intended to affect the validity of a constitutionally authorized inspection conducted without an inspection warrant.

"(4) A representative of the employer and a representative authorized by the employees of the employer shall be given an opportunity to accompany the director during inspection of any place of employment for the purpose of aiding such inspection."

DE MUNIZ, J., concurring.

I agree with the majority's result insofar as it holds that the Board erred in dismissing the citation. However, I write separately because I disagree with the majority's construction of ORS 654.067. The statute provides:

"(1) In order to carry out the purposes of ORS 654.001 to 654.295 and 654.750 to 654.780 [the Oregon Safe Employment Act], the director, upon presenting appropriate credentials to the owner, employer or agent in charge, is authorized:

"(a). To enter without delay and at reasonable times any place of employment;
and

"(b). To inspect and investigate during regular working hours and at other reasonable times, and within reasonable limits and in a reasonable manner, any such place of employment and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein, and to question privately the owner, employer, agents or employees.

"(2) No person shall give an owner, employer, agent or employee advance notice of any inspection to be conducted under ORS 654.001 to 654.295 and 654.750 and 654.780 of any place of employment without authority from the director.

"(3) Except in the case of an emergency, or of a place of employment open to the public, if the director is denied access to any place of employment for the purpose of an inspection and investigation, such inspection or investigation shall not be conducted without an inspection warrant obtained pursuant to ORS 654.202 to 654.216, or without such other authority as a court may grant in an appropriate civil proceeding. Nothing contained herein, however, is intended to affect the validity of a constitutionally authorized inspection conducted without an inspection warrant.

"(4) A representative of the employer and a representative authorized by the employees of the employer shall be given an opportunity to accompany the director during <124 Or App 250/251> inspection of any place of employment for the purpose of aiding such inspection. Where there is no employee representative, or the employee representative is not an employee of employer, the director should consult with a reasonable number of employees concerning matters of safety and health in the place of employment."

The majority characterizes the language of the statute as follows:

"Subsection (1) discusses the director's right to enter, inspect and investigate the premises and question employees. Contrary to employer's suggestion, the reference in paragraph (1)(b) to questioning the 'owner, employer, agents and employees,' read in context, is intended to regulate questioning that takes place on the employer's premises, and does not restrict the SEO's authority to investigate off the premises." 124 Or App at 249.

I disagree with that reading of the statute. In my view, the statute plainly requires the director to present credentials before questioning the owner, employer or employee in connection with an investigation. One obvious purpose of that specific requirement is to make sure that the person being questioned is fully aware of the status and authority of the questioner and of the official and serious nature of the inquiry. Nothing in the statute purports, in any fashion, to limit that requirement to questioning at the employer's premises, nor should it. The reason for requiring the director to present credentials is the same whether the inquiry occurs on the employer's premises or at some other location, such as a hospital. The majority is wrong to read the statute otherwise.

Nonetheless, the majority correctly concludes that the citation should not have been dismissed. Even in the criminal arena, the government's violation of a statute can give rise to suppression only where the statute expressly requires that remedy or "if the law violated was 'designed to protect citizens against unauthorized or illegal [conduct by the government.]'" *State v. Trenary*, 316 Or 172, 176, 850 P2d 356 (1993) (citing *State v. Davis*, 295 Or 227, 237, 666 P2d 802 (1983)). Nothing in ORS 654.067 or other pertinent statutes requires, or even hints, that, in this civil context, a citation should be dismissed because there was not strict <124 Or App 251/252> compliance with the credential presentment required by ORS 654.067.

The manifest purpose of the Oregon Safe Employment Act (the Act) is "to assure as far as possible safe and healthful working conditions for every working man and woman in Oregon." ORS 654.003. Dismissing a valid citation frustrates that purpose. In the absence of an expressed legislative intent to immunize violations of the Act on the basis of procedural irregularities, and in the absence of substantial prejudice to the employer, there is no justification for dismissing the citation.¹

¹ Federal OSHA statutes and administrative rules contain similar requirements for the presentation of credentials. There is virtual unanimity in the federal circuits that, in the absence of prejudice to the employer, an OSHA violation of the credentials requirement does not justify dismissal of the OSHA citation. See, e.g., *Marshall v. C. F. & I. Steel Corp.*, 576 F2d 809, 813-14 (10th Cir 1978); *Marshall v. Western Waterproofing Co., Inc.*, 560 F2d 947, 952 (8th Cir 1977); *Hoffman Construction Co. v. OSHRC*, 546 F2d 281, 282-83 (9th Cir 1976); *Hartwell Excavating Co. v. Dunlop*, 537 F2d 1071, 1073 (9th Cir 1976); *Chicago Bridge & Iron Co. v. OSHRC*, 535 F2d 371, 377 (7th Cir 1976); *Accu-Namics, Inc. v. OSHRC*, 515 F2d 828, 833 (5th Cir 1975), cert den 425 US 903.

Cite as 124 Or App 450 (1993)

November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Howard R. Seney, Claimant.

SAFEWAY STORES, INC., Petitioner,

HOWARD R. SENEY, Respondent.

(WCB 90-10386; CA A73284)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 2, 1992.

Karen O'Kasey argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt.

Michael C. Baxter argued the cause for respondent. With him on the brief was Clayton H. Morrison.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

RICHARDSON, C.J.

Reversed and remanded for reconsideration.

124 Or App 452 > Employer seeks review of a Workers' Compensation Board order which affirmed the referee's holding that claimant's shoulder claim was not barred by a previous settlement.¹ We review for errors of law and substantial evidence, ORS 656.298(6), ORS 183.482(7), (8), and reverse.

Claimant compensably injured his right shoulder in December, 1982, while working as a truck driver for employer. As a result of his injury, he also suffered symptoms in his neck and left shoulder. He filed a claim that was accepted and processed to closure. Because of continued exacerbations of his symptoms, the claim was reopened several times. In May, 1989, a determination order was issued declaring claimant medically stationary and awarding nine percent permanent partial disability and a two percent award for loss of use of his right arm. Claimant timely requested a hearing, arguing that the claim was prematurely closed and that he was entitled to additional temporary and permanent disability benefits.

Over the next several months, claimant and employer engaged in settlement negotiations. One of the issues discussed was the possibility of future aggravation claims. In November, 1989, during the negotiations, claimant injured his left shoulder at work. Claimant's physician diagnosed his symptoms as being a temporary aggravation of the old injury. Claimant's counsel informed employer's counsel of the physician's diagnosis and requested temporary disability benefits. On December 18, employer informed claimant that it believed his aggravation rights had expired and that it would not pay time loss benefits for his November, 1989, injury on the basis of the information it had from his physician. Employer also notified the Board that it was denying the reopening of claimant's claim for time loss benefits. On February 27, 1990, the parties signed and the referee approved a stipulation resolving claimant's appeal of the determination order. The stipulation provided, in part:

124 Or App 453 > "IT IS HEREBY ORDERED that the claimant be and he is hereby awarded additional compensation for 10% unscheduled permanent partial disability equal to 32 degrees for the injury of December 28, 1982, said award amounting to \$3,200, and payment therefore to be made in a lump sum, and

* * * * *

"IT IS FURTHER ORDERED that this stipulation resolves all issues which were raised or which could have been raised by either party on or before the date this settlement is approved by a Referee, and

* * * * *

¹ The Board's order also affirmed the referee's award of penalties for unreasonable claims processing and reduced the referee's award of attorney fees. Employer does not assign error to either of these conclusions by the Board.

"IT IS FURTHER ORDERED that claimant's request for hearing be and it is hereby dismissed with prejudice as to all issues which were raised or which could have been raised."

On March 5, 1990, claimant's physician reversed his previous opinion and stated that claimant's November, 1989, episode was in fact a new injury. Claimant requested time loss benefits from employer and, when he did not receive them, he requested a hearing. In June, 1990, employer denied compensability of the claim on the basis of the February settlement agreement. The referee concluded that the stipulation did not bar the new injury claim, because there had not been a "meeting of the minds" regarding the new injury issue. The Board affirmed.²

Employer argues that the new injury claim is barred by the stipulation, because it was an issue "which could have been raised" before the approval of the settlement. ORS 656.236³ allows the compromise and release of all matters regarding a claim, except for medical benefits, when approved by the Board. The settlement of workers' compensation claims is favored. See *Kasper v. SAIF*, 93 Or App 246, 250, 761 <124 Or App 453/454> P2d 1345 (1988). By the terms of their settlement, the parties settled all issues that were raised or that could have been raised before the settlement was approved. During the negotiations, claimant suffered what both parties believed to be an aggravation of the prior injury. Claimant sought treatment for his condition and requested benefits. Employer denied the benefits for his condition well before the settlement was approved. At this point, claimant was on notice that there was a problem with the compensability of his injury. He did not seek additional consultation regarding his injury, nor did he appeal employer's denial. Both employer and claimant believed that the November injury was covered by the settlement. Regardless of whether claimant's November injury was characterized as an aggravation or as a new injury, his condition and the compensability of a potential claim were at issue during the negotiations and before approval of the settlement. Claimant may not escape his bargain by recharacterizing his claim after the fact.

Reversed and remanded for reconsideration.

² The Board supplemented the referee's findings regarding the nature of claimant's injury and discussed a contention raised by the employer below, but not on appeal. Neither of these additions are pertinent to our discussion.

³ ORS 656.236(1) provides, in pertinent part:

"The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the director may prescribe. Any such disposition shall be filed for approval with the board."

Cite as 124 Or App 484 (1993)

November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald E. Beck, Claimant.

DONALD E. BECK, Petitioner,

v.

JAMES RIVER CORPORATION, Respondent.
(WCB 91-01904; CA A78680)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 10, 1993.

Edward J. Harri argued the cause for petitioner. With him on the brief were Stanley Fields and Law Office of Michael B. Dye.

Margie G. Masters argued the cause for respondent. With her on the brief were John L. Klor and Wallace & Klor, P.C.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

WARREN, P.J.

Reversed and remanded for reconsideration.

124 Or App 486> Claimant seeks review of a Workers' Compensation Board order that upheld employer's denial of claimant's need for medical treatment. We reverse.

Claimant suffered a noncompensable left shoulder injury in 1983. In 1986, he compensably injured the same shoulder and received a permanent partial disability award for that injury. In 1991, claimant received a diagnostic EMG for treatment of an unrelated neck condition. The EMG procedure caused violent muscle contractions in the left shoulder and resulted in a need for medical treatment. Claimant sought payment for the medical treatment of the shoulder.¹ Employer denied that that medical treatment was compensable. The referee and the Board agreed.

The issue is what standard applies to determine the compensability of the medical treatment claim. Claimant argues that the claim is for medical services resulting from the compensable injury under ORS 656.245(1), and that the treatment is compensable if it was caused in material part by the compensable shoulder injury.² Employer argues that this claim for medical services under ORS 656.245 is subject to the major contributing cause standard of ORS 656.005(7)(a)(B).³ We agree with claimant that the material contributing cause standard applies, and disagree with employer that ORS 656.005(7)(a) applies to claims under ORS 656.245 for continued medical treatment for a compensable injury.

124 Or App 487> The Board held that the claim for medical services under ORS 656.245 is subject to ORS 656.005(7)(a)(A), which provides:

"No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

Following *Albany General Hospital v. Gasperino*, 113 Or 411, 833 P2d 1292 (1992), it concluded that claimant's need for treatment was not caused directly by the 1986 industrial accident and, therefore, claimant must show that the compensable shoulder injury was the major contributing cause of the need for treatment. Because claimant had not shown that, it held that the medical services claim was not compensable. The Board did not address employer's argument under ORS 656.005(7)(a)(B).

The Board erred. Medical services "for conditions resulting from the injury" are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245. In *Roseburg Forest Products v. Ferguson*, 117 Or App 601, 845 P2d 930, *rev den* 316 Or 528 (1993), we held that ORS 656.245, rather than ORS 656.005(7)(a)(A), applied to a determination of compensability of a need for resuturing a surgical wound that was originally sutured as treatment for a compensable condition. The claimant had fallen at home following the surgery, causing the sutures to come out. We concluded that the resuturing of the wound was compensable, because it was materially related to the compensable condition. We agreed with the Board that ORS 656.005(7)(a)(A) did not apply, because the fall at home had not given rise to a new injury, and therefore the resuturing was properly characterized as a condition resulting from the injury under ORS 656.245. That treatment was compensable as "continued medical treatment bearing a material relationship to the compensable carpal tunnel syndrome." 117 Or App at 604.

¹ We understand that claimant is seeking review only of the denial of compensability of the need for medical treatment of the left shoulder following the 1991 EMG, and not of any other medical treatment.

² Claimant argued to the Board in the alternative that the claim was for an aggravation of the compensable injury under ORS 656.273. The Board concluded that this was not a claim for an aggravation, and claimant does not challenge that determination on review.

³ ORS 656.005 provides, in part:

"(7)(a) 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; * * * subject to the following limitations:

* * * * *

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

The same is true here. Employer does not argue that the EMG caused a new injury, and claimant does not seek compensation for a new injury or condition. The EMG merely caused a need for further treatment of the compensable shoulder condition.

124 Or App 488 > The Board's attempt to distinguish Ferguson fails. It said:

"In *Ferguson*, the court found that emergency room treatment was compensable under ORS 656.245 as continued medical treatment bearing a material relationship to a compensable carpal tunnel syndrome (CTS) condition. However, there, the claimant had fallen at home following a compensable CTS surgery and required emergency room treatment to resuture his surgical wound. Here, the diagnostic EMG, unlike the CTS surgery and resuturing in *Ferguson*, was unrelated to claimant's compensable condition."

The Board made the wrong analogy. The diagnostic EMG in this case is analogous to the noncompensable fall at home in *Ferguson*. Both were unrelated events that intervened to require further treatment of the compensable condition. The medical treatment for claimant's shoulder condition is analogous to the resuturing in *Ferguson*. Just as that resuturing was necessary to repair damage to the claimant's compensable condition in *Ferguson*, here claimant needed medical treatment to repair damage that the EMG had caused to his compensable shoulder condition. That treatment is compensable if it is materially related to the compensable condition.

The Board's reliance on ORS 656.005(7)(a)(A) and employer's reliance on ORS 656.005(7)(a)(B) is misplaced. ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability of a condition, i.e. to claims for new injuries or conditions different from an already accepted claim. Accord *Roseburg Forest Products v. Ferguson*, *supra*; c.f. *SAIF v. Drews*, 318 Or 1, ___ P2d ___ (1993); *Weyerhaeuser Co. v. Pitzer*, 123 Or App 1, 858 P2d 886 (1993); *Tektronix, Inc. v. Nazari*, 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993). It does not apply to a claim for continued medical treatment of a compensable condition under ORS 656.245(1). Because the Board applied the wrong legal standard, we remand for it to consider whether the need for medical services bears a material relationship to the compensable injury.

Reversed and remanded for reconsideration.

Cite as 124 Or App 538 (1993)

November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gary D. Gallino, Claimant.

GARY D. GALLINO, Petitioner,

v.

COURTESY PONTIAC-BUICK-GMC and SAIF CORPORATION, Respondents.
(WCB 91-07125; CA A78248)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 22, 1993.

Edward J. Harri argued the cause for petitioner. On the brief were Jon C. Correll and Malagon, Moore, Johnson, Jensen & Correll.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

RIGGS, J.

Reversed and remanded.

124 Or App 540 > Claimant seeks review of a Workers' Compensation Board order holding that ORS 656.726(3)(f)(C) vests unreviewable discretion in the director of the Department of Insurance and Finance (DIF) to promulgate temporary disability standards when an impairment is not addressed by existing standards. He also seeks review of the Board's holding that it lacks authority to remand the matter to DIF for further agency action.

While at work, claimant compensably injured his knee. He first saw Dr. Smith and then Dr. Freudenberg. Freudenberg diagnosed grade II chondromalacia, a disability not covered by existing standards. Claimant became medically stationary and returned to work. A notice of closure awarded him 5 percent scheduled permanent disability for the use of his knee. Freudenberg had found a 15 percent loss of knee function due to the chondromalacia.

Claimant requested reconsideration on the ground that his disability was improperly rated. The Order on Reconsideration, dated May 29, 1991, found that

"claimant was declared to be medically stationary on September 26, 1990 by his attending physician, Michael Casey, M.D. The closing examination failed to reveal any permanent loss of use or function in the claimant's injured left knee. However, the Notice of Closure * * * did find claimant to be entitled to 5 percent scheduled permanent partial disability as a result of a chronic condition, even though claimant was released to his regular work. We have concluded that this is adequate compensation for claimant's impairment * * *"

The reference to "Dr. Michael Casey" is enigmatic because the only Michael Casey in the record is a claims adjuster. Presumably the doctor referred to was Freudenberg, claimant's treating physician, who found a 15 percent loss of knee function due to grade II chondromalacia. The order contained no express finding that existing standards adequately addressed claimant's disability.

Claimant requested a hearing. ORS 656.268(6)(b). The referee found that claimant had chondromalacia and that the order on reconsideration made no finding concerning whether chondromalacia could be adequately addressed by <124 Or App 540/541> existing standards. However, he concluded that neither the Board nor its referees can compel the director to make findings about whether existing standards address claimant's disability and he affirmed.

On review, a divided Board affirmed the referee. The Board rejected claimant's argument that ORS 656.726(3)(f)(C) required DIF to promulgate a temporary disability standard rating claimant's disability. The Board also held that it had no authority to remand an order to DIF for findings concerning whether claimant's chondromalacia is adequately addressed by existing standards.

We first address whether ORS 656.726(3)(f)(C) requires DIF to promulgate a temporary rule when a disability is not addressed by existing standards. That statute reads in part:

"When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

SAIF argues that ORS 656.726(3)(f)(C) unambiguously grants the director sole discretion to determine whether a temporary rule is required to compensate claimant. However, that position cannot be squared with the mandatory language of the statute: Upon a finding that a disability is not addressed by existing standards the director *shall* stay further proceedings and *shall* adopt temporary rules. Under ORS 656.295(5), the Board has the authority to review the correctness of the director's application of standards. We understand that authority to include the power to review the director's application of existing standards to address chondromalacia.

SAIF next argues that, even if it were mandatory for the director to promulgate a temporary rule, the Board lacks authority to remand the order on reconsideration. SAIF cites *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, __ P2d __ (1993), for the proposition that the statutory scheme makes no provision for the Board to remand a case to DIF. In *Pacheco-Gonzalez*, we said that ORS 656.283(7) did not <124 Or App 541/542> authorize the remand of cases to DIF when DIF did not consider the medical arbiter's report. 123 Or App at 317. We noted that the correct procedure was for the referee to hear the case. *Pacheco-Gonzalez* is distinguishable because, in that case, the referee could grant relief. Here, only the director can grant the relief requested. By necessary implication, the Board has the power to remand the case to the director and must do so. See *Ochoco Construction v. DLCD*, 295 Or 422, 426, 667 P2d 499 (1983).

Reversed and remanded.

Cite as 124 Or App 622 (1993)

November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Steven L. Furnish, Claimant.

STEVEN L. FURNISH, Petitioner,

v.

MONTAVILLA LUMBER COMPANY and SAIF CORPORATION, Respondents.
(91-04257; CA A74814)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1993.

Darrell E. Bewley argued the cause for petitioner. With him on the brief was Glen J. Lasken. Steven Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General. Before Deits, Presiding Judge, and Riggs and Durham, Judges.

DURHAM, J.

Reversed and remanded for reconsideration.

124 Or App 624 > Claimant seeks review of an order of the Workers' Compensation Board that upheld employer's denial of claimant's occupational disease claim for a low back condition. We review for errors law and substantial evidence, ORS 656.298(6); ORS 183.482(7) and (8), and reverse.

Claimant was employed as a driver/salesman. His duties included operating a forklift and assembling, loading and delivering lumber. On March 13, 1991, claimant experienced back pain at work. The pain gradually increased, and claimant sought medical attention. Dr. Pape diagnosed lower back pain caused by repetitive lifting at work. A test showed that claimant had two disc bulges. Employer denied claimant's occupational disease claim and sent him to Dr. Woolpert. Woolpert diagnosed degenerative disc disease and concluded that work activity was not the major contributing cause of the onset of symptoms. Woolpert could not suggest an alternative cause of the pain. The referee concluded that Pape was more persuasive, found that "[c]laimant's work activities were the major cause of his disability and need for treatment" and reversed employer's denial. The Board concluded that Woolpert was more persuasive and reversed the referee.

Claimant argues that the Board's order is not adequate for review because the order fails to explain why the findings lead to the Board's conclusion. We agree.

The referee found that claimant's work activities "involved repetitive lifting and repetitive climbing onto and off a forklift," and that "[c]laimant's off-work activities do not involve the repetitive climbing and lifting required in his job." The referee concluded that Pape's opinion was more persuasive, because Woolpert did not consider repetitive lifting when he dismissed work activity as the cause of claimant's symptoms. The Board adopted all of the referee's findings, but concluded that Woolpert's opinion was more persuasive, because "Dr. Pape's opinion is based on his mistaken belief that claimant's work involved repetitive work activities." That statement is contrary to the referee's finding, which the <124 Or App 624/625> Board adopted, that claimant's work activity involved repetitive lifting and climbing. The Board made no additional findings to explain the inconsistency.

Employer acknowledges that the conclusions of the referee and Board are contradictory, but argues that we should affirm the Board because the record contains substantial evidence that supports the conclusion that claimant's work involved some lifting, but not repetitive lifting. That argument misperceives the defect in the Board's order.

We review the Board's order for, among other things, the existence and soundness of its rationale to determine whether it is supported by substantial reason. The requirement of a rational explanation is designed to facilitate "meaningful judicial scrutiny of the activities of an administrative agency * * *." *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975).

The contradiction between the Board's finding about the nature of claimant's work and the reason it gave for according lesser weight to Pape's opinion deprives the order of substantial reason. The Board order must:

"clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes." *Home Plate, Inc. v. OLCC, supra*, 20 Or App at 190.

The order must state "a reasoned opinion based on explicit findings of fact." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). We are not required to speculate about whether the factual contradiction in the order is intentional or an oversight, and whether the Board might be able to explain it away. Until the Board resolves the inconsistency in its findings and adequately explains why its findings lead it to its conclusion, we have no occasion to decide whether substantial evidence supports either version of the contradictory findings.

Claimant also argues that the Board improperly required him to prove an injury rather than an occupational disease, because it cited Woolpert's opinion that claimant had not suffered any "noticeable incident or trauma" at work. We do not address the contention because, on remand, the Board may adopt different findings or conclusions that resolve it.

Reversed and remanded for reconsideration.

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Cite as 124 Or App 651 (1993)

November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE ACCIDENT INSURANCE FUND CORPORATION (SAIF), Respondent - Cross-Appellant,
v.
MILES ANDERSON, D.C., and NORTH SALEM CHIROPRACTIC CLINIC, an assumed business name
of MILES ANDERSON, Appellants - Cross-Respondents.
(90C-10487; CA A74840)

Appeal from Circuit Court, Marion County.

Robert B. McConville, Judge.

Argued and submitted June 30, 1993.

Anthony A. Allen argued the cause for appellants - cross-respondents. With him on the opening brief was Gatti, Gatti, Maier & Associates. With him on the reply brief was Gatti, Gatti, Maier, Jackson & LeDoux.

Jas. Adams, Assistant Attorney General, argued the cause for respondent - cross-appellant. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

LEESON, J.

On appeal, reversed and remanded with instructions to dismiss claim for money had and received; affirmed on cross-appeal.

124 Or App 653 > Defendants appeal a circuit court judgment awarding plaintiff SAIF damages on its claim for money had and received. SAIF cross-appeals and assigns error to the dismissal of its other claims based on the same transactions. The issue is whether the Department of Insurance and Finance (DIF) has exclusive jurisdiction over cases where a health care provider is alleged to have violated ORS 656.248(3)¹ by charging workers' compensation patients more than the provider charges the general public for the same services. We conclude that DIF's jurisdiction is exclusive, and, therefore, reverse on the appeal and affirm on the cross-appeal.

Defendant Miles Anderson is a licensed chiropractor. He practices under the assumed business name of North Salem Chiropractic Clinic, which is also named as a defendant. Anderson's practice includes workers' compensation patients who are insured by SAIF. SAIF's complaint alleges that, in violation of ORS 656.248(3), Anderson regularly billed SAIF more than he billed the general public for comparable services. Specifically, SAIF maintained that Anderson regularly billed it for a \$15 "minimum office visit" charge that he did not bill those patients who paid cash.

Based on that allegation, SAIF asserted four claims for relief: one under the Oregon Racketeer Influenced and Corrupt Organizations Act (ORICO), ORS 167.715 *et seq*; one for fraud; one for money had and received; and one for conversion. Defendants moved to dismiss all of the claims on the ground that the circuit court lacked subject matter jurisdiction over them, because SAIF's administrative remedy with DIF "preempted" other remedies. The trial court denied that motion. It later granted defendants' motion for directed verdict on the ORICO, fraud and conversion claims. The jury then returned a verdict for SAIF on the claim for money had and received, and judgment was entered on the verdict.

¹ ORS 656.248(3) provides: "In no event shall a provider charge more than the provider charges to the general public."

Defendants argue that the circuit court lacked subject matter jurisdiction over SAIF's claim for money had and received, because DIF has exclusive jurisdiction over fee <124 Or App 653/654> disputes between health care providers and workers' compensation insurers.²

The Supreme Court set out the framework for analyzing the exclusivity of an administrative remedy that has been provided for a statutory violation in *Brown v. Transcon Lines*, 284 Or 597, 588 P2d 1087 (1978). The threshold determination is the source of the plaintiff's claim. If the claim preexists the statute, then the administrative remedy is exclusive only if, by enacting the statute, the legislature intended to abolish the previously recognized claim. However, if the claim derives from the statute, and the statute does not imply a claim in a court, then the administrative remedy is exclusive, provided that it is not "demonstrably inadequate." 284 Or at 602.³

124 Or App 655> ORS 656.248(3) prohibits a health care provider from charging a workers' compensation insurer more than the provider charges the general public. See also OAR 436-10-090(9). In the light of *Brown*, the first issue is whether SAIF's claim for money had and received derives from ORS 656.248(3). The parties agree that it does. SAIF conceded before the trial court that, absent the health care provider's statutory (and regulatory) obligation to not charge a workers' compensation insurer more than is charged the general public, SAIF would have no claim. That is correct. We find nothing in the statute that implies a claim in a court. The administrative remedy, therefore, is exclusive, unless it is "demonstrably inadequate."

² SAIF contends that the error, if any, was not preserved. Defendants argued, in support of their motion to dismiss: "This Court lacks subject matter jurisdiction because the dispute herein is preempted and governed by administrative regulation. * * *

"The dispute in this case * * * is either a complaint of rule violation governed by OAR 436-10-115 (1990) and/or a fee dispute between a vendor and an insurer governed by OAR 436-10-110 (1990). Under either rule, the division is charged with exclusive jurisdiction to receive complaints, to conduct investigations, and to order appropriate relief.

"For reasons set forth above, this court lacks subject matter jurisdiction because the dispute herein is preempted and governed by a comprehensive administrative scheme. [SAIF] has failed to pursue the administrative procedures established for the resolution of such disputes. Judicial review may be available if and when the administrative remedies are exhausted." (Emphasis supplied.)

SAIF's contention is essentially that "exhaustion" and "preemption" are terms of art that are not appropriate in this context. That may be so. Nonetheless, the motion was adequate to alert the trial court to defendants' contention that SAIF's administrative remedy was exclusive. It is apparent from its response that SAIF, too, understood defendants' meaning.

³ The court said:

"If such a cause of action must rest upon the provisions of [a statute] * * *, it may be that any such cause of action for damages in a court of law must be implied from that statutory provision and that plaintiff's sole redress is to file a complaint with the [agency] and pursue the administrative remedies * * *, at least unless such administrative remedies are demonstrably inadequate.

"On the other hand, if * * * [the] cause of action need not be based upon or implied from [the statute], but instead plaintiff had a cause of action for damages * * * based upon previously existing principles of common law, then the primary focus of the problem is * * * whether by the enactment of that statute the Oregon legislature abolished a previously existing common law cause of action." 284 Or at 602.

The dispute in this case is a "dispute regarding the amount of a fee," within the meaning of ORS 656.248(13). That statute authorizes DIF to resolve such disputes. Pursuant to that authorization, DIF has promulgated rules. A provider or insurer involved in a fee dispute may request administrative review. Former OAR 436-10-110(1)(a).⁴ When a request for review is received, the division must investigate. Former OAR 436-10-110(2). The division shall order the relief necessary to resolve the dispute. Former OAR 436-10-110(3). If a rule violation is involved, sanctions may be appropriate as well. Former OAR 436-10-115(3). Sanctions for a violation of ORS 656.248(3) and OAR 436-10-090(9) may include a reprimand, recovery of fees in whole or in part, referral to the appropriate licensing board, or civil penalties of up to \$1,000 per occurrence. Former OAR 436-10-130(2). Administrative decisions under those rules are subject to judicial review under ORS 183.310 to 183.550. ORS 656.248(13).

SAIF contends that that administrative remedy is inadequate because it is too cumbersome. It argues:

"Nothing in the governing statutes or regulations expressly authorizes an insurer to file a single claim for <124 Or App 655/656> multiple instances of overcharging by a medical provider. ORS 656.248(13) authorizes the director of DIF to resolve 'a dispute' regarding the amount 'of a fee for medical services.' That appears to contemplate a case-by-case review of fee disputes."

However, ORS 656.248(13) provides that "the director may resolve a [fee] dispute *in such summary manner as the director prescribes.*" (Emphasis supplied.) In the light of that statutory authorization, we have no reason to presume that DIF would not permit consolidation in certain cases.

SAIF also contends that the administrative remedy is inadequate, because it does not provide for a jury trial, to which SAIF argues it is constitutionally entitled.

A party has a right to a jury trial in the classes of cases for which the right was customary at the time the Oregon Constitution was adopted. Or Const, Art I, 17; *Cornelison v. Seabold*, 254 Or 401, 405, 460 P2d 1009 (1969); *Salem Decorating v. Natl. Council on Comp. Ins.*, 116 Or App 166, 169-70, 840 P2d 739 (1992), *rev den* 315 Or 643 (1993). A claim by a workers' compensation insurer to recover money paid to a health care provider in excess of what the provider charges the general public did not exist at the time the Oregon Constitution was adopted. SAIF, therefore, has no constitutional right to a jury trial to resolve this dispute.

Finally, SAIF argues that the administrative remedy is inadequate, because it does not provide for punitive damages or equitable relief, and thus fails to include a "full panoply of remedies." The sanctions authorized by OAR 436-10-130, including civil penalties of up to \$1,000 per occurrence, are the functional equivalent of punitive damages. Notwithstanding that equitable relief is not available, the administrative remedy is adequate to address the problem that ORS 656.248(3) seeks to solve. We conclude that the administrative remedy is not "demonstrably inadequate."

Nonetheless, SAIF maintains that the legislature could not have intended that the administrative remedy be exclusive, because it did not make provision of an administrative remedy mandatory. SAIF relies on the language of ORS 656.248(13), which provides that "the director *may* resolve a [fee] dispute in such summary manner as the director *may* <124 Or App 656/657> prescribe." (Emphasis SAIF's.) That language is not inconsistent with an intention to make the administrative remedy exclusive, if an adequate one is provided. OAR 436-10-110 to OAR 436-10-130 provide such a remedy.

Because SAIF's administrative remedy is exclusive, the circuit court lacked jurisdiction over SAIF's claim for money had and received. It erred by failing to dismiss the claim.

⁴ OAR chapter 436, division 10, was amended in 1992. Neither party contends that those amendments alter the remedies that would be available to SAIF in this case.

SAIF's cross-appeal assigns error to the trial court's orders dismissing its ORICO and fraud claims. Like the claim for money had and received, those claims derive from defendants' violation of ORS 656.248(3). But for that statute, those claims would not exist. Therefore, the above analysis of the claim for money had and received is equally applicable to the ORICO and fraud claims. We reject defendants' concession that the ORICO claim was properly before the circuit court. Although it is true that the remedies provided by ORICO "shall not preclude the application of any other remedy, civil or criminal," ORS 166.725(12), it does not necessarily follow that the ORICO civil remedies shall not be precluded by other remedies. ORICO does not have the effect of undermining DIF's exclusive jurisdiction to resolve disputes between health care providers and workers' compensation insurance carriers regarding alleged violations of ORS 656.248(3). The trial court did not err by dismissing SAIF's ORICO and fraud claims.

On appeal, reversed and remanded with instructions to dismiss claim for money had and received; affirmed on cross-appeal.

Cite as 124 Or App 663 (1993) November 17, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robin R. Oliver, Claimant

ROBIN R. OLIVER, Petitioner,

v.

SCAMPS PET CENTER and SAIF CORPORATION, Respondents.

(91-07680; CA A77617)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 17, 1993.

Kevin Keaney argued the cause for petitioner. On the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.

Steven Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before De Muniz, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge.

LEESON, J.

Affirmed.

124 Or App 665 > Claimant petitions for review of an order of the Workers' Compensation Board (Board) awarding her time loss as an "irregularly employed" worker. We affirm.

In February, 1989, while working for employer, claimant developed psittacosis, commonly known as "parrot's disease." Her occupational disease claim was accepted by employer's insurer, EBI. Claimant was asymptomatic by April, 1989, and EBI closed the claim in July, 1989.

After the claim was closed, claimant reduced her work hours for personal reasons from 40 per week to 20-30 per week. In September, 1989, she sought medical treatment for a new infection of psittacosis. She developed an acute phase of the disease and left work in October. She filed an occupational disease claim with SAIF, which became employer's insurer on October 1, 1989. Both SAIF and EBI denied responsibility.¹ The Board assigned responsibility to SAIF, because the claim was based

¹ EBI subsequently denied compensability as well. We addressed the issue of penalties and attorney fees for EBI's refusal to process the claim in *Oliver v. Norstar, Inc.*, 116 Or App 333, 840 P2d 1382 (1992).

on a new, separate infection of psittacosis. SAIF paid claimant TTD benefits, calculating compensation under the formula for "irregularly employed" workers. OAR 436-60-025(5).²

Claimant contends that her benefits should be calculated based on her wages at the time of the February, 1989, claim. She argues that she was entitled to compensation as a "regularly employed" worker under ORS 656.210(2)(b)(B),³ because, in February, 1989, she was working 40 hours per week. We disagree. Although there is evidence that claimant <124 Or App 665/666> continued to experience symptoms of her first exposure to psittacosis through the summer of 1989, the Board found that the October claim was based on a new, separate exposure to psittacosis, and that that infection was not a continuation of the disease contracted in February. Substantial evidence supports those findings. Accordingly, pursuant to ORS 656.210(2)(b)(B), the Board was required to calculate her benefits based on the wages she earned at the time of the second occupational disease.

Claimant does not challenge the Board's finding that she was working irregular hours at the time of her October claim. The Board did not err in calculating her benefits pursuant to OAR 436-60-025(5).

Affirmed.

² OAR 436-60-025(5) provides, in part:

"The rate of compensation for workers employed with * * * irregular * * * earnings shall be computed on the wages determined by this section. * * *

"(a) For workers employed * * * with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks * * *."

³ ORS 656.210(2)(b)(B) provides:

"The benefits of a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease."

Cite as 125 Or App 47 (1993) December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jesus R. Corona, Claimant.

JESUS R. CORONA, Petitioner,

~~PACIFIC RESOURCE RECYCLING~~ and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(WCB 91-10031; CA A75988)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 17, 1993.

Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.

Alexander Libmann argued the cause and filed the brief for respondents.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

WARREN, P.J.

Affirmed.

125 Or App 49 > Claimant seeks review of a Workers' Compensation Board order dismissing for lack of jurisdiction claimant's request for hearing regarding penalties and attorney fees under ORS 656.262(10) and ORS 656.382(1). We affirm.

Following what claimant asserts was an unreasonable delay in the payment of compensation on his compensable claim, he sought a hearing on the issues of temporary partial and temporary total disability, and sought a penalty under ORS 656.262(10) and attorney fees under ORS 656.382(1). Before the hearing, employer paid the benefits. The only issue remaining at the time of hearing was claimant's entitlement to penalties and fees. In his brief to the Board, claimant described employer's conduct that he asserted provided a basis for an award of penalties under ORS 656.262(10). Further, he asserted that the same conduct, "[t]he carrier's continued insistence in issuing time loss benefits more than 14 days past the due date[,] also constitutes an unreasonable resistance to the payment of compensation under ORS 656.382(1)." (Emphasis supplied.) The Board dismissed the request for hearing, holding that the matter was within the exclusive jurisdiction of the director of the Department of Insurance and Finance (DIF).

Under ORS 656.262(10)(a), a claimant is entitled to an additional amount as a penalty "[i]f the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim * * *." If the claimant is represented by an attorney, that penalty shall be paid one-half to the attorney, "in lieu of an attorney fee." "[T]he director [of DIF] shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." ORS 656.262(10)(a).

ORS 656.382(1) provides:

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee * * *."

125 Or App 50 > The Board concluded that it did not have jurisdiction over claimant's request for penalties and attorney fees, because the sole issue was the assessment of a penalty under ORS 656.262(10)(a). We agree. The portion of a penalty that is paid to a claimant's attorney under ORS 656.262(10)(a) is "in lieu of an attorney fee." We have held that the same conduct cannot be the basis for both a penalty under ORS 656.262(10)(a) and an award of attorney fees under ORS 656.382(1):

"[W]hen the misconduct is such that a penalty may be assessed under ORS 656.262(10), no fees are available under ORS 656.382(1). See *Martinez v. Dallas Nursing Home*, 114 Or App 453, 836 P2d 147[, rev den 315 Or 271] (1992). When, however, the employer's conduct would not subject it to a penalty, but is of the type that would give rise to an assessment of attorney fees under ORS 656.382(1), attorney fees may be awarded." *Oliver v. Norstar, Inc.*, 116 Or App 333, 336, 840 P2d 1382 (1992).

Unlike in *Oliver*, claimant here does not assert that one act of misconduct would support a penalty and that a different act of misconduct would support an attorney fee. Nonetheless, claimant argues that, in an appropriate case, the findings might support both a penalty under ORS 656.262(10)(a) and a fee under ORS 656.382(1), and in that situation, both awards may be made. Under *Martinez* and *Oliver*, that is true only if there are two separate acts of misconduct, one of which would not support a penalty under ORS 656.262(10)(a).

We agree with the Board's reasoning in this case: When the claimant raises a viable request for a penalty under ORS 656.262(10)(a), and the unreasonable conduct that supports the penalty is the sole issue, the director has exclusive jurisdiction.¹ Here, claimant raised a viable request for a penalty under ORS 656.262(10)(a). The misconduct asserted in support of that penalty is identical to the misconduct <125 Or App 50/51> asserted in support of attorney fees. Therefore, the sole issue is the entitlement to a penalty under ORS 656.262(10)(a), and the director has exclusive jurisdiction. The Board did not err in dismissing claimant's request for hearing.²

Affirmed.

¹ Claimant argues that the Board must make a finding that fees are not recoverable under ORS 656.382(1) before there can be a determination that the sole issue is entitlement to a penalty under ORS 656.262(10)(a), over which the director has exclusive jurisdiction. Claimant is wrong. The same misconduct cannot result in the assessment of both a penalty and a fee. Therefore, when the only misconduct asserted would, if proved, support a penalty, no fees can be assessed, and the sole issue is entitlement to a penalty.

² The Board took "administrative notice" that the director had awarded claimant a penalty for employer's late payment of temporary disability compensation.

Cite as 125 Or App 57 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Steven E. Coghill, Claimant.

STEVEN E. COGHILL, Petitioner,

v.

BEND MILLWORKS, Respondent.

(91-08342; CA A77969)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 23, 1993.

Edward J. Harri argued the cause for petitioner. With him on the brief was Philip H. Garrow.

David P. Levine argued the cause for respondent. With him on the brief were Scott H. Terrall and Law Offices of Scott Terrall & Associates.

Before Rossman, Presiding Judge, and De Muniz and Leeson, Judges.

ROSSMAN, P.J.

Affirmed.

125 Or App 59 > Claimant seeks review of an order of the Workers' Compensation Board holding that his low back condition is not compensable.

In December, 1990, claimant noticed low back pain. Over the next few months, claimant's symptoms increased. On May 10, 1991, claimant filed a workers' compensation claim.

Relying on claimant's account of the onset of his symptoms, each of the doctors who examined him related his condition to his employment as a millworker. Employer attempted to show that claimant's symptoms were caused by a ski accident. Two of claimant's co-workers testified that claimant had told them that he had injured his back while skiing. Claimant denied having told anyone at work that he had been injured while skiing.

The referee found

"claimant's testimony consistent with medical evidence and credible based on his demeanor. The employer's attempts to impeach both claimant and the history upon which the medical opinions are based, were less persuasive than claimant's testimony."

The referee found that claimant had suffered a series of traumatic events or occurrences in the course of his employment and that the employment was the major contributing cause of his disability and need for treatment. Accordingly, pursuant to ORS 656.802, the referee concluded that claimant had suffered a compensable occupational disease.

The Board reversed. Finding contradictions in claimant's testimony regarding the onset of his symptoms, the Board concluded that claimant was not a reliable witness. Additionally, it concluded that, because claimant had not told his doctors about the skiing accidents, their opinions concerning the cause of the back condition were based on an inaccurate history. The Board found the medical opinions not persuasive for that reason, and determined that claimant had failed to establish that work was a cause of his low back condition.

125 Or App 60> Claimant contends that the Board erred in rejecting the referee's assessment of the evidence and his determination that claimant was credible. However, the Board was not required to accept the referee's credibility assessments, or even to address them. See *Erck v. Brown Oldsmobile*, 311 Or 519, 526-527, 815 P2d 1251 (1991). Our only responsibility in reviewing the Board's order is to determine whether it is supported by substantial evidence. *Erck v. Brown Oldsmobile, supra*. Although the factfinder could reasonably have gone the other way, we conclude that the Board's findings are supported by substantial evidence.

Affirmed.

Cite as 125 Or App 134 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joseph A. Turney, Claimant.

CHARLES FAESSLER and GERALDINE FAESSLER, Petitioners,

v.

JOSEPH A. TURNEY and SAIF CORPORATION, Respondents.

(WCB 92-00587; CA A78400)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 22, 1993.

Chess Trethewy argued the cause for petitioners. With him on the brief was Garret, Hemann, Robertson, Paulus, Jennings & Comstock.

Edward J. Harri argued the cause for respondent Joseph A. Turney. With him on the brief was Stanley Fields.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

RIGGS, J.

Affirmed.

125 Or App 136> Employers seek review of an order of the Worker's Compensation Board determining that claimant's injury was within the course and scope of his employment and therefore compensable. We affirm.

The Board found that employers, who are claimant's stepfather (Faessler) and mother, operate a dairy farm. In November, 1989, claimant was working full time for them as a farm laborer. Saturday was claimant's regular day off, but he would sometimes help with farm chores when he would otherwise be off work. Employers had an unwritten policy that prohibited drinking alcoholic beverages while working; however, that policy was not expressly communicated to claimant.

Saturday November 4, 1989, claimant was off work. He drank beer at a local restaurant throughout the afternoon. In the early evening, he returned drunk to the farm and went to the barn. There, Faessler was unloading hay bales from a trailer and placing them on a noisy elevator. The elevator carried the bales up to the hayloft where Pete Turney, claimant's brother, was stacking them. The floorboards in the hayloft had water rot.

When claimant reached the barn, Faessler saw that he was drunk. Faessler told claimant not to work but did not stop working himself. Faessler's command could not be heard over the loud noise of the elevator. Within a few minutes, Faessler saw claimant in the hayloft at the top of the elevator picking up bales of hay. Faessler continued to unload the hay bales and place them on the elevator carrying them to claimant and his brother.

In the hayloft, claimant was unloading and stacking the hay bales. As claimant was throwing a bale up onto the stack, the rotten hayloft floorboards gave way. Claimant fell through to a dirt floor 15 to 20 feet below and sustained multiple injuries. His blood alcohol level was later determined to be 0.26 percent. Claimant filed a workers' compensation claim on April 24, 1991. The Board concluded that claimant's injury was compensable, and employers seek review.

125 Or App 137 > Employers first argue that the following finding is not rationally related to any issue in the case:

"Within one or two months after claimant's accident, Mr. Faessler notified Mutual of Enumclaw, who held his homeowner's policy, of the accident. The claim against the homeowner's policy was denied on the basis that the accident occurred within the course and scope of claimant's employment."

According to employers, this finding shows the Board's desire to do "social justice" and is not rationally related to whether claimant was in the course and scope of employment. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). However, this finding involves the timeliness of the claim, a different issue from course and scope of employment. The timeliness of the claim was also before the Board but, the resolution of that issue was not appealed and is not on review to this court. The finding is rationally related to the issue of timeliness, and employers' assignment of error is without merit.

Employers next argue that substantial evidence does not support the finding that claimant was acting within the course and scope of employment. ORS 183.482(8)(c). Relying on the seven-factor analysis developed in *Jordan v. Western Electric*, 1 Or App 441, 443-444, 463 P2d 598 (1970),¹ the Board found claimant's injury to be in the course and scope of employment. The Board found that six of the seven factors described in *Jordan* weighed in claimant's favor and that only one weighed against him.

125 Or App 138 > Employers attack only the finding that the activity was "directed by or acquiesced in by the employer." Employers assert that no testimony or other evidence supports the finding that Faessler "continued to unload the hay bales and place them on the elevator" after seeing claimant in the loft. Substantial evidence supports a finding "when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). Faessler testified that he did not stop loading hay bales until after he saw claimant move a couple of bales. Claimant testified that he was moving bales for ten minutes before he fell through the floor. Substantial evidence supports the finding of employers' acquiescence.

¹ The seven factors are:

- (a) Whether the activity was for the benefit of the employer * * *;
- (b) Whether the activity was contemplated by the employer and employee either at the time of hiring or later * * *;
- (c) Whether the activity was an ordinary risk of, and incidental to, the employment * * *;
- (d) Whether the employee was paid for the activity * * *;
- (e) Whether the activity was on the employer's premises * * *;
- (f) Whether the activity was directed by or acquiesced in by the employer * * *; [and] * * *;
- (g) Whether the employee was on a personal mission of his own * * *.

All of those factors may be considered, and no one factor is dispositive. *Preston v. SAIF*, 88 Or App 327, 330, 745 P2d 783 (1987).

Employers next argue that claimant's intoxication was a departure from or abandonment of employment. They rely on *Underwood v. Pendleton Grain Growers*, 112 Or App 170, 827 P2d 948 (1992) for the proposition that a worker "cannot just ordain himself to be in the course and scope of employment by walking onto the job site." In *Underwood*, an employee was to deliver tires on his way home. He stopped at a tavern before the delivery, got drunk, and then was injured when he wrecked employer's truck. The Board decided that the employee had abandoned his work and, therefore, that the injury was non-compensable. In this case, unlike in *Underwood*, Faessler saw claimant after he was drunk. Claimant did not "unilaterally ordain himself to be in the course and scope of employment." Instead, Faessler watched claimant work and continued to encourage that work by sending up more bales of hay. Substantial evidence supports the Board's order.

Affirmed.

125 Or App 139 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PORT BLAKELY TREE FARMS, Respondent,

v.

The filings of the NATIONAL COUNCIL ON COMPENSATION INSURANCE, Respondent below, and SAIF CORPORATION, Petitioner.

(91-08-049; CA A77447)

Judicial Review from Department of Insurance and Finance.

Argued and submitted September 24, 1993.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongski, Attorney General, and Virginia L. Linder, Solicitor General.

Timothy R. Volpert argued the cause for respondent. On the brief were Shelley Larkins and David C. Knowles.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

RIGGS, J.

Affirmed.

125 Or App 141 > SAIF Corporation (SAIF) seeks review of an order of the Department of Insurance and Finance (DIF), which required SAIF to rebill its insured, Port Blakely Tree Farms, and to delete premiums paid by Port Blakely on behalf of two loggers. We affirm.

The two loggers, Thronson and Bryant, contracted to thin trees for Port Blakely. They supplied their own equipment. Both filed Section C income tax forms and maintained their own business phones and business insurance. Neither logger worked exclusively for Port Blakely. SAIF conducted a premium audit and contended that Port Blakely was liable for worker's compensation premiums for both loggers. Port Blakely sought review.

In its final order, DIF held that the loggers were "workers" under ORS 656.005(28).¹ DIF next determined whether the loggers were "subject workers" under ORS 656.027(7).² It found that the

¹ ORS 656.005(28) provides, in part:

"Worker" means any person * * * who engages to furnish services for remuneration, subject to the direction and control of an employer."

² ORS 656.027(7) provides:

"All workers are subject to this chapter except those non-subject workers described in the following subsections:

* * * * *

"(7) Sole proprietors. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor."

loggers were nonsubject workers, because they were sole proprietors who qualified as independent contractors under ORS 670.600. Because it found that the loggers were nonsubject workers, DIF held that Port Blakely did not have to pay workers' compensation premiums for them.

SAIF makes three arguments on review. It first argues that, even if the loggers were sole proprietors under ORS 656.027(7), their status as "non-subject workers" merely exempts them from coverage while they are self-employed. Citing *Little Donkey Enterprises, Inc. v. SAIF*, 118 Or App 54, 845 P2d 1298, mod 121 Or App 643, 856 P2d 323 (1993), SAIF reasons that any employer who employs sole <125 Or App 141/142> proprietors must pay premiums on their behalf. SAIF misconstrues *Little Donkey*. That case held that a sole proprietor can function in the capacity of a subject employee. A sole proprietor can also function in the capacity of a nonsubject worker if he or she also qualifies as an independent contractor. See *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, 854 P2d 944, rev allowed 318 Or 60 (1993).

SAIF next argues that the loggers are not independent contractors. To qualify as an independent contractor, a person must satisfy all eight subsections of ORS 670.600. According to SAIF, the loggers did not satisfy the first and fourth subsections.

Under ORS 670.600(1), an independent contractor must be

"free from direction and control over the means and manner of providing the labor or services, subject only to the right of the employer to specify the desired results."

The parties do not dispute the proposition that Port Blakely had a right to control the loggers, but did not exercise actual control over them. Their dispute centers instead on whether the statute incorporates a "right to control" or an "actual control" test. SAIF argues that ORS 670.600(1) incorporates a "right to control" test. After this case was briefed, we held in *S-W Floor Cover Shop* that, in ORS 670.600(1), "control" means "actual control." The loggers satisfied ORS 670.600(1) under *S-W Floor Cover Shop*.

SAIF next argues that the loggers did not satisfy ORS 670.600(4), which provides:

"The individual or business entity providing labor or services has the authority to hire and fire employees to perform the labor or services."

SAIF's argument rests on two facts: that neither logger testified that he had the right to hire and fire his own employees and that, under the terms of their contract with Port Blakely, the loggers were required to get the written approval of Port Blakely before subcontracting. From those two facts, SAIF reasons that there is no substantial evidence that the loggers had the authority to hire and fire. ORS 183.482(8)(c).

125 Or App 143> Although the loggers never testified that they had the right to hire and fire their employees, their contract clearly contemplates that they, in fact, did have that right. Paragraph 7 of the contract states:

"It is agreed that all costs shall be borne by Logger, including all labor employed in the performance of this contract * * *."

Paragraph 12 of the contract imposes on the loggers the duty to pay all insurance and unemployment compensation "applicable to Logger as an employer." Paragraph 14 of the contract makes the loggers liable for all actions brought by any employee of the logger. The contract provision requiring Port Blakely's approval for subcontracting does not limit the loggers' control over their own employees. The contract provides substantial evidence that the loggers had the right to hire and fire employees, thus satisfying ORS 670.600(4).

We conclude that the loggers were not subject workers under ORS 670.600; and that Port Blakely, therefore, was not required to provide workers' compensation for them.

Affirmed.

Cite as 125 Or App 156 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON

RICHARD T. RAWLINS, Appellant,

v.

RONALD L. BOHY, Defendant, and BRUCE D. SMITH, BRAD G. GARBER and MICHAEL B. DYE,

Respondents:

(91C-11446; CA A76570)

Appeal from Circuit Court, Marion County.

Jackson L. Frost, Judge.

Argued and submitted July 8, 1993.

Gary M. Georgeff argued the cause for appellant. With him on the briefs was McGaughey & Georgeff.

O. R. Skopil, III argued the cause for respondents Brad G. Garber and Michael B. Dye. On the brief were Frank Moscato and Moscato, Byerly & Skopil.

Robert H. Grant argued the cause and filed the brief for respondent Bruce D. Smith.

Before Warren, Presiding Judge, and Edmonds and Landau, Judges.

EDMONDS, J.

Reversed and remanded as to defendants Smith and Dye on plaintiff's second claim for relief; otherwise affirmed.

125 Or App 158 > Plaintiff brought this legal malpractice action against defendants¹ alleging that they were negligent in their representation of him in a workers' compensation claim. His claim against defendants Bohy and Dye is still pending in the trial court and is not before us on appeal. The trial court granted partial summary judgments and entered judgments pursuant to ORCP 67B in favor of defendants Smith and Dye on plaintiff's second claim for relief and in favor of defendants Garber and Dye on his third and fourth claims. Because Dye's liability is wholly dependent on the alleged negligence of the other defendants, we will discuss only the claims against Smith and Garber. Plaintiff argues that the trial court improperly granted the summary judgments, because issues of material fact exist, and assigns error to the trial court's denial of his cross-motions for partial summary judgment on the issue of liability against Garber. ORCP 47. We affirm in part and reverse in part.

Bohy represented plaintiff in his claim before the Workers' Compensation Hearings Division. After the referee denied plaintiff's claim, Smith filed a timely request for review by the Workers' Compensation Board on behalf of plaintiff. Plaintiff alleges that, because Smith failed to dispute certain findings made by the referee and to argue certain theories before the Board, the Board erroneously adopted the referee's findings and conclusions. Garber represented plaintiff on judicial review of the Board's order in this court. However, he failed to serve the Board with a copy of the petition, which resulted in our dismissing it. Plaintiff alleges that, but for that failure, we would have reversed the Board's decision and would have found that he was within the course of his employment at the time he was injured.

In a legal malpractice action, the plaintiff must demonstrate that, except for the negligence of his attorney, the plaintiff's claim would have succeeded. *St. Paul Fire & Marine Ins. v. Speerstra*, 63 Or App 533, 540, 666 P2d 255, rev den 295 Or 773 (1983). The trial court ruled that, as a <125 Or App 158/159> matter of law, the omissions by Smith were immaterial to the Board's ruling. To understand the court's reasoning, we take the facts as found by the referee:

¹ All claims against defendant Dye are based on the doctrine of respondeat superior. There is no judgment against Bohy, and he is not properly designated as a respondent on the appeal. Accordingly, we have amended the case caption to show Bohy as a defendant.

"On the date of injury, claimant was the president and general manager of Rawlins Realty, Inc., located in Salem, Oregon. As such, he was responsible for the operation of the business, including administrative and financial concerns. On the date of injury, claimant's mother, father, and two brothers * * * were on the Board of Directors of the corporation; claimant was not. Claimant made all decisions regarding the business. He relied heavily on his father's expertise and he sought his father's advise [sic] on a regular basis.

"Claimant's father lived in Salem just down the road from claimant's residence, and he maintained an office adjacent to the Rawlins Realty premises for his own affairs. Claimant discussed business with his father almost daily at various locations, including at breakfast meetings, while playing basketball and tennis, at the business office, and by phone.

"For several months prior to the date of injury, the business had been in financial trouble. The office was approximately three months behind in the payment of phone and advertising bills, and vendors were threatening to terminate services. Claimant had a line of credit from which he could obtain a loan. However, in this instance, as in others, he intended to ask his father for a loan first.

"The business was also suffering the effects of the depressed real estate market, and claimant had worked on a commission reorganization plan to better meet the competition. He intended to implement the plan on October 1, 1987.

"In April, 1987, a ranch near John Day, Oregon, was purchased from King Williams, in the name of Rawlins Family Trust. * * * The ranch, operated by brother Pete, was intended to be a recreational facility for the family. In partial consideration for the property, the titles to three rental properties * * * were transferred free and clear to King Williams. Although it was not a priority to King Williams, he and claimant had, on several occasions, by phone and in person, discussed the listing of the properties for sale through Rawlins Realty.

"King Williams * * * sold the ranch's 700 cattle which had been grazing on [the ranch]. The cattle were to be loaded onto trucks on Monday, September 14, 1987. Early in the preceding week, Pete had called claimant from the ranch and <125 Or App 159/160> asked him to come to the ranch the following weekend to help spot and chase cattle for loading on Monday. Claimant was the only family member available who could fly the plane which was registered to Tim Rawlins and maintained by Rawlins Realty Corporation. Claimant agreed, and the event developed into a family gathering * * *.

"Claimant decided it would be a good opportunity to request a loan from his father for immediate operating expenses for Rawlins Realty, Inc.,^[2] to discuss the proposed commission split reorganization plan, and to discuss a presentation claimant was going to make to an insurance company * * *. Claimant also intended to firm up an agreement with King Williams for listing the three Salem properties.

* * * * *

"Claimant and [a friend] arrived at the early Saturday morning. They spent Saturday and Sunday, September 12 and 13, with Pete, claimant's father and King Williams, spotting and chasing cattle. Claimant made several flights on Saturday and Sunday to spot cattle * * *.

"Claimant discussed business with his father while the two were riding horses on Saturday and Sunday. On Sunday, * * * claimant also presented the figures on the reorganization plan * * *.

² Plaintiff testified that, when he made this trip, his father was at the ranch. Furthermore, the father testified that he had spent a lot of time at the ranch in the months before plaintiff's trip.

"During the weekend, claimant also discussed with Mr. Williams the listing of his three properties and the two agreed on asking prices. No listing agreement was prepared or signed, however.

"After spotting cattle early Monday morning, claimant flew to the airport to top off the fuel tanks in preparation for the flight back to the Willamette Valley where the plane would be serviced and kept for the winter. He also had a short discussion with his father in which his father agreed to loan him the money to cover the corporation's immediate operating needs. His father did not actually give him the money at that time or indicate when or how it would be paid.

"Claimant and [his friend] departed the ranch by plane * * * on September 14, 1987. Shortly after takeoff, the plane crashed and claimant was injured." (Emphasis supplied.)

125 Or App 161> Relying on *Magee v. SAIF*, 48 Or App 439, 617 P2d 295, rev den 290 Or 211 (1980), *Brown v. SAIF*, 43 Or App 447, 602 P2d 1151 (1979), rev den 288 Or 335 (1980), and *Rosencrantz v. Insurance Service*, 2 Or App 225, 467 P2d 664 (1970), the referee said:

"The law regarding the dual purpose doctrine is clear. If the trip during which the injury occurred involves the performance of a service for the employer which would have caused the trip to be taken by someone even if it had not coincided with the personal mission, the injury is compensable."

Applying the dual-purpose doctrine, she concluded:

"I find from claimant's credible testimony that he was going to the ranch for the primary purpose of spotting and chasing cattle with his family and friends, and that, knowing that his father and King Williams would be present, he seized the opportunity to prepare some business topics for discussion with them. The trip would have been made in the absence of any business purpose. I do not find from the testimony, however, that the trip would have had to have been made by someone had the claimant's personal mission been canceled.

"I conclude, therefore, that the claim is not compensable under the dual-purpose doctrine."

The basis for plaintiff's malpractice claim against Smith is two-fold. First, he argues that Smith negligently failed to challenge the referee's finding that plaintiff "had a line of credit from which he could obtain a loan," and that Smith "should have raised grounds for compensation based on the use of the airplane." Because we hold that the issue of whether plaintiff had an existing line of credit was relevant to the Board's inquiry, we do not decide the issue concerning the use of the airplane.

A jury could find that Smith had a duty to dispute all relevant findings made by the referee that were based on conflicting evidence, and that if he had done so, it would have changed the Board's decision. Whether a fact is relevant depends on whether it has the tendency to make the existence of any fact that is of consequence to the determination more probable or less probable than it would be without the evidence. OEC 401. Under the dual-purpose doctrine, the fact that is of consequence to the determination is whether plaintiff would have made the trip if the personal mission, the <125 Or App 161/162> cattle round-up, had been canceled. Whether plaintiff had exhausted his line of credit was a fact that would make it more probable or less probable that plaintiff would have made the trip regardless of the round-up. The company's managing broker testified that, in the past, plaintiff had used a line of credit to cover the company's bills. Plaintiff testified that at the time of the trip, his personal resources had been exhausted. There is evidence that the business' advertising and telephone services were about to be discontinued because of lack of funds. From this evidence, the Board could have concluded that plaintiff urgently needed a loan from his father, which would have necessitated the trip regardless of any personal mission. Because the Board reviews the referee's order *de novo*, a trier of fact could find that it was negligent for Smith not to have argued that evidence to the Board, and that his negligence would have affected the decision on its merits. For this reason, the trial court erred when it granted summary judgment to Smith.

Plaintiff's basis for his malpractice claim against Garber is that, had review occurred, we would have reversed the Board's decision on the ground that the Board applied the incorrect legal test, that its finding that there was no urgent need for plaintiff to go to the ranch was not supported by substantial evidence, and that its conclusion was contrary to the law. Garber's liability for malpractice must be assessed on the record before the Board, not on how the record might have appeared had Smith made additional arguments. Otherwise, Garber would be held to a standard of care based on a record that was different from the record on which he filed the petition for judicial review. Plaintiff argues that the Board's conclusion that his "primary purpose" for going to the ranch was to spot cattle demonstrates that the Board applied the wrong legal test:

"The [Board's] use of the rejected 'primary' purpose test was an error of law. That error was critical, as demonstrated by the fact that the [Board] analyzed all of the business aspects of the trip from the viewpoint of whether they were 'urgent,' a 'necessity,' or an 'immediate priority.' The [Board] never considered that some employee of Rawlins Realty Co., at some time, would ultimately have had to attend to all of the business aspects of the trip."

125 Or App 163> Plaintiff is correct that we have held that it is improper to characterize the dual-purpose test as declaring that the trip is a business trip if the primary purpose of the trip is for business. In *Rosencrantz v. Insurance Service, supra*, we quoted 1 Larson, *Workmen's Compensation Law* 294.3, 18.13 at 294.10-294.11 (1968):

"It is inaccurate and misleading to call this test, as sometimes has been done, the 'dominant purpose' test, or to paraphrase it by saying that the trip is a business trip if the 'primary' purpose is business. Judge Cardozo used no such language. He said it was sufficient if the business motive was a concurrent cause of the trip. He then defined 'concurrent cause' by saying that it meant a cause which would have occasioned the making of the trip even if the private mission had been canceled. One detail must be stressed to make this rule complete: It is not necessary, under this formula, that, on failure of the personal motive, the business trip would have been taken by this particular employee at this particular time." 2 Or App at 228-29.

However, when the Board's reference to plaintiff's "primary purpose" is read in context, it is evident that it applied the proper test.

Next, we examine the record to determine whether the facts as found by the Board are supported by substantial evidence and whether the Board correctly applied the law to those facts. Had plaintiff sought review, we would have been bound by the Board's findings if there was substantial evidence to support them. "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c).

"That is, the court must evaluate evidence against the finding as well as evidence supporting it to determine whether substantial evidence exists to support that finding. 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 Corp.*, 309 Or 292, 295, 787 P2d 884 (1990).

We begin our analysis by specifically addressing the findings challenged by plaintiff. First, plaintiff argues that there is no evidence to support the Board's finding that plaintiff "had a line of credit from which he could obtain a <125 Or App 163/164> loan." Plaintiff testified that at the time he went to the ranch to request a loan from his father,

"I was back behind on my bills three months and the office was not operating at a profit and I was -- my own resources were exhausted and I knew to get some additional capital -- which I usually borrow from dad or he helps with the co-signature or something."

He also testified that when his father turned down a loan request he made sometime in 1987, before September, that he "had to scramble a couple thousand bucks out of the credit card to cover he phone bill." A managing broker who worked for the corporation from April, 1986, until November, 1987, testified:

"Q. Did you have any personal knowledge about what [plaintiff] specifically did in terms of finances?

"A. Um-hum. Yeah. That he had to borrow money. You mean --

"Q. Yeah.

"A. I -- I guess, a line of credit. Um-hum.

"Q. You had personal knowledge about that?

"A. Yes, I did.

"Q. And did you have personal knowledge as to who he would borrow money from?

"A. Um-hum. He generally would borrow it from his dad or his grandfather or against a line of credit."

We conclude that the Board's finding that plaintiff had a line of credit from which he could have obtained funds is supported by substantial evidence.

Plaintiff also argues that the Board's finding that there was no urgency regarding the presentation of the commission plan documents is not supported by substantial evidence. Plaintiff testified that he "wanted" his father to review and approve the plan before he intended to implement it on October 1, 1987, two weeks after he was to return from the ranch. There is also evidence that the documents were left with his father for him to examine. In the light of that evidence, we conclude that the Board's finding is supported by substantial evidence.

125 Or App 165 > Plaintiff argues that, even if the Board's findings are supported by substantial evidence, its decision is inconsistent with *Marshall v. Cosgrave, Kester, Crowe, Gidley*, 112 Or App 384, 830 P2d 209, *rev den* 314 Or 391 (1992). In that case, the plaintiff was an advisor for a school district who decided, on her own volition, to pick up cupcakes one night on her way home from work to bring to her students the next day. Because the plaintiff worked in southeast Portland and lived in west Portland, her normal route to and from work required her to cross the Sellwood Bridge. She had planned to pick up the cupcakes at a market near her home in west Portland. As she was crossing the bridge, her car was struck and she suffered serious injuries. We held that her injuries were compensable under the dual-purpose doctrine, because the business mission was accomplished by the plaintiff arranging for a friend to pick up the treats and because the plaintiff's supervisors regarded the trip to be "school-related."

We emphasized in *Marshall* that the overriding inquiry in deciding whether the dual-purpose doctrine applies is "whether the business aspect of the trip was significant enough to have necessitated it, independently of the employee's personal purpose." 112 Or App at 390. That is merely a restatement of what we said in *Rosencrantz v. Insurance Services, supra*. The only additional comment that we made in *Marshall* was that "the employer's later directive to another employee to complete the mission is one possible basis, but not the exclusive one, for determining that the injured employee's journey had a significant business purpose." 112 Or App at 390. That comment has no application in this case, and plaintiff is wrong when he says that *Marshall* is controlling.

The evidence supports the Board's conclusion that plaintiff's injuries were not compensable under the dual-purpose doctrine. Under the dual-purpose test, if plaintiff was injured while on a trip that "had to have been made" to fulfill the business objective, then his injuries are compensable. The Board did not find the factual predicate necessary to make the trip compensable and, even if Garber had perfected review, we would have affirmed as a matter of law.

Plaintiff's remaining assignments of error do not require discussion.

Reversed and remanded as to defendants Smith and Dye on plaintiff's second claim for relief; otherwise affirmed.

Cite as 125 Or App 172 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gladys M. Theodore, Claimant.

GLADYS M. THEODORE, Petitioner,
v.
SAFeway STORES, INC., Respondent.
(90-20641; CA A74889)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 18, 1992.

Jan H. Faber argued the cause for petitioner. With him on the brief was Patrick Lavis, P.C.

Kenneth L. Kleinsmith argued the cause for respondent. With him on the brief was Meyers & Radler.

Before Rossman, Presiding Judge, and De Muniz and Leeson,* Judges.

DE MUNIZ, J.

Reversed and remanded for reconsideration; otherwise affirmed.

*Leeson, J., *vice* Buttler, J., retired.

125 Or App 174 > Claimant seeks review of an order of the Workers' Compensation Board holding that she failed to establish an aggravation of her compensable knee condition and that the referee and the Board lack jurisdiction to consider the dispute concerning the compensability of medical services that she is receiving, because that dispute is a matter exclusively within the jurisdiction of the Director of the Department of Insurance and Finance, pursuant to ORS 656.327(1).

Claimant compensably injured her knee in 1989. After treatment with Dr. Ayres, including arthroscopic surgery, her claim was closed in September, 1989. By stipulation, claimant received an award for five percent permanent partial disability. She began to experience new symptoms in July, 1990, and sought medical advice from Dr. Baskin. The referee and the Board found that Baskin's notes do not document a worsening of claimant's condition. That finding is supported by substantial evidence. Baskin treated claimant in an effort to alleviate her symptoms and provided physical therapy in an effort to strengthen the knee. He ordered an MRI, which showed that the knee was normal. He suggested the possibility of a second arthroscopic procedure to attempt to alleviate her symptoms.

Employer denied that claimant had experienced an aggravation of her compensable condition and also denied that the condition for which Baskin was treating claimant was related to the compensable injury. At the hearing, employer conceded that the treatment is related to the compensable injury, but contended that it is palliative, and therefore not compensable without the approval of the Director. ORS 656.245(1). Employer has not paid any of Baskin's bills.

The first issue is whether the Board erred in concluding that it did not have jurisdiction to consider the dispute concerning the compensability of claimant's medical treatment. The Board held that the question of whether claimant's treatments are palliative, rather than curative, is a question within the exclusive jurisdiction of the Director, pursuant to ORS 656.327, and that the referee and the Board may not consider the issue. ORS 656.327(1) provides, in part:

125 Or App 175 > "If an injured worker, an insurer or self-insured employer or director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, self-insured employer shall so notify the parties and the director."

The Board reasoned:

"The phrase 'excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services' is not statutorily defined and the scope of its plain meaning is significant. Thus, in construing the provision, we have relied on

legislative history, which indicated that the purpose of ORS 656.327 was to remove questions concerning the appropriateness of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75. Accordingly, we have concluded that ORS 656.327 provides a resolution procedure for those medical treatment disputes that are appropriate for review by a medical panel, such as the reasonableness and necessity of medical treatment for a compensable condition. See *Stanley Meyers*, 43 Van Natta 2643 (1991). For the same reason, we have also concluded that ORS 656.327 does not govern medical treatment disputes that primarily involve legal analysis, such as the causal relationship between the need for the treatment and the compensable injury. See *Michael A. Jaquay*, 44 Van Natta 173 (1992).

"The dispute at issue here involves the question of whether claimant's medical treatments are palliative, rather than curative. If found palliative, such care is generally not compensable without prior approval from the carrier or Director. ORS 656.245(1)(b). We find that such a dispute generally concerns the effectiveness and appropriateness of medical treatment at issue and, therefore, believe that it lies within those matters the legislature intended to be resolved by a physician, rather than a referee. Accordingly, because a proceeding for resolving this medical treatment is otherwise provided in ORS 656.327, we hold that original jurisdiction lies exclusively with the Director."

Under ORS 656.245, palliative treatment is not compensable unless approved by the insurer or the Director. The Director is required to appoint a panel of physicians, pursuant to ORS <125 Or App 175/176> 656.327(3), to review the insurer's decision not to reimburse for palliative care.

The substantive issue that the parties seek to resolve here is not whether palliative treatment is compensable, but whether the disputed treatment is palliative or curative. The question on review is which forum has responsibility for resolving that underlying dispute. In *Jefferson v. Sam's Cafe*, 123 Or App 464, P2d (1993), we said that the Director's authority to review medical treatment disputes under ORS 656.327 is limited to disputes concerning treatment that the claimant "is receiving." Accordingly, disputes concerning proposed medical treatment are reviewed pursuant to ORS 656.283, as is any other matter concerning a claim. Because prior approval is required for palliative care, a dispute concerning whether treatment is palliative or curative would ordinarily involve proposed medical treatment and, thus, would not be subject to the provisions of ORS 656.327. When, however, as here, the question of whether the treatment is palliative or curative arises after the claimant has received it, or while the claimant is receiving it, we agree with the Board that the question is a matter within the Director's authority under ORS 656.327, because it is within the category of disputes that the Director is authorized to consider under that statute.

Here, claimant had already received the disputed treatment at the time employer first asserted that the treatment was palliative, and therefore not compensable. Accordingly, we conclude that the dispute could fall within the Director's authority under ORS 656.327. That does not end the inquiry, however. In *Meyers v. Darigold, Inc.*, 123 Or App 217, P2d (1993), we held that the provisions of ORS 656.327 apply only if the insurer or the claimant wishes to have the matter reviewed by the Director and that, if no party seeks review by the Director, the dispute concerning medical treatment is within the jurisdiction of the referee and the Board. Here, no party has sought review by the Director. Accordingly, the Board erred in concluding that it does not have jurisdiction to consider this matter.

The final question on review is whether the Board erred in reversing the referee's assessment of a penalty and <125 Or App 176/177> related attorney fees for employer's denial of the compensability of claimant's medical treatment. In the light of our disposition, the penalty issue is subject to the Board's reconsideration on remand.

Reversed and remanded for reconsideration; otherwise affirmed.

Cite as 125 Or App 205 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David D. Allen, Claimant.

DAVID D. ALLEN, Petitioner,

v.

BOHEMIA, INC. and GOLD BEACH PLYWOOD and LIBERTY NORTHWEST INSURANCE
CORPORATION, Respondents.
(88-18698, 88-18699; CA A72536)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 11, 1992.

Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun & Green.

David O. Wilson argued the cause for respondents Bohemia, Inc. and Liberty Northwest Insurance Corporation. With him on the brief was Employers Defense Counsel.

M. Kathryn Olney, Senior Trial Counsel, argued the cause for respondents Gold Beach Plywood and Liberty Northwest Insurance Corporation. With her on the brief was Liberty Northwest Insurance Corporation.

Before Richardson, Chief Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

125 Or App 207 > Claimant seeks review of an order of the Workers' Compensation Board. The Board held that employer Bohemia, Inc. (Bohemia) did not accept compensability of a claim when it requested designation of a paying agent pursuant to ORS 656.307 and, therefore, its subsequent denial did not constitute an impermissible backup denial. We affirm.

Claimant compensably injured his back in March, 1985, while working for Bohemia, which was insured by Liberty Northwest Insurance Corporation (Liberty Northwest). The claim was closed in November, 1985, with an award of temporary disability. Claimant sought treatment for back pain in November, 1987, and became medically stationary in May, 1988. He saw his chiropractor once in June and once in July. In July, after a pre-employment physical, claimant began working for Gold Beach Plywood, which is also insured by Liberty Northwest.

Claimant received routine manipulations by his treating chiropractor on September 2 and 6. On September 7, claimant argued with his stepmother over her request that he pay rent. On the same day, claimant scheduled an appointment with Gold Beach Plywood's physician for back and personal problems, and he saw the physician the next day. On September 9, claimant completed his work shift. That was his last day at work.

Claimant received treatment for back pain from his chiropractor on September 13. On September 27, the chiropractor filed a report with Bohemia, stating that claimant had suffered a flare up of his 1985 injury, and that he was unable to work.

On October 12, Bohemia issued a denial of claimant's aggravation claim. On the same day, Bohemia said that it denied responsibility only,¹ and requested a determination,

¹ The denial letter said:

"The medical evidence seems to support that you did, in fact sustain a new injury on September 8, 1988, while in the employment of Gold Beach Plywood. Therefore, your claim for aggravation is being denied."

The subsequent letter said:

"Our records indicate your current condition may be the result of an industrial injury on September 8, 1988 at Gold Beach Plywood who was insured by Liberty Northwest Insurance. Because we feel your current condition is related to that injury on October 12, 1988, we are issuing a denial of responsibility only for your present condition. * * * We do feel your condition is work related but it is the responsibility of Gold Beach Plywood." (Emphasis in original.)

Bohemia's concession that claimant's condition is work related does not alter the denial of the claim.

125 Or App 207/208> pursuant to ORS 656.307 of responsibility for payment.² On October 18, claimant filed a new injury claim with Gold Beach Plywood alleging a new injury on September 1. Gold Beach Plywood denied compensability and responsibility on October 26. An order under ORS 656.307 never issued, because Gold Beach Plywood denied compensability. At the hearing on May 25, 1989, Bohemia orally denied compensability of the aggravation claim.

Claimant argues that, by denying only responsibility and requesting an order under ORS 656.307, Bohemia conceded the compensability of his aggravation claim. He contends that Bohemia's oral denial violated ORS 656.262 (since amended by Or Laws 1990 (Special Session), ch 2, 15)³ and constituted an impermissible backup denial. See *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983).

Bohemia denied claimant's aggravation claim in writing, within 60 days, and therefore complied with ORS 656.262(6). Although Bohemia clarified its denial to include responsibility only, it never paid or agreed to pay compensation. At all times, responsibility remained at issue and claimant's claim was in denied status.

125 Or App 209> Bohemia's denial is not a backup denial prohibited by *Bauman v. SAIF, supra*.⁴ In *Bauman*, SAIF accepted a claim and paid medical benefits for three years. When the claimant attempted to reopen the claim for an aggravation, SAIF denied compensability of the original claim. The Supreme Court held that SAIF could not deny compensability:

"The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability." 295 Or at 794.

The court based its holding on three policy concerns: retrospective denials add instability to the system, proof problems may result from the passage of time, and speedy and final resolution of claims is important to the system. 295 Or at 793; *Jeld-Wen, Inc. v. McGehee*, 72 Or App 12, 14, 695 P2d 92, rev den 299 Or 203 (1985). Those concerns are not present here. Bohemia did not accept the claim. *Bauman* only applies to a claim specifically or officially accepted by the insurer. *Johnson v. Spectra Physics*, 303 Or 49, 55, 733 P2d 1367 (1987). The Board did not err in concluding that *Bauman* does not bar Bohemia's denial.

Claimant also argues that the Board's conclusions regarding the medical evidence do not follow from its findings. Claimant contends that the medical evidence requires that the Board find either an aggravation or a new injury. The medical opinion the Board relied on was equivocal as to a new injury. Substantial evidence supports the Board's findings that claimant did not suffer an aggravation of an earlier compensable injury or a new injury. ORS 656.295(5). The Board's conclusion is rationally related to those findings.

Affirmed.

² ORS 656.307(1) provides:

"Where there is an issue regarding:

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries: * * *

"the director shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262(4)."

³ ORS 656.262(6) provided, in part:

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

⁴ Effective July 1, 1990, the legislature amended ORS 656.262 to allow backup denials in certain circumstances. Or Laws 1990 (Special Session), ch 2, 15. The amendment was intended to modify the holding in *Bauman v. SAIF, supra*. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 285, 850 P2d 396 (1993). The amendment does not apply to this case.

Cite as 125 Or App 278 (1993)

December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Thurman M. Mitchell, Claimant.

THURMAN M. MITCHELL, Petitioner,

v.

BURNT MOUNTAIN LOGGING and SAIF CORPORATION, Respondents.
(91-14771; CA A78818)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 18, 1993.

Edward J. Harri argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll.

Steven Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

125 Or App 279 > Claimant seeks review of a Workers' Compensation Board order holding that the hearings division lacked jurisdiction to review his claim for reimbursement of travel expenses that he incurred in the course of medical treatment. We review for errors of law, ORS 656.298(6); ORS 183.482(7), (8), and reverse.

Employer argues that ORS 656.704(3),¹ and ORS 656.327(1)(a),² grant original jurisdiction of this dispute to the Director of the Department of Insurance and Finance. However, employer did not demonstrate that it desired director review by giving the notice required by ORS 656.327(1)(a). Without compliance with that statutory procedure, the dispute remains within the Board's jurisdiction. *Meyers v. Darigold, Inc.*, 123 Or App 217, ___ P2d ___ (1993).

We do not address claimant's alternative argument that the denial of reimbursement for travel expenses does not raise a question regarding medical treatment that is subject to director review under ORS 656.327(1).

Reversed and remanded for reconsideration.

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 worker's right to receive 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."

² ORS 656.327(1)(a) provides:

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

Cite as 125 Or App 280 (1993) December 8, 1993

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald J. Bradley, Claimant.

DONALD J. BRADLEY, Petitioner,

v.

WILLAMETTE ELECTRIC and SAIF CORPORATION, Respondents.
(91-02782; CA A74815)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 15, 1993.

Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy.

Steve Cotton, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and Riggs and Durham, Judges.

PER CURIAM

Affirmed.

125 Or App 281 > Claimant seeks review of a Workers' Compensation Board order that awarded a penalty against insurer under ORS 656.262(10) for unreasonable claim processing, but declined to assess an attorney fee for the same conduct under ORS 656.382(1). He acknowledges that the unreasonable conduct of which he complains is a single act, not separate acts.

We have held that a single unreasonable act cannot be the basis for both a penalty under ORS 656.262(10)(a) and an award of attorney fees under ORS 656.382(1). *Corona v. Pacific Resource Recycling*, 125 Or App 47, 50, P2d (1993); *Oliver v. Norstar, Inc.*, 116 Or App 333, 336, 840 P2d 1382 (1992); *Martinez v. Dallas Nursing Home*, 114 Or App 453, 836 P2d 147, *rev. den.* 315 Or 271 (1992). Claimant criticizes that rule, but does not successfully distinguish this case from the authorities cited.

Affirmed.

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1835	348	2503	1323
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1323	77	576,646,1211,1816, 1873,2448,2459,2481	1823
<u>9.320</u>	<u>58.075(1)</u>	<u>174.020</u>	<u>183.480</u>
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<u>9.536(3)</u>	<u>60.531(1)(c)</u>	<u>180.220(2)</u>	<u>183.480(2)</u>
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<u>18.160</u>	<u>82.010</u>	<u>183.310 to .550</u>	<u>183.482</u>
113,163,270,2473	47,216	645	469,576,600,1332
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<u>656.214(2)(b)</u> 641	<u>656.236(2)</u> 586,758,995,1487	<u>656.245(3)(b)(B)</u> 34,93,105,114,118, 158,291,512,805,866, 1096,1268,1484,1528, 1734,1748,1785,1794, 1807,2014,2017,2077, 2091,2094,2097,2135, 2183,2218,2261,2266, 2279,2409	<u>656.262(4)(d)</u> 1121,1306
<u>656.214(2)(g)</u> 2464	<u>656.236(3)</u> 1064,1779	<u>656.245(4)</u> 13,1830	<u>656.262(5)</u> 1300
<u>656.214(3)</u> 325,576,641,1838, 1843,2481	<u>656.236(4)</u> 995,2109	<u>656.245(4)(a)</u> 13	<u>656.262(6)</u> 129,198,318,322,369, 435,457,546,557,619, 651,664,719,725,763, 829,856,905,936,940, 942,960,972,977,994, 1007,1056,1102,1115, 1117,1140,1215,1225, 1264,1300,1319,1467, 1515,1562,1633,1638, 1642,1676,1763,1861, 1865,1871,2036,2078, 2158,2189,2306,2478, 2490,2521
<u>656.214(4)</u> 576,641,1288,1838, 1843,2481	<u>656.236(6)</u> 995,1442	<u>656.248</u> 1102,1728,2054	
<u>656.214(5)</u> 567,576,788,1147, 1173,1250,1288,1544, 1584,1595,1615,1670, 1843,2261,2293,2481	<u>656.240</u> 1502	<u>656.248(3)</u> 2503	<u>656.262(6)(a)</u> 651,1642
<u>656.216</u> 2493	<u>656.245</u> 111,136,165,179,315, 398,426,482,611,626, 742,773,795,837,853, 867,930,995,1023, 1064,1102,1167,1194, 1234,1295,1446,1479, 1491,1532,1559,1574, 1638,1699,1830,2071, 2090,2112,2182,2198, 2201,2248,2327,2414, 2459,2497,2519	<u>656.248(13)</u> 424,1102,2503	<u>656.262(6)(b)</u> 651,1642
<u>656.222</u> 1329,1670		<u>656.254</u> 1830	<u>656.262(6)(c)</u> 391,651,1343,1642, 2179,2194,2289,2360
<u>656.230</u> 995,1779,2148		<u>656.262</u> 366,600,805,894,994, 1047,1102,1140,1194, 1264,1300,1319,1462, 1467,1563,1782,1830, 1861,2179,2194,2521	<u>656.262(8)</u> 504,619,887,1881
<u>656.230(1)</u> 2148			

656.262(9)

99,129,330,419,421,
446,457,874,951,1115,
1513,1999,2040,2073;
2189

656.262(10)

40,88,96,149,152,
173,192,198,216,237,
256,282,287,308,330,
344,348,419,425,444,
446,462,466,488,490,
508,529,543,557,573,
629,645,656,659,664,
789,805,815,829,839,
960,1035,1047,1056,
1079,1080,1136,1140,
1169,1193,1221,1243,
1278,1319,1330,1341,
1442,1454,1536,1538,
1601,1628,1631,1642,
1666,1678,1768,1786,
1991,2013,2036,2102,
2114,2124,2128,2158,
2234,2257,2285,2308,
2340,2389,2390,2396,
2409,2423,2426,2490,
2508,2524

656.262(10)(a)

152,183,192,200,207,
237,419,453,645,656,
728,789,1078,1169,
1221,1341,1455,1517,
1536,1567,1768,1773,
1782,1855,2102,2177,
2234,2389,2508,2524

656.262(10)(b)

1855

656.262(12)

452,1343

656.265

242

656.265(1)

889

656.265(2)

889

656.265(4)(a)

361,889

656.265(5)

242

656.266

45,69,86,190,219,
335,348,369,403,564,
737,755,844,995,1087,
1191,1202,1225,1343,
1452,1484,1533,1707,
1745,1748,1852,1868,
2032,2094,2126,2238,
2261,2286,2293,2333,
2475

656.268

27,47,125,152,173,
192,200,205,207,212,
219,262,282,308,318,
391,432,435,438,452,
484,485,548,573,605,
629,651,721,776,805,
821,840,891,972,1100,
1117,1252,1268,1306,
1340,1343,1435,1454,
1457,1626,1642,1681,
1719,1734,1782,1794,
1829,1842,1869,2094,
2133,2179,2227,2284,
2308,2368,2390,2467,
2499

656.268(1)

158,187,308,403,591,
640,805,935,944,985,
1505,1565,1573,1604,
1713,1738,1796,2224,
2261,2308

656.268(2)

5,308,543,591,2308

656.268(2)(a)

1343

656.268(2)(c)

935,2308

656.268(3)

152,192,207,219,355,
425,432,466,548,644,
935,1097,1117,1121,
1169,1211,1243,1300,
1306,1454,1631,1684,
1749,1782,1851,1869,
2061,2128,2216,2308,
2390

656.268(3)(a)

152,192,207,219,298,
432,548,644,1097,
1121,1197,1300,1306,
1631,1869,2308

656.268(3)(b)

192,207,219,548,644,
1121,1300,1306,1812,
1869,2061,2383

656.268(3)(c)

152,192,207,219,298,
548,644,1121,1169,
1211,1300,1306,1749,
1869,2390

656.268(4)

5,457,1497,1829

656.268(4)(a)

805

656.268(4)(b)

1117

656.268(4)(e)

260,651,776,893,944,
972,988,1036,1268,
1282,1719,1829

656.268(4)(f)

173,573

656.268(4)(g)

173,280,562,886,
1078,1082,1193,1543,
1665,1734,1739,2014

656.268(5)

76,118,125,186,200,
391,438,491,651,776,
821,831,893,972,984,
988,1036,1117,1161,
1268,1435,1457,1484,
1497,1631,1719,1734,
1785,1794,1807,1812,
1842,2014,2017,2077,
2091,2097,2135,2172,
2266,2279,2293

656.268(5)(e)

651

656.268(6)

305,391,491,1117

656.268(6)(a)

68,76,110,460,524,
1268,1484,1553,1558,
1576,1834,1835,2097,
2130,2467

656.268(6)(b)

125,305,438,805,840,
918,1036,1268,1457,

656.268(6)(b)-cont.

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2077,2097,2275,2276,
2420,2467,2499

656.268(7)

68,76,93,105,114,
118,144,260,394,427,
438,460,512,524,721,
866,944,958,1036,
1082,1096,1117,1201,
1268,1285,1435,1465,
1484,1528,1553,1558,
1601,1681,1734,1748,
1785,1794,1807,2014,
2017,2077,2091,2094,
2097,2130,2135,2218,
2261,2266,2275,2276,
2279,2420,2467

656.268(8)

1069

656.268(9)

391,1457,1834

656.268(10)

1821

656.268(11)

391,1782,2179,2194,
2289

656.268(12)**656.268(13)**

13,1261,1821,2183,
2227,2242

656.268(14)

260,1225

656.270

1829

656.273

24,120,122,165,205,
249,435,485,492,586,
763,771,795,837,972,
995,1088,1100,1119,
1295,1300,1487,1642,
1658,1659,1878,2063,
2075,2221,2248,2338,
2360,2459,2475,2497

656.273(1)

17,65,101,120,142,
179,187,206,225,379,
421,453,466,492,751,

656.273(1)-cont.
755,771,827,847,947,
995,1021,1076,1087,
1092,1097,1140,1175,
1207,1246,1273,1295,
1298,1300,1638,1642,
1649,1659,1709,1843,
1868,2025,2050,2059,
2065,2075,2193,2221,
2243,2292,2312,2338,
2385,2403,2459,2475

656.273(1)(a)
492

656.273(1)(b)
492

656.273(2)
198,924,1295,2459

656.273(3)
65,101,432,453,492,
751,924,1076,1092,
1140,1295,1300,1659,
1709,2065,2193,2385

656.273(4)
485,605,651,763,1295,
1343,1642

656.273(4)(a)
5,67,122,322,485,605,
1100,1343

656.273(4)(b)
5,435,485,605,1100,
1343,2360

656.273(6)
198,453,771,1097,
1140,1300,2124

656.273(8)
65,101,187,225,322,
344,462,492,751,771,
827,847,1076,1092,
1097,1175,1300,1638,
1709,2025,2059,2065,
2075,2221,2403

656.277
5,432,452,651,972,
1782,2360

656.277(1)
432,452,651,863,972,
1642

656.277(2)
651,972,1642,1659,
2063,2289

656.277(3)
651,972

656.277(3)(a)
651,972

656.277(3)(b)
435,651,972

656.277(3)(c)
432,435,651,972

656.277(3)(d)
651,972

656.278
24,27,165,205,249,
586,763,837,995,1100,
1487,1552,1591,1830,
2060,2201,2206,2224

656.278(1)
249,590,995

656.278(1)(a)
73,111,112,113,122,
136,255,346,364,426,
742,759,779,795,867,
868,872,930,933,968,
1438,1440,1462,1546,
1552,1559,1567,1574,
1580,1581,1612,1699,
1701,1712,1714,1771,
2021,2073,2112,2182,
2197,2201,2202,2206,
2224,2318,2414

656.278(1)(b)
1446,2008

656.278(2)
205,1100

656.278(3)
590,2008

656.278(4)
968

656.283
125,270,322,335,391,
512,519,770,776,905,
995,1020,1023,1155,
1457,1613,1619,1724,
1782,1842,1889,2097,
2252,2275,2276,2344,
2365,2420,2439,2467,
2519

656.283(1)
237,260,325,346,482,
718,753,846,926,1447,
1619,1642,1692,1724,
1728,1861,1889,2097,
2194,2275,2277,2305,
2467

656.283(2)
249,325,335,463,508,
600,950,961,1241,
1613,1685,1889,2344,
2365,2441,2467

656.283(2)(a)
249,325,463,600,950,
961,1241,1889,2441

656.283(2)(b)
249,325,600,950,961,
1241,1889

656.283(2)(c)
325,600,950,961,1241,
1889

656.283(2)(d)
325,600,950,961,1241,
1613,1889

656.283(3)
335,1282,1619,1889

656.283(4)
335

656.283(5)
335

656.283(6)
335,802,2344

656.283(7)
43,68,76,95,186,200,
225,270,291,305,328,
335,358,366,415,438,
474,543,567,721,776,
788,883,893,955,974,
985,995,1036,1116,
1147,1215,1250,1268,
1285,1295,1469,1480,
1484,1497,1553,1570,
1607,1626,1655,1681,
1685,1705,1719,1734,
1748,1778,1785,1794,
1807,1842,1867,2014,
2017,2042,2077,2091,
2094,2097,2105,2135,
2172,2232,2261,2266,
2276,2279,2293,2301,
2305,2344,2365,2420,
2467,2499

656.283(8)
335

656.289
1691

656.289(1)
408,526,1150

656.289(3)
69,92,156,408,424,
543,784,990,1020,
1150,1221,1447,1450,
1619,1730,1757,1834,
2119,2123,2254,2330,
2424

656.289(4)
13,586,838,1589,1633,
1724,1845,1861

656.295
69,92,156,348,389,
408,424,784,974,1020,
1150,1619,1629,1691,
1715,1730,1757,2119,
2254

656.295(1)
1446

656.295(2)
69,92,156,408,424,
784,967,990,1150,
1629,1757,2119,2254

656.295(3)
43,335,1838,2013

656.295(5)
13,63,68,83,105,107,
181,195,225,230,237,
272,289,291,301,305,
335,363,438,470,482,
519,526,535,718,732,
753,755,768,776,864,
878,948,971,977,978,
1010,1036,1044,1143,
1147,1161,1173,1191,
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1271,1285,1288,1295,
1450,1457,1465,1466,
1474,1480,1482,1484,
1497,1523,1538,1561,
1597,1607,1622,1626,
1629,1631,1642,1652,
1655,1662,1681,1690,
1691,1696,1698,1715,
1719,1727,1728,1741,

656.295(5)-cont.
1772,1773,1803,2013,
2028,2077,2093,2140,
2174,2179,2187,2191,
2232,2270,2274,2276,
2287,2289,2291,2305,
2330,2420,2432,2439,
2441,2499,2521

656.295(6)
270,405,466,543,990,
995,1207,1525,1660,
1691

656.295(8)
178,425,532,591,1834,
2028

656.298
600,1821,1830

656.298(1)
178,2028

656.298(3)
1629,2254,2458

656.298(6)
576,612,622,1336,
1343,1848,1868,2459,
2469,2488,2496,2501,
2523

656.304(6)
2475

656.307
140,232,330,419,444,
446,472,636,905,1007,
1167,1181,1321,1517,
1521,1552,1792,2114,
2206,2234,2282,2306,
2473,2521

656.307(1)
905,2303,2521

656.307(1)(a)
905

656.307(1)(b)
905,1552,2206,2303

656.307(1)(c)
905,2521

656.307(1)(d)
905

656.307(2)
52,140,636,837,905,
1181,2142

656.307(3)
905

656.307(5)
25,140,825,905,2142

656.308
232,278,345,472,662,
738,851,905,956,1058,
1234,1266,1321,1521,
1547,1702,1800,2003,
2114,2146,2151,2174,
2243,2362,2429,2444

656.308(1)
65,79,232,268,278,
281,295,345,385,405,
446,474,492,533,624,
636,662,905,1017,

1031,1058,1074,1167,
1234,1266,1321,1482,
1517,1521,1529,1638,
1660,1702,1709,1775,
1991,2114,2142,2146,
2151,2212,2243,2303,
2448

656.308(2)
1,328,748,1321,1450,
1709,1792,1800,2146,
2216,2306,2362,2478

656.310
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656.310(2)
871,977,2042,2312

656.313
47,178,192,207,216,
282,290,318,389,488,
490,532,573,600,646,
840,1145,1221,1252,
1348,1356,1506,1678,
1855,2044,2102,2308

656.313(1)
47,192,282,318,354,
466,600,646,659,840,
1145,1243,1754,1855,
2044,2102

656.313(1)(a)
47,216,318,354,573,
646,659,840,1145,

656.313(1)(a)-cont.
1243,1348,1506,1678,
1754,1768,1855,2044,
2059,2308

656.313(1)(a)(A)
47,152,192,207,290,
318,466,646,659,805,
811,840,1221,1252,
1348,1506,1754,2308

656.313(1)(a)(B)
318,646,659,1348

656.313(1)(b)
47,216,646,1353

656.313(2)
282,466,1457

656.313(4)
600,646

656.319
611,619,1069,1215,
1597,1889,2467,2478

656.319(1)
71,163,378,393,605,
619,922,2040,2413,
2473

656.319(1)(a)
63,71,163,216,270,
378,393,504,619,921,
2413,2473

656.319(1)(b)
63,71,163,378,393,
921,950,1249,2413,
2473

656.319(4)
47,305,1457,2102

656.325
348,1291

656.325(1)
335,645

656.325(1)(a)
270,1044

656.325(2)
219,2040

656.325(3)
219,576,1812

656.325(4)
219

656.327
163,335,346,759,856,
930,933,974,995,1102,
1190,1440,1462,1589,
1658,1809,2108,2187,
2191,2224,2268,2291,
2305,2331,2344,2364,
2371,2459,2519

656.327(1)
856,1102,1190,2036,
2187,2224,2268,2291,
2331,2364,2370,2439,
2459,2519

656.327(1)(a)
328,335,1102,1589,
2224,2268,2344,2364,
2459,2523

656.327(1)(b)
1102,1589,2224,2268,
2328,2330,2344,2364,
2370,2459

656.327(1)(c)
856,2459

656.327(2)
335,770,1023,1102,
1155,1155,1190,1589,
1728,1809,2187,2191,
2268,2291,2305,2328,
2330,2344,2364,2438,
2459

656.327(3)
335,1023,2364,2519

656.340
165,463,576,600,837,
935,995,2441

656.340(1)
1867

656.340(1)(a)
1054,1889

656.340(1)(b)(A)
1054,1241

656.340(4)
1054,1241

<u>656.340(5)</u> 463,576	<u>656.382(1)-cont.</u> 1567,1601,1631,1642, 1739,1768,1991,2014, 2027,2036,2114,2124, 2128,2192,2216,2234, 2251,2285,2303,2308, 2322,2340,2396,2426, 2439,2490,2508,2524	<u>656.382(2)-cont.</u> 2133,2144,2146,2151, 2163,2165,2167,2179, 2189,2216,2228,2230, 2232,2243,2246,2247, 2259,2261,2267,2282, 2292,2303,2321,2323, 2329,2337,2341,2358, 2362,2371,2375,2376, 2387,2390,2393,2408, 2409,2431	<u>656.386(2)-cont.</u> 384,432,536,1082, 1123,1214,1330,1484, 1490,1528,1621,2165, 2179,2183,2232,2400
<u>656.340(6)</u> 249,463,508,536,576, 1889			<u>656.388</u> 607,1193,1830
<u>656.340(6)(a)</u> 249,463,479,508,536, 1889	<u>656.382(2)</u> 4,7,16,25,38,69,80, 84,93,95,116,120, 124,137,140,141,170, 178,203,205,213,230, 232,235,237,242,246, 267,272,281,282,288, 298,299,308,328,341, 342,344,345,355,366, 379,383,384,415,417, 431,435,444,449,462, 466,472,477,491,499, 504,506,509,510,516, 518,519,526,528,533, 543,548,557,562,563, 566,572,573,650,738, 743,748,748,749,751, 755,756,757,759,763, 769,783,787,789,805, 811,815,821,840,842, 849,854,860,865,889, 890,891,898,929,932, 942,948,960,963,983, 985,987,1007,1010, 1016,1021,1031,1057, 1067,1074,1081,1082, 1093,1097,1116,1121, 1129,1132,1136,1145, 1156,1165,1173,1175, 1178,1179,1188,1208, 1221,1224,1234,1252, 1261,1266,1268,1271, 1278,1333,1448,1454, 1457,1469,1482,1495, 1497,1502,1515,1528, 1529,1532,1536,1540, 1541,1562,1563,1570, 1579,1582,1584,1593, 1606,1622,1628,1636, 1652,1666,1668,1676, 1680,1689,1692,1702, 1708,1715,1724,1733, 1734,1749,1751,1754, 1766,1772,1773,1777, 1792,1793,1794,1800, 1805,1807,1808,1991, 1993,1999,2001,2003, 2011,2040,2046,2047, 2049,2051,2059,2097, 2102,2106,2106,2124,	<u>656.382(3)</u> 1536,1867	<u>656.388(1)</u> 216,282,572,1193, 1743,2081,2376,2383, 2408
<u>656.340(6)(b)</u> 463,1889		<u>656.386(1)</u> 13,17,27,28,32,55, 74,85,86,97,149,183, 187,198,211,216,225, 272,330,332,341,357, 361,376,385,388,410, 443,453,518,546,567, 566,715,716,719,725, 728,741,747,780,792, 811,825,827,832,836, 838,842,847,856,860, 863,869,878,896,936, 947,959,994,1009, 1047,1056,1074,1076, 1080,1085,1115,1119, 1123,1127,1131,1136, 1140,1152,1167,1181, 1208,1214,1215,1219, 1246,1256,1317,1327, 1330,1333,1467,1471, 1490,1499,1510,1513, 1517,1525,1541,1601, 1604,1617,1633,1647, 1666,1686,1702,1709, 1718,1773,1786,1828, 1991,1997,2018,2019, 2022,2024,2025,2035, 2036,2051,2055,2060, 2063,2065,2090,2110, 2111,2114,2137,2138, 2155,2158,2169,2170, 2179,2192,2199,2207, 2223,2255,2282,2303, 2323,2331,2333,2335, 2375,2381,2387,2396, 2403,2405,2424,2426, 2433,2478,2490	<u>656.388(2)</u> 607,1743,2081
<u>656.340(6)(b)(A)</u> 463,508,1889		<u>656.386</u> 1193,1243,1256,1541, 1548,1577,1668	<u>656.390</u> 216,1867
<u>656.340(6)(b)(B)</u> 463,508,576,1889			<u>656.506(3)</u> 591
<u>656.340(6)(b)(B)(i),(ii)</u> 1889			<u>656.508</u> 593
<u>656.340(6)(b)(B)(iii)</u> 463,576,1889,2441			<u>656.508(2)</u> 2452
<u>656.340(7)</u> 249,1889			<u>656.526</u> 593
<u>656.340(9)</u> 249			<u>656.538</u> 1830
<u>656.340(9)(c)</u> 249,463			<u>656.576</u> 21,995,1731
<u>656.340(11)</u> 1613			<u>656.578</u> 1586,2068,2324
<u>656.340(14)</u> 576			<u>656.580</u> 995
<u>656.340(14)(b)</u> 576			<u>656.580(1)</u> 1088
<u>656.382</u> 342,488,664,829,856, 1193,1243,1256			<u>656.580(2)</u> 1088,1586,2068
<u>656.382(1)</u> 40,145,149,173,192, 198,200,216,282,287, 330,419,432,446,449, 508,518,557,573,629, 659,747,856,863,878, 886,942,1009,1035, 1047,1054,1078,1079, 1080,1082,1115,1132, 1140,1193,1194,1317, 1341,1466,1513,1543,			<u>656.583(1)</u> 2324
			<u>656.583(2)</u> 2324
			<u>656.587</u> 21,413,1548,1879

<u>656.591</u> 1088,2324	<u>656.632(3)</u> 593	<u>656.726(3)(a)</u> 173,348,1288	<u>656.794</u> 1830
<u>656.593</u> 873,995,1088,2068, 2324	<u>656.634</u> 593,2452	<u>656.726(3)(f)</u> 291,325,567,995, 1288,1681,1719,2232, 2261,2293	<u>656.801(1)</u> 1663
<u>656.593(1)</u> 21,413,873,995,1064, 1487,1548,1586,2068, 2407	<u>656.634(1)</u> 593,2452	<u>656.726(3)(f)(A)</u> 1250,1288,1480,1484, 1655,1842,2105	<u>656.802</u> 1,150,272,499,736, 748,876,887,905,1093, 1129,1202,1509,1857, 1871,2034,2064,2142, 2238,2429,2433,2509
<u>656.593(1)(a)</u> 21,873,995,1064, 1487,1548,1586,2068	<u>656.640</u> 2452	<u>656.726(3)(f)(B)</u> 34,382,438,988,1096, 1528,1681,2368	<u>656.802(1)</u> 74,85,385,1224,1786, 1857,2003,2022,2064, 2151,2176,2387,2444
<u>656.593(1)(b)</u> 21,873,995,1064, 1487,1586,2068	<u>656.642(2)(b)</u> 2452	<u>656.726(3)(f)(C)</u> 125,155,173,291,400, 512,524,929,958,1435, 1655,1685,1733,2441, 2499	<u>656.802(1)(a)</u> 272,1628,1857
<u>656.593(1)(c)</u> 21,873,995,1064,1088, 1487,1586,1586,2065, 2068	<u>656.700</u> 443	<u>656.735</u> 237	<u>656.802(1)(b)</u> 150,924,1093,1607, 1786,1857
<u>656.593(1)(d)</u> 873,995,1064,1487, 1586,2068	<u>656.700(1)-(8)</u> 443	<u>656.740</u> 939,1563,1619,1691	<u>656.802(1)(c)</u> 1,32,190,543,636,715, 728,766,792,1129, 1604,1668,1705,1715, 1718,1857,2011,2019, 2101,2176,2189,2199, 2243,2255,2338,2372, 2433,2488
<u>656.593(2)</u> 873,995,1064,1487	<u>656.704(1)</u> 237,846	<u>656.740(1)</u> 12,1563,1861,2214, 2252	<u>656.802(2)</u> 1,13,28,32,55,74,104, 190,228,272,307,358, 361,385,492,543,648, 715,728,730,741,766, 792,924,940,966,1093, 1129,1178,1200,1202, 1215,1219,1234,1321, 1463,1517,1593,1604, 1607,1647,1718,1766, 1786,1857,1871,2003, 2011,2019,2022,2114, 2146,2151,2176,2199, 2203,2238,2243,2255, 2260,2265,2280,2338, 2362,2372,2393,2433, 2464
<u>656.593(3)</u> 21,873,995,1064,1487, 1548,1731,1790,2068, 2407	<u>656.704(3)</u> 52,424,482,759,926, 1020,1023,1102,1457, 1479,1491,1579,1589, 1619,1809,1855,2036, 2252,2371,2439,2459, 2523	<u>656.740(2)</u> 1338	
<u>656.593(3)(c)</u> 1487	<u>656.704(4)</u> 1579	<u>656.740(3)</u> 12,1563,1861,2214, 2252	
<u>656.600</u> 443	<u>656.704(4)(c)</u> 1579	<u>656.740(4)</u> 627,1619,2376	
<u>656.600(3)</u> 443	<u>656.708</u> 519,926,1457,1855	<u>656.740(4)(a)</u> 1691	
<u>656.600(4)</u> 443	<u>656.723(1)</u> 1295,1298	<u>656.740(4)(c)</u> 12,1020,1338,1619, 1691,2252,2376	
<u>656.622</u> 1830	<u>656.726</u> 721,776,935,1295, 1435,1626,1719,2274	<u>656.740(5)</u> 846,939	
<u>656.625</u> 73,255,995,1701,1712, 2008	<u>656.726(2)(c)</u> 335	<u>656.745</u> 508	
<u>656.632(2)</u> 593	<u>656.726(3)</u> 173	<u>656.790</u> 318,586,646,1348, 1830	<u>656.802(2)(b)</u> 272,924,1857

<u>656.802(2)(d)</u> 272,1857	<u>659.425</u> 2481	<u>701.055(9)</u> 1823	<u>436-10-040(1)(a)</u> 2036
<u>656.802(3)</u> 150,189,272,431,876, 991,1093,1278,1607, 1840,1857,2064,2203	<u>659.425(1)</u> 2481	<u>701.060</u> 1823	<u>436-10-040(2)</u> 770,2459
<u>656.802(3)(a)</u> 924,1093,1607,1786, 2203,2238	<u>659.425(1)(a),(c)</u> 2481	<u>737.318</u> 638	<u>436-10-040(3)</u> 770
<u>656.802(3)(b)</u> 189,431,924,966, 1093,1539,1607,1786, 2203,2236,2238	<u>670.600</u> 443,787,1136,1312, 1318,1351,1476,1816, 1819,1820,1823,2512	<u>737.350 et seq</u> 665	<u>436-10-040(3)(a)</u> 2036
<u>656.802(3)(c)</u> 924,1093,1786,1857, 2203,2238	<u>670.600(1)</u> 787,1351,1476,1823, 2512	<u>737.505</u> 638	<u>436-10-041</u> 1023,1190
<u>656.802(3)(d)</u> 876,924,1093,1786, 2203,2238	<u>670.600(2),(3)</u> 787,1351,1476,1823	<u>737.505(1)</u> 638	<u>436-10-041(2)</u> 1023
<u>656.802(4)</u> 228,264	<u>670.600(4)</u> 787,1351,1476,1823, 2512	<u>737.505(2)</u> 638	<u>436-10-041(3)</u> 1023,2224
<u>656.807</u> 2362	<u>670.600(5),(6)</u> 787,1351,1476,1823	<u>737.505(3)</u> 638	<u>436-10-041(4)</u> 126,482,1023
<u>656.807(1)</u> 361,748,2362,2464	<u>670.600(8)</u> 443,787,1351,1476, 1823	<hr/> <u>ADMINISTRATIVE RULE CITATIONS</u>	
<u>656.807(1)(a)</u> 361,2362	<u>684.100(1)</u> 1323	<u>Rule</u> Page(s)	<u>436-10-041(5)</u> 482,1023
<u>656.807(1)(b)</u> 361,2362	<u>684.100(1)(g)(A)</u> 1323	<u>137-76-010(7)</u> 1157,1673,2417	<u>436-10-041(8)</u> 1023
<u>656.807(4)</u> 2464	<u>684.100(1)(j)</u> 1323	<u>137-76-010(8)</u> 1157,1673,2417	<u>436-10-041(9)</u> 1023
<u>656.990(1)</u> 1225	<u>684.100(9)(g)</u> 1323	<u>137-76-025</u> 1759	<u>436-10-041(10)</u> 1023
<u>657.042</u> 1823	<u>701.025</u> 443,787,1312,1318, 1476,1816,1819,1820	<u>436-10-003(3)</u> 1462	<u>436-10-041(11)</u> 1023
<u>657.176(2)(a)</u> 1334	<u>701.025(1)</u> 1816	<u>436-10-005(31)</u> 2224	<u>436-10-046</u> 856,933,1190,1440, 1461,1658,2224,2344
<u>659.040 through .121</u> 1727	<u>701.025(7)</u> 1816	<u>436-10-008(6)</u> 853,1023,2364	<u>436-10-046(1)</u> 759,1190
<u>659.410</u> 2031	<u>701.035(1)</u> 1823	<u>436-10-008(6)(c)</u> 1023	<u>436-10-046(2)</u> 2191
<u>659.410(1)</u> 898	<u>701.035(2)-(4)</u> 1823	<u>436-10-030</u> 1132	<u>436-10-046(2)(d)</u> 770
		<u>436-10-030(15)</u> 1132	<u>436-10-046(3)</u> 1462
			<u>436-10-046(4)</u> 2459
			<u>436-10-046(7),(9),(11)</u> 2344

<u>436-10-046(16),(18)</u> 2344	<u>436-30-035</u> 158,2261	<u>436-30-050(2)</u> 776,893,1282	<u>436-35-003(2)</u> 134,200,1250,1435, 1484,1544,1582,1584, 1595,1615,1733,1794, 2010,2091,2274,2284, 2368
<u>436-10-050(1)</u> 2268	<u>436-30-035(1)</u> 158	<u>436-30-050(3)</u> 1457,1520	<u>436-35-003(3)</u> 134,506
<u>436-10-060</u> 187	<u>436-30-035(4)</u> 2094	<u>436-30-050(4)</u> 776	<u>436-35-003(4)</u> 1584,1595,1615,1641, 1681,1719,1725,1794, 2218,2232,2274,2284
<u>436-10-070</u> 856,1513	<u>436-30-035(6)</u> 2094	<u>436-30-050(4)(c)</u> 1719	<u>436-35-005(1)</u> 833,1069
<u>436-10-070(2)</u> 1513	<u>436-30-035(7)</u> 1854	<u>436-30-050(4)(e)</u> 984	<u>436-35-005(2)</u> 833
<u>436-10-080</u> 2261	<u>436-30-035(7)(a)</u> 2293	<u>436-30-050(4)(f)</u> 2293	<u>436-35-005(3)</u> 833
<u>436-10-080(1)</u> 2261	<u>436-30-035(7)(b)</u> 2293	<u>436-30-050(11)(a)</u> 1285	<u>436-35-005(4)</u> 59,74,969,1201,1452, 1748,2094,2368
<u>436-10-080(2)</u> 2261	<u>436-30-035(7)(c)</u> 158	<u>436-30-050(11)(c)</u> 1082	<u>436-35-005(5)</u> 186,291,415,883
<u>436-10-080(5)</u> 1268,2261	<u>436-30-035(8)</u> 158	<u>436-30-050(12)</u> 1078,1082	<u>436-35-005(6)</u> 1082
<u>436-10-090(9)</u> 2503	<u>436-30-036</u> 355	<u>436-30-050(13)</u> 1082	<u>436-35-005(7)</u> 186,400,415
<u>436-10-100(1)</u> 1291	<u>436-30-036(1)</u> 355,381,1285	<u>436-30-050(14)</u> 110,173,562	<u>436-35-007</u> 567
<u>436-10-110 to 130</u> 2503	<u>436-30-036(4)(f)</u> 355	<u>436-30-055(1)(c)</u> 2133	<u>436-35-007(1)</u> 128,719,1096
<u>436-10-110</u> 2503	<u>436-30-036(4)(g)</u> 355	<u>436-30-065(7)</u> 1497	<u>436-35-007(2)</u> 438,749
<u>436-10-110(1)(a)</u> 2503	<u>436-30-045</u> 147,452,821,2179	<u>436-30-065(7)(a)</u> 1497	<u>436-35-007(3)</u> 1329
<u>436-10-110(2),(3)</u> 2503	<u>436-30-045(1)(a)</u> 432	<u>436-35-001 et seq.</u> 567,1295,1626	<u>436-35-007(4)</u> 567
<u>436-10-115</u> 2503	<u>436-30-045(2)</u> 2179	<u>436-35-002</u> 1295	<u>436-35-007(5)</u> 567
<u>436-10-115(3)</u> 2503	<u>436-30-045(4)</u> 2179	<u>436-35-003</u> 39,118,291,567,883, 1161,1295,1544,1584, 1595,1615,1626,1748, 2010,2091,2094,2261, 2284,2293	<u>436-35-007(6)</u> 105,143,512,866,2014
<u>436-10-130</u> 2503	<u>436-30-045(5)</u> 391	<u>436-35-003(1)</u> 39,118,134,291,567, 883,1480,1655	<u>436-35-007(7)</u> 34,93,512,737,866, 1018,1082,1165,1528
<u>436-10-130(2)</u> 2503	<u>436-30-045(5)(b)</u> 2179		<u>436-35-007(8)</u> 2172
<u>436-30-008(1)</u> 2033	<u>436-30-045(7)</u> 821		

<u>436-35-007(11)</u> 1595,2172	<u>436-35-020 thru -060</u> 505	<u>436-35-100(1)</u> 1582	<u>436-35-220(4)</u> 155
<u>436-35-007(14)</u> 31,1188,1538,2010, 2094	<u>436-35-020(1)</u> 641	<u>436-35-110</u> 105	<u>436-35-220(5)</u> 893,1655
<u>436-35-007(14)(a)</u> 105	<u>436-35-020(2)</u> 641	<u>436-35-110(2)</u> 31,143,325,1538,2010	<u>436-35-220(6)</u> 1655
<u>436-35-007(15)</u> 1604	<u>436-35-040(1)</u> 2437	<u>436-35-110(2)(a)</u> 31,74,752,2010	<u>436-35-220(9)</u> 1147
<u>436-35-007(16)</u> 1435,1582,1655	<u>436-35-040(3)</u> 325,870,2437	<u>436-35-110(2)(b)</u> 325	<u>436-35-220(10)</u> 1147,1655
<u>436-35-007(17)</u> 2172	<u>436-35-040(4)</u> 870	<u>436-35-110(2)(c)</u> 325	<u>436-35-220(11)</u> 1147
<u>436-35-010 thru -260</u> 291,325,969	<u>436-35-040(5)</u> 2437	<u>436-35-110(3)</u> 31	<u>436-35-220(12)</u> 1655
<u>436-35-010(1)</u> 219,1018	<u>436-35-040(6)</u> 325	<u>436-35-110(7)</u> 1188	<u>436-35-230(1)</u> 1147
<u>436-35-010(2)</u> 128,833,1114,1748, 2094,2218	<u>436-35-050(2)(b)</u> 567	<u>436-35-110(8)</u> 2094	<u>436-35-230(3)</u> 457,555
<u>436-35-010(2)(a)</u> 833,988,1147	<u>436-35-050(2)(b)(B)</u> 567	<u>436-35-110(8)(a)</u> 2094	<u>436-35-230(4)</u> 76,1435
<u>436-35-010(2)(b)</u> 1147	<u>436-35-050(23)</u> 567	<u>436-35-120</u> 59	<u>436-35-230(4)(d)</u> 457,1069
<u>436-35-010(3)</u> 128	<u>436-35-055(4)</u> 2165	<u>436-35-120(1)</u> 2010	<u>436-35-230(5)</u> 1147,1838,2266
<u>436-35-010(6)</u> 59,76,128,219,300, 391,749,958,969, 1018,1114,1435,1452, 1538,1626,1748,2091, 2094,2230,2368,2437	<u>436-35-060(5)</u> 325	<u>436-35-120(2)</u> 1582	<u>436-35-230(5)(b)</u> 457
	<u>436-35-060(7)</u> 325	<u>436-35-120(4)</u> 1179,1582	<u>436-35-230(7)</u> 438
	<u>436-35-070</u> 2437	<u>436-35-190(6)</u> 2091	<u>436-35-230(7)(b)</u> 833
<u>436-35-010(6)(b)</u> 128,147,200	<u>436-35-070(1)</u> 300	<u>436-35-190(8)</u> 2091	<u>436-35-230(7)(c)</u> 833
<u>436-35-010(6)(c)</u> 2010	<u>436-35-075</u> 1626	<u>436-35-200</u> 219	<u>436-35-230(8)</u> 76
<u>436-35-010(7)</u> 1069,1452	<u>436-35-080</u> 105	<u>436-35-200(1)</u> 438	<u>436-35-230(9)</u> 76
<u>436-35-010(8)</u> 39,1452	<u>436-35-080(11)</u> 2010	<u>436-35-200(4)</u> 1156	<u>436-35-230(13)</u> 565,1435
<u>436-35-010(8)(a)</u> 438,1452	<u>436-35-090(1)</u> 1179	<u>436-35-220(1)</u> 76,291,457,1435,1484	<u>436-35-230(13)(d)</u> 155,565,1495

<u>436-35-230(13)(b)</u> 155,565,1495	<u>436-35-270(3)(h)</u> 415,517,854,928,954	<u>436-35-300(2)</u> 415,505,1595	<u>436-35-310(1)-cont.</u> 2232,2261,2284,2293, 2301,2365
<u>436-35-240</u> 59	<u>436-35-270(3)(h)(A)</u> 2172	<u>436-35-300(2)(a)</u> 1288,1480,1544,1595, 1670	<u>436-35-310(1)(a)</u> 186,415,883,1641, 1681,1725,2172,2218, 2293
<u>436-35-240(1)</u> 155	<u>436-35-270(3)(h)(E)</u> 2172	<u>436-35-300(2)(e)</u> 1719	<u>436-35-310(1)(b)</u> 1641,1681,2293
<u>436-35-250(2)</u> 851	<u>436-35-280 thru -310</u> 1544,1584,1595,1670, 1733,2148,2284,2301	<u>436-35-300(3)</u> 415,1641,1670,1681, 1725,2172,2218,2232, 2293,2378	<u>436-35-310(1)(c)</u> 1641,1681,2293
<u>436-35-250(2)(a)</u> 2464	<u>436-35-280</u> 291,400,567,796,1582, 1584,1615,1641,1719, 1794,2232,2261,2284, 2293	<u>436-35-300(3)(a)</u> 59,61,291,400,2148	<u>436-35-310(1)(c)</u> 1641,1681,2293
<u>436-35-250(7)</u> 2288	<u>436-35-280(4)</u> 1480,1544,1582,1584, 1595,1615,1641,1670, 1733,2218,2365,2378	<u>436-35-300(3)(b)</u> 1161	<u>436-35-310(2)</u> 186,280,400,505,539, 1188,1288,1582,1584, 1595,1615,1641,1670, 1681,1733,1794,2148, 2172,2218,2261,2293, 2301,2365
<u>436-35-270 thru -450</u> 186,291,400,415,438, 505,1069	<u>436-35-280(6)</u> 510,539,1480,1544, 1582,1584,1595,1615, 1641,1670,1733,2172, 2218,2365,2378	<u>436-35-300(3)(c)</u> 2232	<u>436-35-310(2)</u> 1288,1480,1544,1670
<u>436-35-270(1)</u> 291,1096,1558	<u>436-35-280(7)</u> 118,510,539,883,1069, 1250,1480,1544,1582, 1584,1595,1615,1641, 1681,1733,2006,2105, 2172,2218,2365,2378	<u>436-35-300(3)(e)</u> 1670,1794,2218,2232, 2284,2293	<u>436-35-310(3)</u> 59,61,510,517,823, 854,883,928,951,954, 1641,1681,2105,2261, 2284,2293,2378
<u>436-35-270(2)</u> 291,506,737,988,1201, 2368	<u>436-35-290</u> 291,1544,1584,1595, 1615,1670	<u>436-35-300(4)</u> 59,291,400,415,833, 1250,1282,1595,1719, 2261,2293	<u>436-35-310(3)(a)</u> 291,2105
<u>436-35-270(3)</u> 291,954,2218,2378	<u>436-35-290(1)</u> 59,2301	<u>436-35-300(4)(c)</u> 1282	<u>436-35-310(3)(b)</u> 291
<u>436-35-270(3)(c)</u> 186,280,400,539,1188, 1595,1670,1733	<u>436-35-290(2)</u> 61,400,415,505,1288, 1595,1794,2261,2284, 2293	<u>436-35-300(4)(d)</u> 1282	<u>436-35-310(3)(c)</u> 1250
<u>436-35-270(3)(d)</u> 510,1595,1733,2148, 2301	<u>436-35-290(2)(a)</u> 1288,1480,1544,1670	<u>436-35-300(4)(e)</u> 61,291,400,1161,1282	<u>436-35-310(3)(d)</u> 291,1161,2105
<u>436-35-270(3)(d)(A)</u> 415	<u>436-35-300</u> 291,1544,1584,1595, 1615	<u>436-35-300(5)</u> 59,61,291,415,1282, 1541,1595,1641,1670, 1719	<u>436-35-310(4)</u> 118,796,2105
<u>436-35-270(3)(d)(B)</u> 415	<u>436-35-300(1)(a)</u> 1719	<u>436-35-300(6)</u> 400,415	<u>436-35-310(4)(c)</u> 1147
<u>436-35-270(3)(d)(C)</u> 415	<u>436-35-300(1)(a)</u> 1719	<u>436-35-310</u> 1480,1544,1582,1584, 1595,1615	<u>436-35-320</u> 1201
<u>436-35-270(3)(e)</u> 951	<u>436-35-300(1)(a)</u> 1719	<u>436-35-310(1)</u> 400,415,854,954, 1544,1582,1584,1641, 1670,1681,1725,1733, 1794,2148,2172,2218,	<u>436-35-320(1)</u> 506,512,1201,2183
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<u>436-35-320(3)</u> 510	<u>436-35-360</u> 1595	<u>436-35-390(7)(b)</u> 2288	<u>436-60-020(4)(c)</u> 348
<u>436-35-320(4)</u> 1069,1147,2006,2183	<u>436-35-360(1)</u> 291	<u>436-35-400</u> 788	<u>436-60-025</u> 926
<u>436-35-320(5)</u> 34,59,260,506,788, 1201,1794,1797,2293, 2368	<u>436-35-360(2)</u> 134,291	<u>436-35-400(4)(b)</u> 2409	<u>436-60-025(4)</u> 926
<u>436-35-320(5)(a)</u> 59,2368	<u>436-35-360(3)</u> 134,291	<u>436-35-400(5)(b)</u> 2261,2409	<u>436-60-025(4)(a)</u> 487,926
<u>436-35-330</u> 291	<u>436-35-360(4)</u> 134,291	<u>436-35-400(5)(b)(B)</u> 788	<u>436-60-025(5)</u> 2506
<u>436-35-330(1)</u> 2172	<u>436-35-360(5)</u> 134,291	<u>436-35-420(1)(a)</u> 400	<u>436-60-025(5)(a)</u> 746,1631,2128,2506
<u>436-35-330(3)</u> 2172	<u>436-35-360(6)</u> 134,1069,2006	<u>436-35-440</u> 438,953	<u>436-60-025(5)(e)</u> 325
<u>436-35-330(5)</u> 2172	<u>436-35-360(7)</u> 61,134,1069,1161, 1595	<u>436-35-440(2)</u> 438,833	<u>436-60-030</u> 629,1197,1869,2481
<u>436-35-330(7)</u> 2172	<u>436-35-360(8)</u> 134,1069,1595	<u>436-35-450(1)(b)</u> 510	<u>436-60-030(1)</u> 192,629,1631,2481
<u>436-35-330(9)</u> 2172	<u>436-35-360(9)</u> 61,134,1069,1595	<u>436-50-030</u> 443,787,1476	<u>436-60-030(2)</u> 83,192,629,1197,1631, 2031,2390,2481
<u>436-35-330(11)</u> 2172	<u>436-35-360(10)</u> 134	<u>436-50-050(1)</u> 477	<u>436-60-030(3)</u> 192,629,2390
<u>436-35-330(13)</u> 2172	<u>436-35-360(11)</u> 134	<u>436-54-225</u> 2481	<u>436-60-030(4)</u> 629,929
<u>436-35-330(14)</u> 2172	<u>436-35-360(19)</u> 1595,2368	<u>436-60-005(2)</u> 192,308	<u>436-60-030(4)(a)</u> 192,629
<u>436-35-330(19)</u> 291	<u>436-35-360(20)</u> 1595,2368	<u>436-60-005(9)</u> 397,552,894,1014, 1557	<u>436-60-030(4)(b)</u> 214,629,2390
<u>436-35-340(1)</u> 893	<u>436-35-360(21)</u> 1595,2368	<u>436-60-017</u> 1194	<u>436-60-030(4)(c)</u> 629
<u>436-35-350(2)</u> 567,1069,1162,2006	<u>436-35-360(22)</u> 1595	<u>436-60-017(1)</u> 1194	<u>436-60-030(5)</u> 308
<u>436-35-350(2)(a)</u> 61,567,1541	<u>436-35-360(23)</u> 61	<u>436-60-017(5)</u> 1194	<u>436-60-030(5)(c)</u> 1121
<u>436-35-350(2)(b)(A)</u> 567	<u>436-35-385(2)</u> 510	<u>436-60-020(3)</u> 348	<u>436-60-030(6)</u> 308,1197
<u>436-35-350(3)</u> 2172	<u>436-35-385(4)</u> 510	<u>436-60-020(4)(a)</u> 348	<u>436-60-030(6)(a)</u> 308
	<u>436-35-390</u> 2288	<u>436-60-020(4)(b)</u> 348	<u>436-60-036(1)</u> 929

<u>436-60-040</u> 1812	<u>436-60-150(3)(e)</u> 811,1221	<u>436-60-180(1)(b)</u> 905	<u>436-120-005(6)(a)</u> 2441
<u>436-60-045(1)</u> 861	<u>436-60-150(4)</u> 1678,2177	<u>436-60-180(1)(c)</u> 905	<u>436-120-005(6)(b)</u> 463
<u>436-60-045(3)</u> 861	<u>436-60-150(4)(e)</u> 47,1221,2044	<u>436-60-180(4)</u> 811	<u>436-120-025</u> 2441
<u>436-60-060(7)</u> 2148	<u>436-60-150(4)(f)</u> 47,290,811,1221,1243, 1678,1768	<u>436-60-180(5)</u> 811	<u>436-120-025(1)</u> 2441
<u>436-60-085</u> 548	<u>436-60-150(4)(i)</u> 6,397,523,552,758, 861,885,894,1014,	<u>436-60-180(6)</u> 905	<u>436-120-025(1)(a)</u> 2441
<u>436-60-090(6)</u> 270	1042,1043,1445,1493, 1557,1747,1779,1781, 2109,2113,2327,2380	<u>436-60-180(7)</u> 72,905	<u>436-120-025(1)(b)</u> 325,2441
<u>436-60-095</u> 548,645	<u>436-60-150(5)</u> 1221,1768,1812,2177	<u>436-60-180(11)</u> 905	<u>436-120-025(1)(c)</u> 2441
<u>436-60-105</u> 348,548	<u>436-60-150(6)</u> 1855,2044,2102	<u>436-60-180(13)</u> 905,1552,2206	<u>436-120-025(2)</u> 2441
<u>436-60-145</u> 810,995,1043,1451, 1494,2139,2395	<u>436-60-150(6)(c)</u> 659,1221,1855,2044, 2102	<u>436-60-190</u> 905	<u>436-120-035</u> 249,508
<u>436-60-145(1)</u> 1043	<u>436-60-150(6)(d)</u> 1678	<u>436-60-190(6)</u> 905	<u>436-120-035(1)</u> 249
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<u>436-60-145(3)(h)</u> 885	<u>436-60-155(1)</u> 2102	<u>436-80-010</u> 1619	<u>436-120-035(1)(b)</u> 249
<u>436-60-145(3)(j)</u> 875	<u>436-60-155(5)</u> 2102	<u>436-80-060</u> 1619	<u>436-120-035(1)(c)</u> 2322
<u>436-60-145(4)</u> 875,894,1493	<u>436-60-160</u> 96	<u>436-80-060(1)</u> 1619	<u>436-120-035(2)</u> 249,2322
<u>436-60-145(4)(a)</u> 995,1781	<u>436-60-170</u> 13	<u>436-80-060(2)</u> 237,846	<u>436-120-035(2)(a)</u> 1054
<u>436-60-145(4)(b)</u> 1779	<u>436-60-180</u> 905,1552,2206	<u>436-80-060(3)</u> 1060,1619	<u>436-120-035(3)</u> 1054,2322
<u>436-60-145(5)</u> 875,1042	<u>436-60-180(1)</u> 905	<u>436-110-042(1)</u> 950	<u>436-120-035(4)</u> 200,1054
<u>436-60-150</u> 1678,2102	<u>436-60-180(1)(a)</u> 905	<u>436-110-042(1)(b)</u> 950	<u>436-120-035(5)</u> 200
<u>436-60-150(1)</u> 659	<u>436-60-180(1)(a)</u> 905	<u>436-120-001 et seq</u> 995	<u>436-120-035(6)</u> 200,1054
<u>436-60-150(2)(e)</u> 47	<u>436-60-180(1)(a)</u> 905	<u>436-120-003</u> 249	<u>436-120-040</u> 325,508,1054,1241, 2322

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<u>436-120-040(3)(a)</u> 479	<u>437-02-1910.147</u> 1308	<u>438-05-055</u> 905	<u>438-06-091(3)</u> 567,1129,2432
<u>436-120-040(3)(c)</u> 2322	<u>437-02-1910.147(a)(1)(i)</u> 1308	<u>438-05-065</u> 1520	<u>438-06-091(4)</u> 567
<u>436-120-040(4)</u> 200,2322	<u>437-02-1910.147(a)(1)(ii)</u> 1308	<u>438-06-011(4)</u> 1662	<u>438-06-095(1)</u> 1607
<u>436-120-040(7)</u> 463,600	<u>437-02-1910.147(a)(1)(ii)(B)</u> 1308	<u>438-06-031</u> 328,905,967,1457, 1668,1754,2270,2328	<u>438-06-095(2)</u> 1607,1717
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<u>436-120-045(3)</u> 463,600	<u>437-02-1910.269</u> 1308	<u>438-06-038</u> 869,1060,1619,2323	<u>438-06-105(1)</u> 1069
<u>436-120-045(7)</u> 1166	<u>438-05-011</u> 1194	<u>438-06-045</u> 783,1520	<u>438-07-005(2)</u> 2042
<u>436-120-050</u> 950,1889	<u>438-05-035</u> 2086	<u>438-06-071</u> 333,802,1778	<u>438-07-015</u> 348,358,824,1132, 1341,1607,1690,2312
<u>436-120-050(3)</u> 1889	<u>438-05-040(10)</u> 1861	<u>438-06-071(1)</u> 158,270,1262	<u>438-07-015(1)</u> 2093
<u>436-120-055</u> 508	<u>438-05-046(1)(b)</u> 92,156,659,1520,1629, 1696,1757,2097	<u>438-06-071(2)</u> 333,1523	<u>438-07-015(2)</u> 272,366,1132,1136, 1194,1341,1561
<u>436-120-055(1)</u> 325	<u>438-05-046(1)(c)</u> 376,1517,2065,2114	<u>438-06-072(2)</u> 724	<u>438-07-015(3)</u> 1642
<u>436-120-055(2)</u> 325	<u>438-05-046(2)(a)</u> 939,1442	<u>438-06-075</u> 1454	<u>438-07-015(4)</u> 824,1132,1642
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<u>436-120-210(1)</u> 950	<u>438-05-053</u> 905,2478	<u>438-06-081</u> 333,567,724,802,1497, 1523,1662,1802,2164	<u>438-07-017</u> 366,543,1116,1341, 1561
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<u>438-07-018(4)</u> 207,824,1642,2312	<u>438-09-020(2)(b)</u> 861,1445,1781,2113	<u>438-12-020</u> 1264	86,93,95,96,97,112, 116,120,124,134,137, 140,141,145,151,170, 183,187,198,200,203, 213,216,225,230,232, 235,237,246,267,268, 272,281,282,288,295, 298,299,308,313,328, 330,332,341,342,344, 345,346,355,357,361, 366,376,379,383,385, 388,405,410,415,417, 431,435,443,444,446, 449,453,462,474,477, 487,488,491,492,499, 500,504,510,518,519, 526,528,533,538,546, 548,563,566,567,572, 573,715,716,719,725, 728,738,741,743,748, 748,749,754,755,757, 759,763,780,783,787, 789,792,805,811,820, 821,827,832,838,847, 849,854,865,878,889, 890,891,896,898,932, 936,937,940,942,943, 948,959,960,963,974, 983,985,987,988,994, 1007,1009,1010,1016, 1021,1031,1047,1057, 1067,1073,1074,1076, 1081,1085,1093,1097, 1115,1116,1119,1121, 1123,1127,1129,1132, 1136,1140,1145,1152, 1156,1165,1173,1175, 1178,1179,1181,1188, 1208,1215,1219,1224, 1234,1246,1257,1261, 1266,1268,1271,1278, 1285,1440,1442,1448, 1457,1462,1467,1469, 1471,1477,1482,1495, 1497,1499,1501,1502, 1515,1521,1525,1528, 1529,1532,1536,1541, 1562,1563,1567,1568, 1570,1582,1584,1593, 1601,1604,1606,1617, 1622,1628,1633,1636, 1647,1652,1660,1666, 1668,1676,1680,1686, 1689,1692,1701,1702, 1708,1709,1712,1715, 1716,1718,1724,1733,
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